NHS
Manchester University
NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS' MEETING

Meeting Date: 11th March 2019

(Held in Public)

43/19 Apologies for Absence

Apologies were received from

44/19 Declarations of Interest

There were no declarations of interest received for this meeting.

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

45/19 Patient Story – 'What Matters to Me'

The Group 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

46/19 Minutes of the Board of Directors Meeting held on 14th January 2019

The minutes of the meeting held on the 14th January 2019 were agreed as a correct record.

47/19 Matters Arising

The Board reviewed the actions from the Board of Directors meeting 14th January 2019 and noted progress.

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

48/19 Group Chairman's Report

i). The Group Chairman reported that the MFT Excellence Awards had been successfully held on 8th March 2019 with over 500 attending. She thanked the Communications & OD teams for their oversight over many months leading up to the event and also on the night itself. The Group Chairman was also pleased to report that the Manchester Health Academy was involved with the MFT Awards for the first time with the Principal, Kevin Green, presenting an award to one of his Staff in the Academy. On behalf of the Board of Directors, the Group Chairman wished to thank everyone who attended and especially the Winners of the various categories.

ii). The Group Chairman reported that she had recently chaired an excellent *Transform Together Shared Learning Event* with a particular focus on patient care and experience.

iii). The Board noted that a Workshop focused on the MFT Clinical Service Strategy Programme and especially the Wave 2 Clinical Specialities/MCS had been held with MFT Governors the previous week. The Group Chairman thanked Governors who attended and explained that similar events will follow over the coming months.

iv). The Group Chairman invited the Group Chief Nurse to report on MFT's first group of Nursing Associates who had recently registered with the NMC and were paving the way for the new role. It was noted that the new Nursing Associates would provide a vital and most welcome contribution to ensuring patient's receive the best possible care.

v). The Group Chairman congratulated the Manchester Royal Eye Hospital team for their nomination in this year's Health Service Journal (HSJ) Partnership Awards. It was noted that the team had been shortlisted in the *Best Pharmaceutical Partnership* category for innovating the delivery and capacity expansion of macular services. It was also noted that winners would be announced on 20th March 2019.

vi). The Group Chairman congratulated the MFT Stroke services who had been awarded a Quality Improvement Champion Award by the Sentinel, Stroke National Audit Programme (SSNAP).

vii). The Group Chairman announced that it was with great sadness that colleagues had learnt earlier in February that one of the former CMFT's Medical Directors and dear friend, Professor Malcolm Chiswick, had passed away. The Board of Directors recalled that Professor Chiswick had been a Pioneer of Neonatal Intensive Care & Special Care in the UK and spent 30 years as a Consultant Neonatologist & General Paediatrician caring for newborn babies on the Neonatal Intensive Care Unit which he established at Saint Mary's Hospital. The Group Chairman also recalled that Professor Chiswick was a founder member of the British Association of Perinatal Medicine (BAPM) and its President from 2002 – 2005. He also became the Clinical Director of SMH and later, the Medical Director of the former CMFT for four years until his retirement in 2006. The Board was reminded that Professor Chiswick was also elected as a Public Governor on the Council of Governors of the former CMFT in 2008 until 2015 and was also elected (and re-elected) as CMFT's Lead Governor between 2009 and 2013.

The Group Chairman confirmed that a Memorial Service was being held for Professor Chiswick on the same afternoon as the MFT Board of Directors (11.03.19) at Dunham Crematorium (Altrincham). She also confirmed that representatives of the MFT Board of Directors, along with Professor Chiswick's many friends and former colleagues from across the Trust, were in attendance.

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

49/19 Group Chief Executive's Report

i). The Group Chief Executive wished to echo the Group Chairman's comments and thank you following the MFT Excellence Awards held the previous Friday evening. He explained that it was a truly inspirational event.

ii). The Group Chief Executive provided a brief overview of the national changes vis-à-vis NHS I/E and especially in the context of the recently published NHS Long Term Plan (with further insight captured under Agenda Item 51/19).

iii). The Group Chief Executive reported that the 2018 Staff Survey results had been recently published by the Survey National Co-ordination (NCC). He explained that overall, MFT's staff survey scores had improved on the 2017 position (with further insight captured under Agenda Item 52/19).

iv). The Board noted that the NW Genomics Laboratory Hub (hosted by MFT) had recently appointed the following individuals to its leadership team - Professor Graeme Black (as Scientific and Academic Director); Dr Lorraine Gaunt (as Scientific Operations Director); and, Dr Lynn Greenhalgh (as Medical Director).

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

50/19 Operational Performance

Board Assurance Report

The Joint Group Medical Director was pleased to report that there had not been a 'Never Event' (NE) reported throughout the Trust for 6 months (August 2018) and that it had been agreed at the most recent Group Risk Management Committee to downgrade the NE High Level Risk from a Level 16 to a Level 12. It was also noted that the Mortality Metrics at Group level continued to be within accepted performance level and improving over time and the Trust's Mortality Review procedures were currently under review and awaiting National guidance before finalising.

The Group Chief Nurse reported that she would provide an update on Complaints performance within the Trust under Agenda Item No. 52/19 (later on the agenda). She also confirmed that infection prevention and control remained a priority for the Trust and that the total number of attributable bacteraemias in January 2019 was 13, increasing from 10 in December 2018. The Group Chief Nurse was pleased to report that C. difficile lapses in care remained below the Trust's threshold with 31 cases since April 2018 compared to a year to date threshold of 85 cases.

The Group Chief Operating Officer reported that the Trust's performance against the Diagnostic performance standard in January 2019 was 2.3% which was better than the national picture of 3.3% (December). She explained that ongoing demand pressures, for MRI scans, coupled with workforce challenges in CSS and Adult Endoscopy, had continued as a risk to recovery in January and into Q4 (2018/19). It was noted that the 'Intensive Support Team' had recently been assisting the MRI to scope available capacity to meet anticipated heightened demand in 2019/20.

The Group Chief Operating Officer reported that the Trust's A&E 4 hours performance was 81.93% in January, 82.4% in February and currently >86% in March 2019 (MFT 2nd in GM). It was noted that whilst the Trust was focused on improvement work streams for 'Wait to be Seen' (WTBS) breaches at Wythenshawe and 'Minors' breaches at the Manchester Royal Infirmary (MRI), it was also recognised that there was heightened Emergency/Urgent Care demand and pressures experienced in Saint Mary's Hospital (SMH), the Manchester Royal Eye Hospital (MREH), and, the Royal Manchester Children's Hospital (RMCH). The Group Chief Operating Officer also reported that the Trust's close working relationship with system partners relating to additional winter funding for adult social care, reductions in long length of stay patients and Joint working with GMMH, had resulted in a 23% reduction in Mental health breaches at MRI compared to the same period in 2017.

The Board noted the Trust's RTT reported performance of 87.8% in January 2019 which reflected tactical actions taken for closed pathways. The Group Chief Operating Officer explained that the Trust had seen an increase in the RTT waiting list and that the national focus for 2018/19 was to maintain the waiting list size in March 2019 compared to the previous year. She went on to explain that the Trust was taking additional action in Q4 (2018/19), working with Commissioners on securing additional activity and demand management. It was also noted that at the end of January 2019, there remained a total of fifteen 52+ weeks patients waiting for *'Deep Inferior Epigastric Perforators'* (DIEP) procedures at Wythenshawe Hospital which was in line with the Trust's agreed trajectory (a reduction from a total of 300 patients waiting 52+ weeks during Summer 2018).

The Group Chief Operating Officer confirmed that performance against the cancer standard was challenged in the MRI and SMH, with strong performance at WTWA (Wythenshawe, Trafford, Withington & Altrincham). It was reported that the Trust's position was 80.52% against the 85% standard for Q3 (2018/19), with the greatest pressures in Urology and GI. It was noted that a task force with MRI, CSS (Clinical Scientific Services) and the corporate performance team had been established to focus on improving timeliness of pathways, with MRI and CSS taking action to improve capacity. Furthermore, it was reported that an exceptional meeting of the Trust Cancer Committee took place in January 2019 to bring clinical teams together to review the cancer pathways and best practice.

In response to questions from Dr Benett, it was agreed to provide a more detailed update on cancelled operations to the Quality and Performance Scrutiny Committee in June 2019.

The Executive Director of Workforce & OD reported that 'Attendance' performance throughout the Trust was disappointing. She explained that the latest figures released by NHS Digital showed that for October 2018, the monthly NHS staff sickness absence for the whole of the North West HEE region was 5.00% (these figures included all provider organisations and commissioners) and that MFTs performance for the same period was 5.2%. It was noted that performance in the North West was significantly below that of the South East sector. It was further noted that work was underway to ensure Health & Wellbeing (HWB) initiatives were focussed in areas where the biggest improvements could be achieved and the HWB programme for 2019/20 was currently in development.

The Executive Director of Workforce & OD highlighted the Trust's 'Appraisal' performance (against a target of 90%) in February 2019 and explained that Medical Appraisal was 91.2% and Non-Medical was 84.4%. It was noted that Appraisal Reports continued to be forwarded to Hospital HR Directors to support their management teams in planning appraisal activity to redress the negative trend for Non-Medical Appraisals. It was also noted that the new Appraisal policy was on target to be implemented from 1st April 2019.

The Group Chief Finance Officer reported that an update on the Trust's financial position would be presented under Agenda Item No. 50/19 (later on the agenda).

The Group Executive Director of Strategy reported that the Trust was in the process of developing its Clinical Service Strategy, and, the development of Annual Plans for 2019/20 was also underway. He explained that a further update would be presented under Agenda Item No. 51/19 (later on the agenda).

The Board Assurance Report was noted

Decision:	Report Noted Refinements to the cancelled operations dataset to be presented to the QPSC	**Action by:** Group Chief Operating Officer	**Date:** June 2019

Progress Report on the Single Hospital Service

The Director Single Hospital Service provided an updated on the Single Hospital Service (SHS) Programme. He reminded the Board that the proposal to establish the SHS in Manchester was a key element of the Manchester Locality Plan and that the Programme was being delivered through two connected projects, namely, Project One (the programme of integration activity following the creation of MFT through a merger of two NHS Foundation Trusts on 1st October 2017), and, Project Two (the proposed acquisition and transfer of North Manchester General Hospital into MFT from Pennine Acute Hospital NHS Trust).

The Board noted the overview of Project One which had a particular focus on integration activity (supported by a robust governance framework) with increasing emphasis on the more complex programmes of work aimed at harmonising patient pathways.

The Director Single Hospital Service explained that in order to support the robust integration planning for 'Year 2' post-merger (and beyond), the Post Transaction Integration Plan (PTIP) had been updated to reflect the position at one year post merger. He reminded the Board of the background and function of the PTIP with a particular emphasis on providing an overview of the management and delivery arrangements, including the progress monitoring and risk management process, in addition to the approach taken to benefits management. He explained that the PTIP now presented would be the final iteration relating to the merger since work streams would increasingly continue to the deliver their integration benefits through 'business as usual' processes overseen by the relevant Group Executive Director, or, Hospital/Managed Clinical Service Chief Executive.

In response to a question from Dr Benett, the Director Single Hospital Service confirmed that all key integration workstreams expected in Year 1 had been successfully delivered (as previously reported in the 'One Year Post-Merger Report' – November 2018).

The Board also noted accountability framework for the delivery of a series of measureable patient benefits outlined in the Manchester Investment Agreement. The Director Single Hospital Service confirmed that the latest return to the Greater Manchester Health and Social Care Partnership (GMH&SCP) was made on 1st February 2019 and MFT had reported compliance with the metrics that were currently monitored.

The Director Single Hospital Service also provided an overview of Project 2 and confirmed that MFT continued to progress the proposed transaction to acquire NMGH from PAHT as part of an overall plan to dissolve PAHT and transfer the remaining hospital sites to Salford Royal NHS Foundation Trust (SRFT).

The Board noted that as previously reported, a strategic case relating to the proposed acquisition of NMGH was continuing to be developed in line with NHSI's regulatory framework and guidance governing transactions. The Director Single Hospital Service explained that despite progress with the development of the strategic case, there remained a number of significant challenges to address in relation to the acquisition of NMGH, including the condition of the NMGH estate and the financial investment that would be required to remediate this and support the safe transfer of NMGH to MFT. He confirmed that the Group Executive Directors were attentive to these issues as part of the preparation of the strategic case.

It was noted that regular updates were being presented to the MFT Council of Governors, the Manchester Health and Wellbeing Board, and, the Manchester Health Scrutiny Committee.

In conclusion, the Board was advised that the post-merger integration work to realise patient benefits and ensure that the new Trust was operating efficiently and effectively was progressing well. The Board also noted that the PTIP had recently updated to reflect the position at one year post-merger and the MFT Integration Steering Group would continue to maintain oversight of the breadth of the integration programme.

The Board also agreed that MFT would remain committed to fully establishing the Manchester Single Hospital Service by transferring NMGH to MFT and that in order to enable this, MFT would progress the development of a strategic case and continue to engage with all key stakeholder, in particular, with GMH&SCP and NHS I in their roles to oversee the plan to dissolve PAHT.

The Board of Directors noted the content of the Progress Report as presented

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

Group Chief Finance Officer's Report

The Group Chief Finance Officer presented a summary overview of his Month 10 report.

It was noted that performance for the ten months to January 2019 was a bottom line deficit (on a control total basis excluding Provider Sustainability Fund) of £9.8m (0.7% of operating income). The Group Chief Finance Officer explained that the Trust delivered a surplus in January consistent with the plan submitted to NHS Improvement and this was underpinned by an improved performance across many of the Hospital financial results. It was recognised that this needed to be sustained into the final two months of the year in order to achieve the Trust's control total.

In response to questions from Mr Clare, the Group Chief Finance Officer explained that Hospitals/MCSs had taken specific further actions at the start of the fourth quarter, to build upon the recovery and improvement trajectories which were committed to in October (2018) for the third quarter and secure stronger, more consistent delivery of the required results. It was also noted that whilst there had been some 'one-off' non-recurrent benefits secured in January 2019, the focus was on supporting the Hospitals/MCS in the delivery of a sustained cumulative position going forward into 2019/20 (and beyond).

The Board noted that a further 'deep dive' into the Month 11 position at Hospital/MCS Level, alongside a review of the 2019/20 MFT Financial Plan, would be undertaken at the next Finance Scrutiny Committee on 13th March 2019.

The Chief Finance Officer's Month 10 Report was noted.

Decision:	Month 10 Report Noted	**Action by:** n/a	**Date:** n/a

51/19 Strategic Review

Update on Key Strategic Developments

The Group Executive Director of Strategy provided an update in relation to strategic issues of relevance to the Trust. He described the approach and process adopted within the Trust following the publication of the NHSE and NHSI Planning Guidelines in early January for the 2019/20 Operational Plan submissions. It was confirmed that the draft narrative had been successfully submitted on 12th February 2019 and the Trust was now awaiting any feedback from NHS I (with the final versions required for submission 4th April 2019).

The Board noted NHS England's plans for the integration of specialised services with local health and care systems. The Board was also reminded that with the current legislative framework, NHSE retained formal responsibility for the commissioning of specialised services. However, it was explained that NHSE had identified three options which were possible within the current legislative framework to support better integration of specialised commissioning with local systems. The options were noted by the Board as presented in the report. The Group Executive Director of Strategy explained that the Trust was currently awaiting further information from NHSE in the form of 'readiness criteria' to determine whether systems should pursue these advanced arrangements, and would need to work through how this could affect services across the North West and Greater Manchester.

The Board received an overview on a range of Greater Manchester related strategic issues including the 'Improving Specialist Care Programme', and, the 'One Manchester' PET CT project.

At a more local level, the Group Executive Director of Strategy described progress with the MFT Service Strategy development programme. He explained that following approval of the overarching Group Service Strategy by the Board of Directors in November 2018, the Trust was now seeking the views of external stakeholders, in particular commissioners and those involved in its development. It was also noted that internally, communications were being cascaded through the usual engagement mechanisms such as MFT iNews and Hospital / MCS staff forums. The Board was advised that the Service Strategy document would remain a 'live' working document until completion of Waves 2 and 3, and the Managed Clinical Services (MCS) strategies so that it could be updated to reflect any feedback received and to capture the outputs from the whole programme.

The Group Executive Director of Strategy also described progress in developing the Clinical Service Strategies (Waves 1, 2 and 3). He confirmed that the Wave 1 clinical service strategies were reviewed by the Board in February 2019 and Wave 2 were now complete and were progressing through the approval process. It was also noted that the Wave 3 clinical strategy programme had commenced and was planned to conclude in May 2019, with presentation to the Board in July 2019.

The Board was advised that development of the strategies for the Managed Clinical Services (Children's, Saint Mary's, Eye and Dental) was on-going and that they were planned to be completed by mid-April 2019 and presented to the Board of Directors in May 2019.

In response to observations and questions from Mrs McLoughlin and Mr Gower, the Group Executive Director of Strategy confirmed that MFT had received confirmation that it had been chosen as the preferred provider for Trafford Community Services following an external tender process. It was noted that MFT had been chosen as the preferred provider following a meeting of the Trafford procurement moderation panel in December 2018 and that a due diligence process was now underway.

The Board noted the update report as presented.

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

Approve Delegated Authority to 'Sign-off' the MFT Operational Plan (2019/20) to the Group Chairman & Group CEO

The Group Executive Director of Strategy presented a report which provided an update in relation to the NHSI/E Operational Plan for 2019/20 and requested approval for delegated sign- off by the Chair and Chief Executive.

The Board noted the background to the 2019/20 NHS I/E requirements for an MFT level operational plan along with the key headlines captured in what was regarded as a very technical document and not the MFT Annual Plan. It was confirmed that the financial, activity and performance, workforce and triangulation templates were completed by the Group Finance Department and approved by the Finance Scrutiny Committee (on behalf of the Board of Directors).

The Group Executive Director of Strategy provided a summary overview of the Operational Plan narrative requirements presented in the report. It was noted that following submission of the draft MFT Operational Plan narrative to NHSI/E on 12th February 2019 and receipt of feedback (expected by 29th March 2019), an updated version of the narrative, which would reflect any feedback received and further work to ensure that a consistent narrative flowed through the document, would be completed by 1st April 2019 in line with submission on 4th April 2019.

The Group Executive Director of Strategy explained that as the next meeting of the Board of Directors was not until the 8th April 2019, the Board was requested to approve delegated authority for the 'sign-off' of the plan to the Group Chairman and Group Chief Executive in order to meet the NHSI deadline.

In conclusion, the Board of Directors noted the draft Operational Plan narrative submitted to NHSI/E on 12th February 2019 along with the further work to be undertaken and approved the request for delegated authority for the 'sign-off' of the plan to the Group Chairman and Group Chief Executive.

Decision:	Report Noted Approval of delegated authority for the 'sign-off' of the MFT Operational Plan (2019/20) to the Group Chairman and Group Chief Executive.	**Action by:** n/a	**Date:** n/a

Update Report on the Manchester Local Care Organisation (MLCO)

The Chief Executive of the MLCO presented a summary overview of a report which provided a more detailed update from the MLCO (following its first 12 months operation) under the key headlines of system resilience and escalation; new care models; development at neighbourhood level; adult social care improvement programme; engagement; MLCO business plan and phase 2; and, MFT Scrutiny.

In response to questions from Mr Gower, Dr Benett & Mrs McLoughlin, particular attention was drawn to a number of key priority areas for 2018/19 including the development of Integrated Neighbourhood Teams; the Manchester Community Response seven-day service (Crisis Response & Discharge 2 Assess); and, High Impact Primary Care. It was noted that the MLCO was currently working to finalise its neighbourhood operating model, neighbourhood governance arrangements, and accountability and assurance arrangements.

The Chief Executive of the MLCO reported that a series of drop in sessions had taken place in February 2019 for elected members to meet with the MLCO Executive, understand the progress of MLCO to date and priorities for the coming year.

It was reported that the activity of the MLCO in 2018/19 was defined by its Business Plan and the work which was undertaken in collaboration with MHCC that defined a core set of deliverables. The Chief Executive of the MLCO explained that both these documents remained valid and provided the framework for all MLCO activity, although it should be recognised that additional programmes of work and priorities had emerged throughout the course of year, notably the work to support an expedition of the transfer of care for patients with significant lengths of stay in MRI.

The Chief Executive of the MLCO went on to explain that in order to support the development of MLCO into 2019/20, including the business planning process, a series of 'road maps' (agreed by the MLCO Partnership Board) were in the process of being developed to support further integration (with the key headlines noted by the Board as presented in the report).

The Board was reminded that the MLCO would realise its full potential in a three year phased approach as set out in the Partnering Agreement and that the majority of services that were transferred in year one were community health services (including North Manchester Community Health Services) and directly provided Adult Social Care.

The Chief Executive of the MLCO explained that Year Two would see a range of other services move under the management of MLCO including a host of commissioned services such as Home Care and Residential and Nursing Care. He also reported that work was ongoing, led by Manchester Health and Care Commissioning, to define the approach to be taken to support the further development of MLCO.

In response to observations by Mr Rees, it was confirmed that MFT's oversight of MLCO was undertaken by the MLCO Scrutiny Committee chaired by the Group Chairman with a focus on key areas such as 'Winter resilience and system escalation'; 'High Impact Primary Care'; and, 'Neighbourhood Target Operating Model'.

The Board noted the contents of the report as presented.

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

52/19 Governance

Safer Staffing Bi-Annual Report

The Group Chief Nurse presented the bi-annual, comprehensive report which detailed the Trust position against the requirements of the National Institute of Health and Care Excellence (NICE) guidance for adult wards issued in July 2014, the National Quality Board (NQB) Safer Staffing Guidance 20162, NQB Speciality Staffing Improvement Guidance 20183 and the NHS Improvement (NHSI) Developing Workforce Safeguards Guidance, published in October 2018.

The Board noted that the provided analysis of the Trust workforce position at the end of December 2018 and the actions being taken to mitigate and reduce the vacancy position, specifically within the staff nurse and midwifery band 5 and 6 workforce.
The Group Chief Nurse explained that a workforce modelling exercise had been undertaken to present the information by Hospitals and Managed Clinical Services (MCS) and the Hospital/MCS Directors of Nursing and the Director of Health Care Professionals (HCP) were required to present a quarterly Nursing/Midwifery workforce report to their Hospital/MCS Board.

The Board particularly noted that the report outlined the continuing challenges in relation to Nursing and Midwifery staffing and that whilst the Trust had experienced an improving Nursing and Midwifery workforce position since August 2018, it was nevertheless recognised that work was still required to reduce the number of nursing and midwifery vacancies. It was also recognised that whilst there were Nursing and Midwifery staffing challenges nationally, it was widely accepted that retention of staff would need to be a key focus on future workforce planning.

In response to questions from Mr Rees & Professor Bailey, the Group Chief Nurse described the introduction, where appropriate, of new roles such as the Nursing Associate, enhanced, advanced and consultant roles which were welcomed by the Trust to improve career opportunities and specifically retention.

The Board noted the position of individual Hospitals/MCS's within the Group and recognised that areas with high vacancies were deemed a priority for recruitment and retention and the opportunity to look to create new roles and ways of working had been presented by developing the role of the Nursing Associate in these areas.

The Group Chief Nurse confirmed that the Trust was working in partnership with NHS Professionals who managed the Trust Bank responding to the Trust temporary staffing demands. She explained that this mitigated concerns in relation to safe staffing of the clinical areas and meeting patient care needs. It was also reported that across the Trust, each Hospital/MCS had established a workforce plan together with a retention strategy.

The Group Chief Nurse explained that in January 2019, a Retention Workshop was held with the Hospital/MCS Directors of Nursing, Midwifery, HCP and HR to agree a programme of work to improve nursing and midwifery retention. Details of the programme work streams were noted and it was confirmed that progress on these work streams would be reported to the Hospital/MCS Management Boards by the Directors of Nursing, Midwifery, HCP and HR. It was also confirmed that an update on this work would be provided to the HR Scrutiny Committee in June 2019 and the Board of Directors in September 2019.

The Board received the Bi-Annual Report and noted progress of the work undertaken to address the Nursing and Midwifery vacancy position across the Group

Decision:	Bi-Annual Report Noted Progress Report on the Nursing and Midwifery Retention Programme Work Streams to be presented to the Board	**Action by:** Group Chief Nurse	**Date:** September 2019

QuaReport on the Quarter 3 Complaints Report (2019/20)

The Group Chief Nurse presented an overview of the Quarter 3, 2018/19 complaints report for MFT, covering the period 1st October 2018 – 31st December 2018.

The Board was advised that during Quarter 3 (2018/19), work continued to integrate the Trust's complaints functions and develop a single set of performance metrics. The Group Chief Nurse explained that this had enabled comparisons to be made between the Hospitals/Managed Clinical Services (MCS)/ Manchester Local Care Organisation (MLCO) across the Group. She also explained that an integral part of the integration had involved the reporting alignment of formal complaints and PALS concerns to Hospitals/ MCS and the MLCO for services they managed and based on this reporting alignment, the Quarter 3 report provided more detailed analysis at Hospital/ MCS/ MLCO level than previous reports.

The Group Chief Nurse confirmed that a progress report on the effectiveness of recording 'Compliments' as a quality indicator had been presented to the Quality & Performance Scrutiny Committee for discussion on 5th February 2019 and it was agreed that the receipt of formal compliments through the Chief Executive office were not an assurance measure in themselves; only when considered alongside other patient experience measures and therefore would not be included in future assurance reports.

The Board noted the detail captured within the Quarter 3 (2018/19) complaints report as presented along with the on-going work of the corporate teams and the Hospital/ MCS and MLCO teams to ensure that the Trust was responsive to concerns raised and learnt from patient feedback in order to continuously improve the patient's experience.

It was also noted that the Trust would continue to monitor complaint response timescales against expected response timescales; continue to offer Corporate Nursing Support to Hospitals/ MCSs/ MLCO where performance was deteriorating; continue to review and embed recommendations within MFT's policies from National Guidance, including the recently published 'Ombudsman's Clinical Standard' and *'Complaints about the NHS in England (Quarter 1 – 2018/2019)'*; and, continue to progress the improvements as outlined in the report presented.

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

Report on the Staff Survey

The Group Executive Director of Workforce & OD provided an overview of the 2018 national Staff Survey results. She explained that the purpose was to provide the Board of Directors with detail on the Group level results and a summary of the results for Hospitals, Managed Clinical Services (MCS), Manchester Local Care Organisation (MLCO), Research and Innovation (R & I) and Corporate teams. It was also noted that the report included a review of progress towards delivering the action plan agreed following the 2017 survey.

The Board was reminded that the staff survey was the Trust's primary method by which organisational culture was measured and included how well led and how led are staff and whether they felt sufficiently supported to enable them to fulfil their potential (best described as staff experience). The Board was also reminded that the culture MFT sought to create was described in the MFT Leadership and Culture Strategy and was aimed at developing a compassionate, inclusive and high quality care culture that was underpinned by exemplary leadership and ensured the best outcomes for people; improving the health of the local population.

The Group Executive Director of Workforce & OD explained that the 2018 NHS Staff Survey results were based on staff in post and organisational structures as at 1st September 2018. She pointed out that the 2018 survey was the first to be reported nationally as Manchester University NHS Foundation Trust with 7,037 MFT staff responding to the survey.

The Board noted that MFT received two reports, namely, a national one issued by the Survey Co-ordination Centre (SCC) that was published and available for public scrutiny and provided some benchmark data alongside a private report issued by Quality Health. The Group Executive Director of Workforce & OD explained that the latter provided a more detailed report on MFT's own results but did not provide national benchmark data. The Board also noted that both reports were referred to in the report as presented.

It was noted that whilst detailed review of the 2018 national Staff Survey results would be undertaken at the HR Scrutiny Committee, particular attention was drawn to the workforce Group-level actions planned for 2019-20 that would address the priority areas for improvement identified by staff in the survey. It was recognised that this would further build on existing strengths outlined in MFT's Workforce Strategy & Implementation Plan, Leadership & Culture Strategy and soon to be launched, ED&I Strategy.

In response to questions from the Group Chairman and Mr Rees, the Group Executive Director of Workforce & OD confirmed that Hospital and MCS specific actions were outlined in the Annual Plans for each and were aligned to the Group plans. She also explained that for 2019, the priority areas for improvement would be Staff Engagement (particularly supporting staff to implement improvements); Quality of Appraisals; Quality of Care; Immediate Managers; Health and Well-being; and, Equality, Diversity & Inclusion. The Board noted that the aim was to focus on the key themes with the aim to achieving 'above average' against MFT's benchmark group.

The Board of Directors noted the strengths, improvements and areas for development outlined in the report and agreed the priority areas for action as set out with a mid-year review of progress against these actions to be undertaken by the HR Scrutiny Committee.

Decision:	Report Noted Priority areas for action from the 2018 National Staff Survey to receive a mid-year review of progress against agreed actions by the HR Scrutiny Committee.	**Action by:** Group Executive Director of Workforce & Corporate Business	**Date:** October 2019

Report on the 'Getting it Right First Time' (GIRFT) Programme

The Joint Group Medical Director presented an overview of the 'Getting it Right First Time' (GIRFT) Programme which is a national programme designed to improve medical care within the NHS by reducing unwarranted variations, by sharing best practice between Trusts, by identifying changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.

The Board was advised that the national programme was made-up of a series of 35 medical work streams, each led by a prominent clinician chosen from the specialty they were reviewing. It was explained that each clinician headed a project to compile a data and insight driven report into their specialty, combining publicly available information, including Hospital Episode Statistics (HES), other relevant registry or professional body data, and the results of a questionnaire issued to all the Trusts being reviewed.

The Joint Group Medical Director explained that the report looked at a wide range of factors, from length of stay to patient mortality, and individual service costs through to overall budgets. She also pointed out that MFT had been recognised as an exemplar site for how it was managing the GIRFT information and using it to drive improvements and a case study was being written by the Regional Team.

The Board was informed that the oversight of the GIRFT programme in MFT was via the Clinical Advisory Committee (CAC) chaired by the Joint Group Medical Director. It was also noted that Medical Directors provided oversight within each Hospital / Managed Clinical Service and the Group Transformation Team had a role as conduit between internal specialty teams and the national and regional GIRFT teams, leading on reporting to the Clinical Advisory Committee and facilitating specialty visits and other events as appropriate.

The Joint Group Medical Director described Trust visits and programme of engagement and it was particularly noted that specialty reviews had initially started with surgical specialties and had recently transitioned into medical specialties and the Trust's new standard was that joint visits (e.g. MRI/Wythenshawe) would take place as the norm.

In response to questions from Mr Gower around harmonisation with the Quality & Transformation agendas, the Joint Group Medical Director emphasised that the success of the GIRFT programme would ultimately be driven by embedding the process into 'business as usual'. It was noted that Hospitals and Managed Clinical Services were not using the GIRFT information in isolation but GIRFT, along with model hospital data and benchmark data, was being used to support the integration agenda and drive improvements with a number of benefits reported to date.

The Board of Directors noted the report on how GIRFT was being adopted and embraced within MFT with examples of benefits to date.

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

2018/19 MFT Board Assurance Framework (BAF) and Proposed New 2019/20 BAF Format

The full Board of Directors received and noted the 2018/19 MFT Board Assurance Framework (BAF).

The Group Executive Director of Workforce & OD explained that following a developmental review of Leadership & Governance arrangements using the Well Led framework during the Summer 2018, a Task & Finish Group consisting of Group Non-Executive Directors and Group Corporate Directors had been convened during the Autumn 2018 to refine the format, content and operational effectiveness of the current MFT BAF.

The Board also noted that Internal Audit also completed a review of the current MFT BAF in October 2018 and identified areas of good practice alongside areas where further refinements could be considered. The Board was advised that Internal Audit had graded the arrangements currently in place in relation to the MFT BAF as providing the Trust with "*significant assurance with minor improvement opportunities*."

The Board ratified the proposed refinements to the existing BAF which had been approved by the Audit Committee in February 2019. It was also agreed that the new BAF would be introduced during Quarter 1 2019/20 (along with bespoke training and awareness sessions for 'Risk Owners') and received by the Board of Directors at the next meeting in May 2019.

Decision:	BAF (2018/19) Received by the Board Refinements to the BAF format ratified and the new BAF (2019/20) to be received by the Board at the next meeting.	**Action by:** Group Executive Director of Workforce & Corporate Business	**Date:** May 2019

Committee meetings which had taken place:

- Group Risk Management Committee held on 21st January 2019
- Audit Committee held on 6th February 2019
- Finance Scrutiny Committee on 23rd January 2019
- Quality & Performance Scrutiny Committee on 5th February 2019
- MLCO Scrutiny Committee held on 22nd January 2019
- HR Scrutiny Committee held on 19th February 2019

53/19 Date and Time of Next Meeting

The next meeting of the Board of Directors held in public will be on **Monday 13th May 2019** at **2pm** in the **Main Boardroom**

54/19 Any Other Business

There was no other business.

Present:	Mr J Amaechi	- Group Non-Executive Director
	Professor Dame S Bailey	- Group Non-Executive Director
	Mr D Banks	- Group Director of Strategy
	Dr I Benett	- Group Non-Executive Director
	Mrs J Bridgewater	- Group Chief Operating Officer
	Mrs K Cowell (Chair)	- Group Chairman
	Mr B Clare	- Group Deputy Chairman
	Sir M Deegan	- Group Chief Executive
	Professor J Eddleston	- Joint Group Medical Director
	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
	Professor C Lenney	- Group Chief Nurse
	Mrs C McLoughlin	- Group Non-Executive Director
	Miss T Onon	- Joint Group Medical Director
	Mr T Rees	- Group Non-Executive Director
	Mr A Roberts	- Group Chief Finance Officer
In attendance:	Mr P Blythin	- Director Single Hospital Service
	Mr D Cain	- Deputy Chairman Fundraising Board
	Mr M McCourt	- Chief Executive, MLCO
	Mr A W Hughes	- Director of Corporate Services/Trust Board Secretary
Apologies:	No Apologies	

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING (Public)

ACTION TRACKER

Board Meeting Date: 14th January 2019			
Action	Responsibility	Timescale	Comments
Follow-up report on the Gosport Improvement Programme to be provided in the Summer 2019,.	Joint Group Medical Director	July 2019	*Scheduled*
Update Report on progress with Never Events actions	Joint Group Medical Director	July 2019	*Scheduled*

Board Meeting Date: 11th March 2019			
Action	Responsibility	Timescale	Comments
Refinements to the cancelled operations dataset to be presented to the QPSC	Group Chief Operating Officer	June 2019	*Scheduled*
Progress Report on the Nursing & Midwifery Retention Programme Work Streams to be presented to the HR Scrutiny Committee and the Board of Directors	Group Chief Nurse	June 2019 & September 2019	*Scheduled*
Priority areas for action from the 2018 National Staff Survey to receive a mid-year review of progress against agreed actions by the HR Scrutiny Committee.	Group Executive Director of Workforce & Corporate Business	October 2019	*Scheduled*
New BAF (2019/20) to be received by the Board of Directors at the next meeting	Group Executive Director of Workforce & Corporate Business	May 2019	*Scheduled*

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:	March 2019
Subject:	Board Assurance Report
Purpose of Report:	Indicate which by ✓ • Information to Note ✓ • Support • Accept • Resolution • Approval • Ratify
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 commenting on key issues within the Trust.
Recommendations:	The Board of Directors is asked to note the content of the report.
Contact:	Name: Gareth Summerfield, Head of Information Tel: 0161 276 4768

> 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)

Safety
R.Pearson\T.Onon

Core Priorities	✓	◇	×	No Threshold
	3	1	1	0

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

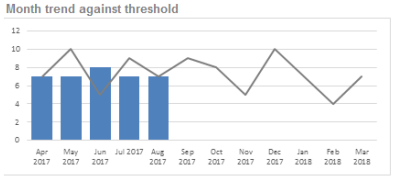
Headline narratives give context to the domain, stating current issues, good news stories, future challenges and risks, and commenting on the latest developments around performance of the indicators. Narrative is provided by the person(s) accountable for the individual domain

Section - Core Priorities

Hospital Incidents level 4-5
MFT

Actual	36	Year To Date	Accountability	R.Pearson\T.Onon
Threshold	38	(Lower value represents better performance)	Committee	Clinical Effectiveness

Month trend against threshold



12 month trend (Sep 2016 to Aug 2017)

Hospital level compliance

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

This is a broad, all embracing category covering incidents at a high level e.g. falls, pressure ulcers, medication errors etc.

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, 57.69 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.

Key issues are a plateau in the level of actual serious harm over the last year against a planned 5% reduction and small cohorts of staff describing dissatisfaction with the reporting and investigation process. A small decrease has been observed in the first 3 months of this year which if sustained would result in achievement of 5% reduction.

Actions
The thematic reports detailed in the last narrative are reviewed at a number of forums and have informed the 2016/17 work plans.

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

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

March 2019

Safety

J. Eddleston\T.Onon

Core Priorities	✓	◇	✕	No Threshold
	4	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. Since April 2018 there have been five 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).

- New MFT Policy in place for Safe procedures and being implemented
- Group wide work is being undertaken on Safe Surgery/Procedure 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 further Safety Alert has been circulated to all Hospital sites with required actions
-All Hospital Sites / MCS are undertaking risk assessment for each Never Event typeincluding identifying controls in place and actions required and adding to the Risk Register
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 below the threshold compared with same period last year.

Mortality Metrics at Group level continue to be within accepted performance level and improving over time. Mortality Review procedures are under review and awaiting National guidance before finalising.

Safety - Core Priorities

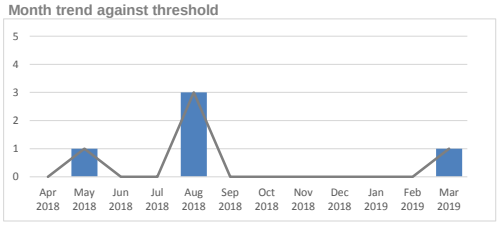
Never Events

MFT

✕

Actual	5	Year To Date	**Accountability**	J.Eddleston\T.Onon
Threshold	0	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

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	Wythenshawe, Trafford, Withington & Altrincham
✕	✓	✕	✓	✓	✓	✕
3	0	1	0	0	0	1

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 have been 5 Never Events: 2 misplaced NG Tubes in critical care areas, 1 wrong site surgery and 1 wrong implant with the most recent event being connection to an air rather than oxygen flowmeter. Investigation for the most recent event is underway and a range of immediate actions have been taken including review of fixings applied to piped air.

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.

A new MFT Safe Procedure Policy is now in place. Further work is now being undertaken Group wide on safer surgery/ procedure checklists and item counts, this work will be reported to the Quality and Safety Committee.

> Board Assurance

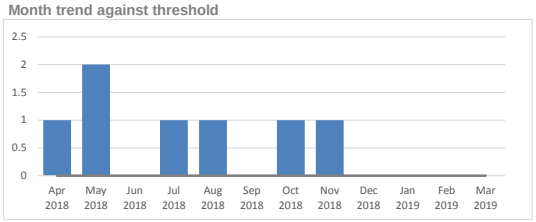
March 2019

Mortality Reviews - Grade 3+ (Review Date)

MFT

Actual	7	Year To Date	**Accountability**	J.Eddleston\T.Onon
Threshold	0	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

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	Wythenshawe, Trafford, Withington & Altrincham
✗	✗	✗	✓	✓	✓	✗
1	1	1	0	0	0	4

The number of mortality reviews completed where the probability of avoidability of death is assessed as definitely avoidable.

Key Issues

Since the inception of MFT in October 2017, a considerable amount has been achieved in developing a coherent and uniform approach to Learning from Deaths to improve the quality and safety of care.

The role of the Group Mortality Review Group in supporting dissemination of good practice, lessons and action plans is being developed. Mortality review processes are generally robust, but will be altered by the introduction of a Medical Examiner system. A deficiency in mortality review for patients with learning disability has been identified, and a new process commenced.

Overall, mortality metrics suggest that the work programs of 2017/2018 to address coding issues have been successful, but that co-morbidity coding requires further work.

Actions

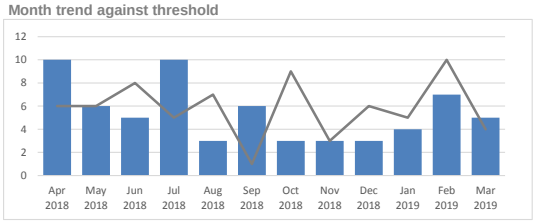
The creation of MFT has provided an opportunity to re-evaluate the approaches to learning from deaths in both organisations, and to implement a new policy based on national guidance and best practice in both organisations. Going forward, the focus will be on learning from deaths, and dissemination of the resulting changes and developments in practice across the organisation.

Hospital Incidents level 4-5

MFT

Actual	65	Year To Date	**Accountability**	J.Eddleston\T.Onon
Threshold	70	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

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	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✗	✗	✓	✓	✓
3	19	7	9	0	0	27

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, 53.03 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 overall number of serious harm incidents ytd compared to the same period last year is slightly lower. In terms of hospital sites the threshold is based on the same period last year and it can be seen that a small increase has been observed in some sites, however these are small numbers and natural variation will occur and a number of these remain unconfirmed. 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 19/20 work plans.

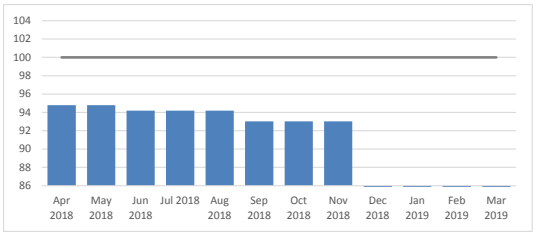
> Board Assurance

March 2019

SHMI (Rolling 12m)

MFT

Actual	93.0	Latest Period	**Accountability**	J.Eddleston\T.Onon
Threshold	100	(Lower value represents better performance)	**Committee**	Clinical Effectiveness



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

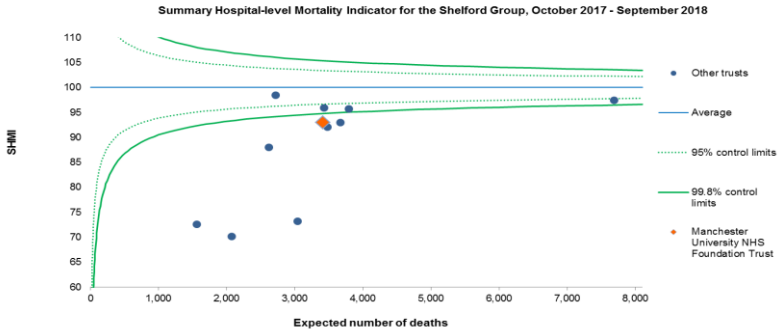
The Learning from Deaths process is currently under review and a Group wide Strategy and Policy is in development. This aims to address inconsistencies in both review and coding to improve learning and assurance processes. Guidance has now been recieved on Involving Families and Carers in the review process and establishing the Medical Examiner role. This guidance is under review and will inform the revised Strategy.

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 well within the expected range.

Hospital level compliance

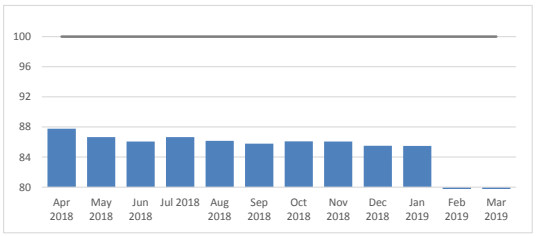
Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✓	NA	NA	NA	NA	✓



HSMR (Rolling 12m)

MFT

Actual	85.5	Latest Period	**Accountability**	J.Eddleston\T.Onon
Threshold	100	(Lower value represents better performance)	**Committee**	Clinical Effectiveness



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)

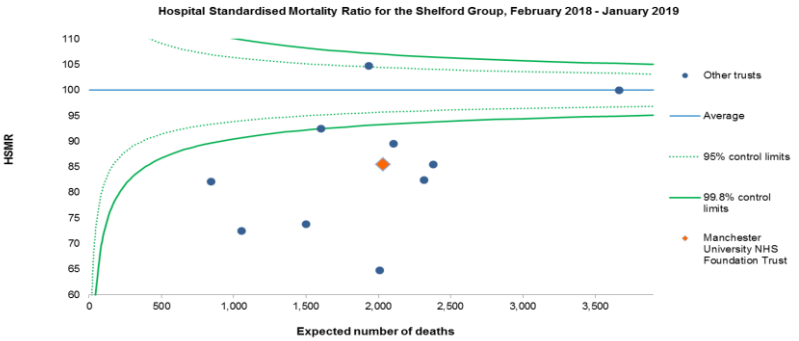
The Learning from Deaths process is currently under review and a Group wide Strategy and Policy is in development. This aims to address inconsistencies in both review and coding to improve learning and assurance processes. Guidance has now been recieved on Involving Families and Carers in the review process and establishing the Medical Examiner role. This guidance is under review and will inform the revised Strategy.

Progress

The Group HSMR is within expected levels.

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	Wythenshawe, Trafford, Withington & Altrincham
NA	✓	NA	NA	NA	NA	✓
NA	82.6	NA	NA	NA	NA	84.2

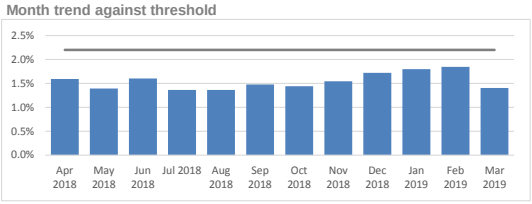


Crude Mortality

MFT

Actual	1.54%	Year To Date	**Accountability**	J.Eddleston\T.Onon
Threshold	2.20%	(Lower value represents better performance)	**Committee**	Audit 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	Wythenshawe, Trafford, Withington & Altrincham
NA	✓	✓	✓	✓	✓	◇
NA	1.8%	0.2%	0.3%	0.1%	0.0%	2.5%

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.

For the Crude Mortality the latest figures are within acceptable range.

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	1	2	2

Headline Narrative

The number of new formal complaints received across the Trust during March 2019 was 165; compared to 126 in February 2019 and 109 in January 2019. Performance is monitored and managed through the Accountability Oversight Framework (AOF). At the end of March 2019 there was a total of 37 cases over 41 days, compared to 33 at the end of February 2019 and 55 cases at the end of January 2019, which reflects a slight increase in cases over 41 days for March 2019. The percentage of complaints resolved within the agreed timeframe with complainants continues to improve, with a significant improvement in March 2019. The closure of complaints within the agreed timescales across MFT in March 2019 was 72.6%, compared to 45.2% in February 2019 and 36.8% in January 2019.

MFT continues to promote the Friends and Family Test (FFT) with an overall score of 93% of respondents 'Extremely Likely' or 'Likely' to recommend the service they received to their Friends and Family during March 2019, this compares to 92.1% in February 2019 and 94.84% in January 2019.

The MFT Nutrition and Hydration (food and drink) Strategy 2019-2022 was launched as part of Nutrition and Hydration Week on 15th March 2019.

Infection prevention and control remains a priority for the Trust. From April 2018 to the end of March 2019, the trust have reported a total of 110 attributable cases of CDI against a trajectory of 95, and 11 attributable MRSA bacteraemias for which the trajectory is set at zero.

Patient Experience - Core Priorities

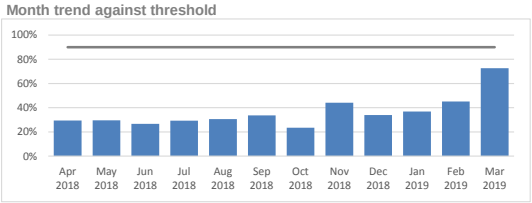
Percentage of complaints resolved within the agreed timeframe

MFT

×

Actual	35.3%	Year To Date	**Accountability**	C.Lenney
Threshold	90.0%	(Higher value represents better performance)	**Committee**	Quality 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	Wythenshawe, Trafford, Withington & Altrincham
×	×	×	×	×	×	×
41.2%	21.5%	33.7%	37.4%	50.0%	38.5%	42.6%

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 timeframe agreed with the complainant is closely monitored and work is on-going with Hospital/MCS management teams to ensure timeframes are appropriate, agreed with complainants and achieved.

The overall MFT performance for March 2019 was 72.6% which is a significant improvement compared to 45.2% in February 2019 and 36.8% in January 2019.

In July 2018 the closure of complaints within the agreed timescales at Manchester Royal Infirmary (MRI) was 13.9%. The issue was identified, therefore an improvement programme was developed with an agreed trajectory for improvement. Closure of cases within agreed timeframe at MRI was 19.4% in January 2019, 38.8% in February 2019 and 46.9% in March 2019, demonstrating a significant improvement in March 2019, in the closure of complaints within the agreed timescales.

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 where Hospitals/MCS receive lower numbers of complaints, small numbers can result in high percentages.

Actions

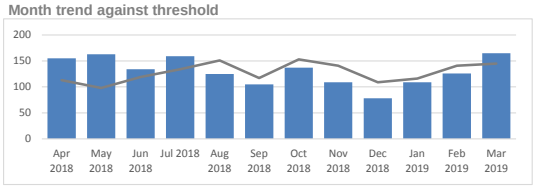
Performance is monitored and managed through the Accountability Oversight Framework (AOF).
MRI is currently receiving additional supported from the Corporate Team to increase compliance with this indicator.

Complaint Volumes

MFT

Actual	1565	Year To Date	**Accountability**	C.Lenney
Threshold	1537	(Lower value represents better performance)	**Committee**	Quality 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	Wythenshawe, Trafford, Withington & Altrincham
✗	✗	✗	✗	✓	✗	✓
87	456	172	194	71	46	443

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 March 2019 was 165. This compares to 126 in February 2019 and 109 in January 2019.

WTWA received the highest number of formal complaints in March 2019 with 49. This number is higher than the number received by WTWA in January 2019 (31) and February 2019 (33). The number of complaints received by WTWA follows the general MFT seasonal variation trend.

At the end of March 2019, there was a total of 37 cases over 41 days old, this compares to 33 cases at the end of February 2019 and 55 cases at the end of January 2019. The Hospital/MCS with the highest number of cases over 41 days at the end of March 2019 was WTWA with 10 (27.02% of total) and also MRI with 10 (27.02% of total) cases at 41 days old.

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. MRI is currently being supported by the Corporate Nursing team to expedite the effective closure of complaints older than 41 days.

Progress

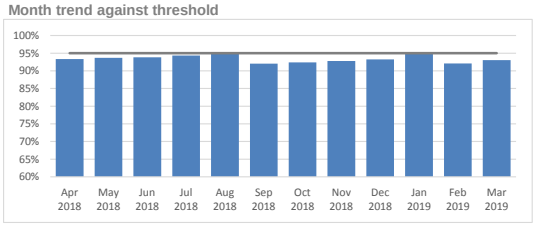
All Hospitals/ MCS have established their governance frameworks to focus on the management of complaints, specifically those that exceed 41 days with a view to expediting closure and identifying learning to inform future complaints prevention and management.

FFT: All Areas: % Extremely Likely and Likely

MFT

Actual	93.4%	Year To Date	**Accountability**	C.Lenney
Threshold	95.0%	(Higher value represents better performance)	**Committee**	Quality 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	Wythenshawe, Trafford, Withington & Altrincham
✓	✗	◇	✓	✓	✓	◇
97.6%	89.6%	94.0%	98.0%	96.4%	97.4%	92.5%

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' and "likely" to recommend the service.

Actions

Each Hospital/Managed Clinical Service reviews and monitors of FFT response rates and patient feedback to identify any areas for improvements in order to increase response rates and act upon the feedback received.

The Patient Services Team are working with Hospitals/ MCSs to improve response rates; once specific project involves introducing the option to answer the FFT question by text for patients/ parents who have attended the Paediatric Emergency Department. Within Patient Services a new role, which includes working across the Group to improve FFT response rates ans outcomes has been developed and the post holder has recently commenced in post.

Progress

The overall response rate for inpatients in March 2019 was 17.1% this compares to 23.0% in February 2019 and 25.3% in January 2019.

For our Emergency Departments the response rates in March 2019 was 11.7% this is a decrease compared to 20.9% in February 2019 and 15.2% in January 2019.

> Board Assurance

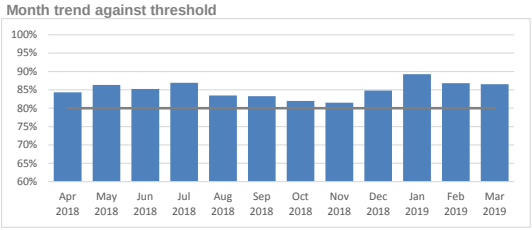
March 2019

Nursing Workforce – Plan v Actual Compliance for RN

MFT

Actual	86.5%	Latest Period	**Accountability**	C.Lenney
Threshold	80.0%	(Higher value represents better performance)	**Committee**	Quality 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	Wythenshawe, Trafford, Withington & Altrincham
NA	✓	✓	✓	✓	NA	✓
	84.2%	81.7%	85.6%	98.0%		90.2%

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.

Progress

At the end of March 2019 there were 20 (18.5%) inpatient wards across the Group that had a registered nurse vacancy factor above 25%. The nurse fill rate continues to reach the 80% target, and has remained static for a second month at 86.5%.

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. Daily senior nurse staffing huddles are in place across the Hospitals

Actions

Where shortfalls in nurse staffing levels occur and this cannot be resolved, staff are redeployed from other areas following a risk assessment and professional judgement based on the acuity and dependency of patients in each area. Nursing assistant levels are increased in some areas to support such a shortfall and provide care and enhanced supervision for less acute but dependant patients. These processes are reviewed by the Directors of Nursing for each Hospital/MCS on a weekly basis.

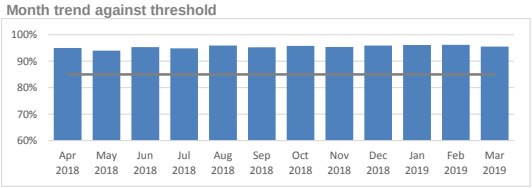
Acuity and dependency data is captured through the Allocate SafeCare system which supports senior nurses to review daily staffing levels and deploy staff safely.

Food and Nutrition

MFT

Actual	95.4%	Year To Date	**Accountability**	C.Lenney
Threshold	85.0%	(Higher value represents better performance)	**Committee**	Quality 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	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✓	✓	✓	✗	✓
97.7%	94.0%	93.6%	96.5%	95.4%	69.2%	86.5%

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 both Ward and Trust-wide level across all aspects of food and nutrition. Patient Dining Forums are established for ORC and WTWA. The Trust Improvement Programme 'Good to Great' is now led by the Head of Nursing (Quality and Patient Expereince) the Improvement Programme has been rolled out to WTWA, led by the Deputy Director of Nursing.

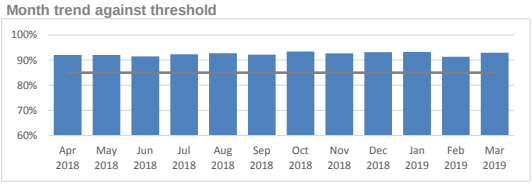
The MFT Nutrition and Hydration (food and drink) Strategy 2019-2022 was launched as part of Nutrition and Hydration Week on 15th March 2019. The Strategy sets out our commitments to improve Nutrition and Hydration.

Pain Management

MFT

Actual	92.4%	Year To Date	**Accountability**	C.Lenney
Threshold	85.0%	(Higher value represents better performance)	**Committee**	Quality 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	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✓	✓	✓	✗	✓
96.2%	87.0%	87.7%	95.1%	97.0%	83.2%	93.3%

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 now provided by the Deputy Director of Nursing, CSS who continues to lead work to establish a future work programme. Performance against this KPI is monitored through the Trust Harm Free Care structure.

> Board Assurance

March 2019

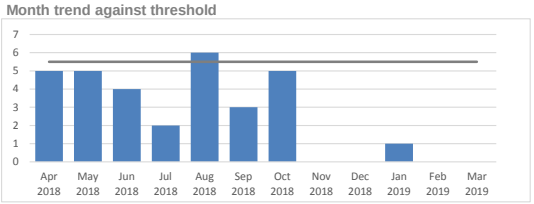
Clostridium Difficile – Lapse of Care

MFT

✓

Actual	31	Year To Date	**Accountability**	C.Lenney
Threshold	96	(Lower value represents better performance)	**Committee**	Quality 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	Wythenshawe, Trafford, Withington & Altrincham
✓	✗	✓	✓	✓	✓	✗
2	10	0	1	0	0	18

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 was 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

MFT reported a total of 197 CDI cases: 110 (56%) of which were trust-attributable against a trajectory of 103. Following the monthly external case reviews, there has been a total of 35 Lapses in Care identified. Wythenshawe Hospital reported a total of 41 trust-attributable cases against a trajectory of 43 with 17 lapses in care. Oxford Road Campus/Trafford reported a total of 69 trust-attributable cases against a trajectory of 60, with 17 lapses in care.

Actions

In response to increased incidents across the Trust, detailed investigations continue to be undertaken by the IPC/TV team. There is a focus on antimicrobial stewardship, IPC practice in the clinical area (including hand hygiene) and enhanced environmental cleaning/use of HPV in high incidence and high risk areas.

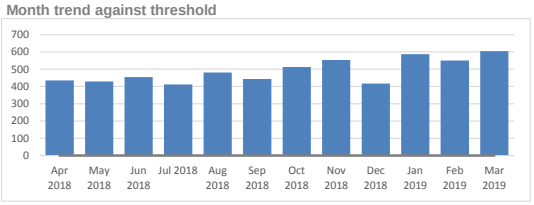
PALS – Concerns

MFT

-

Actual	5878	Year To Date	**Accountability**	C.Lenney
Threshold	None	(Lower value represents better performance)	**Committee**	Quality 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	Wythenshawe, Trafford, Withington & Altrincham
-	-	-	-	-	-	-
276	1674	583	469	360	169	1911

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

Key Issues

A total of 604 PALS concerns were received by MFT during March 2019. This compares to 550 PALS concerns received in February 2019 and received in 587 January 2019. This is within the limits of normal seasonal variation and is monitored closely.

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

Actions

PALS concerns are formally monitored alongside complaints at weekly meetings within each Hospital / MCS.

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

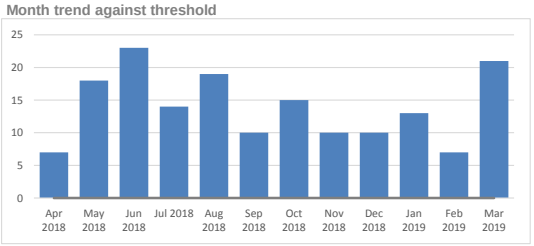
All Attributable Bacteraemia

MFT

-

Actual	167	Year To Date	**Accountability**	C.Lenney
Threshold	None	(Lower value represents better performance)	**Committee**	Quality 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	Wythenshawe, Trafford, Withington & Altrincham
-	-	-	-	-	-	-
20	89	15	8	0	0	35

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. There are currently no sanctions applied to this objective.

Progress

From April 2018 to the end of March 2019, Wythenshawe Hospital reported 5 attributable MRSA bacteraemias and 32 attributable E.coli bacteraemias. Oxford Road Campus/Trafford Hospital reported 6 attributable MRSA bacteraemias and 120 attributable E.coli bacteraemias for the same period.

Operational Excellence

J.Bridgewater

Core Priorities	✓	◇	✕	No Threshold
	5	1	5	0

Headline Narrative

• Diagnostic standard - During March the diagnostic performance continued to improve. MFT delivered a performance of 1.18% This is considerably better than the national picture of 3.6% (January 2019). Key area of risk remains Adult Endoscopy with actions in place to address this. In addition, cancer turnaround is a key priority with delivery of this a risk to routine capacity.

• A&E 4 hours - In March MFT performance improved compared to January and February with 84.90% for the month, overall Q4 performance of 83.10% ranked 2nd in GM. Patient safety remains a key priority with strong performance for ambulance handover and no 12 hour trolley waits. Recovery actions and trajectory in the final 6 weeks of the quarter has improved performance to provide a platform to deliver more sustainable performance in Q1. Continuing to work with system partners around discharge, reducing long length of stay patients, and demand on RMCH.

• RTT - MFT performance reduced slightly in March to 86.4%. Trust waiting list has increased across the year with a peak in March due to a combination of factors related to growth, changes to the Trust PAS system, data quality and reporting and prioritisation of capacity to treat the longest wait patients. A paper on the waiting list has been presented in April to the Trust Quality and Safety Committee outlining the factors and ongoing actions, and oversight is maintianed throught the RTT Task Force and close working with Commissioners.

• +52 week Waits - As of the end of March the Trust exceeded its commitment to reduce long waits by half, with only 6 breaches against the trajectory of 15. Oversight and mitigation of any risks continues through the RTT Task Force.

• Cancer 62 Day - Performance against the cancer standard is challenged in the MRI Hospital and SMH, with stronger performance at WTWA. The Trust reported 80.52% against the 85% standard for Q3, with the greatest pressures in Urology and GI. Hospitals and the Corporate Performance team are working together to take forward the pathway opportunities and improvements identified at the Cancer Committee in January.

• Cancelled operations >28 days - There were 4 reportable breaches in March.

•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

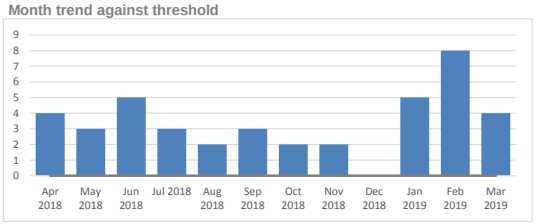
Cancelled operations - rescheduled <= 28 days

MFT

✕

Actual	41	Year To Date	**Accountability**	J.Bridgewater
Threshold	0	(Lower value represents better performance)	**Committee**	Trust Board

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	Wythenshawe, Trafford, Withington & Altrincham
✕	✕	✓	✓	✓	✓	✕
1	23	0	0	0	0	17

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.
Urgent and emergency care pressures
Complex patients requiring specialist skills and beds

Actions

Cancelled operations are escalated and overseen through Hospital / MCS performance meetings, including risks to the 28 day standard.
Capacity and Demand plans are in place to support Trust bed requirements which is a factor in cancellations.

Progress

• In March:
- There were two 28 day breaches on the Oxford Road Site. The breaches occurred in General Surgery and Cardiac Surgery - with both patients treated in March.
- WTWA reported two breaches in Orthopaedics and in Cardiac Surgery, with both patients treated in March.
• MFT continues to perform strongly against this target, within the top three acute Trusts in GM.
• Nationally cancelled operations reschedule within 28 days performance remains high reporting 8.3% in Q3 18/19.

> Board Assurance

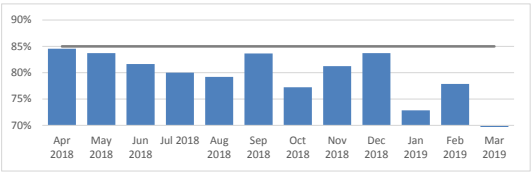
March 2019

Cancer 62 Days RTT

MFT

Actual	75.2%	Quarterly	**Accountability**	J.Bridgewater
Threshold	85.0%	(Higher value represents better performance)	**Committee**	Trust Board

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	Wythenshawe, Trafford, Withington & Altrincham
NA	✗	NA	✗	NA	NA	✗
NA	63.6%	100.0%	60.7%	NA	NA	81.6%

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 and regional profile, circa 20%.
• 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
• Task force established with MRI, CSS and Corporate Performance team to support the review of cancer pathways across the sites.
Key Hospital/MCS Actions:
• Speciality level recruitment of workforce to match demand.
• Pathway developments i.e. Lung, LGI
• SMH increasing 2ww and diagnostic capacity
• CSS increasing diagnostic scan and reporting capacity
• A joint working group between the Performance Team and Hospital Director of Operations will take forward actions from the January Cancer Committee and will continue to report progress to Committee.
• Breach allocation for each Tumour site to meet the standard and weekly reporting against this is taking place in Q4.
• Working with NHSI to access external expertise and assurance, focused on utilisation of demand and capacity tools, strengthening training for teams.

Progress

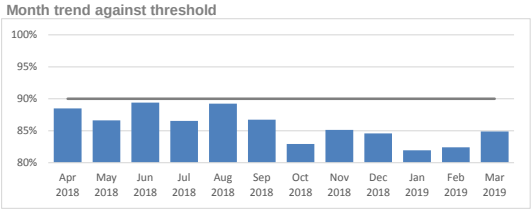
•The Trust is underperforming against the 62 day standard, although this has remained stable despite significant increase in demand.
• Q3 performance was 80.52%.
• MRI/SMH and Wythenshawe all under performed against the standard in January, with February also challenged, although a slight improvement expected for March at Wythenshawe.
• There has been some improvement in Radiology reporting turnaround times, although capacity gaps remain in specialist tests. In addition, national best practice pathways are driving lower scan/reporting turnaround times than MFT is currently delivering presenting a further demand/capacity challenge.
• The GM region is also experiencing increased pressure with demand growth, which is impacting on performance across a number of providers and underperformance of the 62 day standard.
• National performance against the standard: Q1 80.9%, Q2 78.6% Q3 79.5%.

A&E - 4 Hours Arrival to Departure

MFT

Actual	83.10%	Quarterly	**Accountability**	J.Bridgewater
Threshold	90.00%	(Higher value represents better performance)	**Committee**	Trust Board

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	Wythenshawe, Trafford, Withington & Altrincham
NA	✗	◇	✓	✓	✓	✗
NA	75.9%	87.8%	94.3%	100.0%	100.0%	83.7%

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

• Acuity of patients with a high proportion of patients classified as Majors.
• Mutual aid to other GM providers is a risk of increased pressure on A&E and out of area admissions.
• Greatest challenges by Hospital include: Wythenshawe workforce deficits, MRI capacity and flow.
• There is a further opportunity to reduce long length of stay and improve flow, requiring support from system partners.
• Community capacity as alternative to A&E, Primary care capacity to facilitate increased streaming.
• Reduction/changes in community/care home capacity across GM.
• Age profile of presentations to Wythenshawe weighted with older, frail patients.

Actions

▪ Weekly Urgent Care Assurance meeting, chaired by Group COO/Director Performance.
▪ Hospitals have a number of plans in place that are being progressed to support resilience including:
- 2019/20 Capacity Plans
- Transformation plans and patient flow improvement boards
▪ Working with system partners and the LCO to reduce long length of stay and improve discharge, reduction targets have been set. Additional work taking place in Q4 and into Q1 including: a pilot on wards AM1 and AM2 to improve discharge on these wards, and the Manchester ward, furthermore establishing a Integrated Discharge Team at MRI.
▪ Joint working with GMHH, task force established, working to improve ambulatory pathways and timely assessment of patients.
▪ Capital upgrade to Wythenshawe, MRI, and PED.
▪ Working with system partners to seek external expertise and assurance in relation to: long length of stay patients and corridor care.
▪ Escalated internal oversight arrangements are in place for Q4/Q1 with twice weekly meetings between the Group COO and Hospital Chief Executives. In addition, a weekly trajectory and management against this is in place to deliver an improvement in performance by the end of March.

Progress

• MFT reported 84.9% in March, with 83.1% for Q4 overall. There was an improving monthly trend across the quarter.
• The weekly trajectory put in place to improve performance in Q4 was met in all weeks except one.
• MFT GM ranking improved and was 2nd overall for Q4
• GM Performance for March 84.4%, National 86.6%.

> Board Assurance

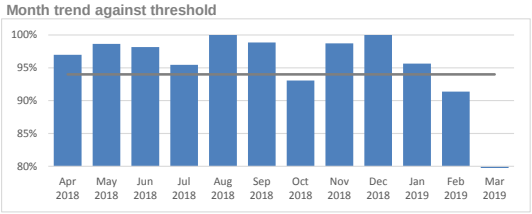
March 2019

Cancer 31 Days Sub Surgical Treatment

MFT

Actual	93.7%	Quarterly	**Accountability**	J.Bridgewater
Threshold	94.0%	(Higher value represents better performance)	**Committee**	Trust Board

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	Wythenshawe, Trafford, Withington & Altrincham
NA	✗	NA	✗	NA	NA	✓
NA	83.3%	100.0%	90.9%	NA	NA	95.9%

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 Q3.

Actions

ORC currently have not met the standard for q1 at a predicted 93.8% but this is still subject to validation.

Progress

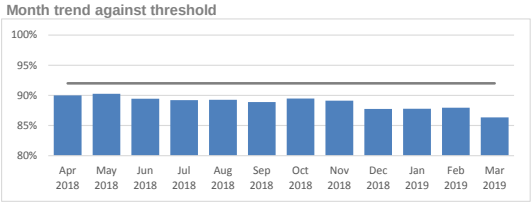
The Trust achieved the target in Q3, performance is 97.1%

RTT - 18 Weeks (Incomplete Pathways)

MFT

Actual	86.4%	Latest Period	**Accountability**	J.Bridgewater
Threshold	92.0%	(Higher value represents better performance)	**Committee**	Trust Board

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	Wythenshawe, Trafford, Withington & Altrincham
✓	◇	✗	✗	◇	✗	✗
92.7%	88.0%	84.9%	83.1%	88.5%	85.5%	86.3%

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 for Trust services continues to grow, particularly for specialist services and cancer.
- WTWA DIEP service - A trajectory to reduce breaches by 50% by March 19 is in place.
- Oxford Road Campus - A review of long waits, identified additional 52+ week breaches between June - September, trajectory to eradicate to zero achieved.
- Work to upgrade the PAS and 18 week reporting systems is a key risk to growth of the waiting list, RTT taskforce providing oversight.

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, and offering patients surgery dates.
- RTT PMO office established from September.
- Continued timely validation of PAS/waiting lists by Hospital sites, and data quality audits on-going.
- Additional resource to support validation and accuracy of data.
- Delivery of Hospital/MCS transformation and capacity plans.
- MFT Patient Access Policy in place.
- Participation in the NHSI Masterclass for RTT
- Participation in NHSI Capacity and Demand modelling training.
- Working with Commissioners in relation to demand management, particularly for specialist hospitals, to support stability of the waiting list.
- Outpatient Transformation - commencing work with ENT.
- Additional independent sector capacity was undertaken in Q4
- Working with NHSI to access external expertise and assurance, focused on utilisation of demand and capacity sustainability tools, strengthening training, knowledge and expertise for hospital teams.

Progress

- The Trust has successfully delivered its commitment to eliminate the non-RTT breaches 52+ weeks at the Oxford Road Campus from September onwards.
- Remaining 52 week breaches relate to DIEP procedures, with performance significantly improved in March at 6 verses the trajectory of 15. The expectation is no breaches from April.
- Trust RTT performance in March of 86.4% marginally below the National profile of 87% (latest February)
- Trust waiting list has increased across the year with a peak in March due to a combination of factors related to growth, changes to the Trust PAS system, data quality and reporting and prioritisation of capacity to treat the longest wait patients. Actions outlined above will support stablisation of the waiting list across 19/20.

> Board Assurance

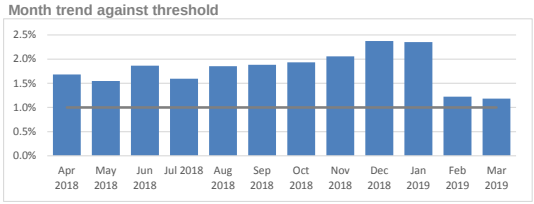
March 2019

Diagnostic Performance

MFT

Actual 1.2% Latest Period **Accountability** J.Bridgewater
Threshold 1.0% (Lower value represents better performance) **Committee** Trust Board

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	Wythenshawe, Trafford, Withington & Altrincham
✓	◇	◇	◇	NA	NA	✓
0.7%	4.5%	1.6%	23.8%	NA	NA	0.4%

NB - the % at RMCH and SMH is high due to the small waiting list in this area, the volume of breaches in these areas are marginal

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

Key Issues
- Demand for Diagnostic tests continues to increase in line with urgent and elective care pressures.
- Capacity constraints within adult Endoscopy and paediatric MRI.
- Ability to secure ad hoc sessions and workforce to increase capacity.
- Prioritisation of cancer scanning/reporting, with is also increasing, is a risk to routine capacity.

Actions
- Recovery trajectory in place for the key under performing tests with monitoring through the Trust AOF process.
- Paediatric MRI - recruitment of additional paediatric anaesthetists has been undertaken, and additional capacity secured.
- Implementation of the business case for the 3rd MRI scanner.
- Additional recurrent radiology sessions.
- Intensive actions being undertaken in adult endoscopy by MRI Director of Operations and include: Review of scheduling, utilisation of clinics, securing additional capacity through the private and community sector.
- Monthly forecasting in place, risks escalated to Hospital Directors.

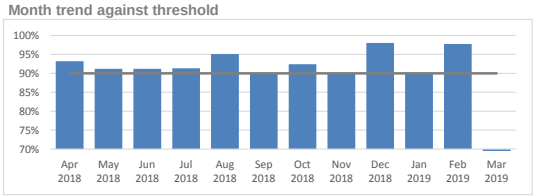
Progress
- March Performance improved on febuary performance at 1.18%, National Picture: 2.3%
- Significant progress in month, although this needs to be sustained and embedded into Q1.
- Key area of risk remains adult Endoscopy within MRI, focused work is being undertaken in this areas to improve capacity and efficiency.

Cancer 62 Days Screening

MFT

Actual 93.3% Quarterly **Accountability** J.Bridgewater
Threshold 90.0% (Higher value represents better performance) **Committee** Trust Board

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	Wythenshawe, Trafford, Withington & Altrincham
NA	✗	NA	✓	NA	NA	✓
NA	28.6%	NA	100.0%	NA	NA	97.9%

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.

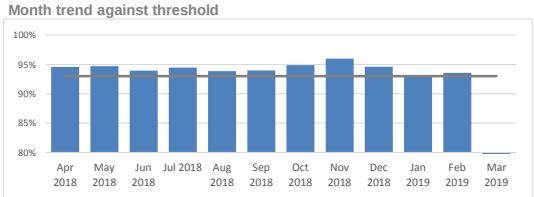
Progress
The Trust achieved this target in Q3, performance is 92.9%.

Cancer Urgent 2 Week Wait Referrals

MFT

Actual 93.2% Quarterly **Accountability** J.Bridgewater
Threshold 93.0% (Higher value represents better performance) **Committee** Trust Board

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	Wythenshawe, Trafford, Withington & Altrincham
NA	✗	✓	✗	NA	NA	✓
NA	89.5%	100.0%	80.0%	NA	NA	96.8%

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. Q3 18/19 has seen an additional 1171 referrals (19%) increase compared to Q2.

Actions
Collaborative actions taken with speciality teams to strengthen performance and increase the volume of patients seen within 7 days, within the workforce available.
SMH have reviewed the Gynaecology pathway and have an action plan in place.
GM have recognised the increase in demand is significant across the region and are reviewing the demand profile.
Actions being taken to support the 62 Day standard will also support 2ww delivery.

Progress
Overall MFT continues to deliver the standard.
Q4 - Performance has reduced although based on current provisional data is marginally over the threshold. key areas of risk have been within Gynaecology and MRI, with actions in place.

> Board Assurance

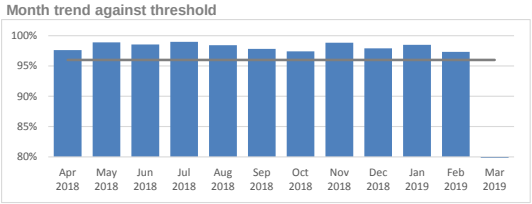
March 2019

Cancer 31 Days First Treatment

MFT

Actual	98.0%	Quarterly	**Accountability**	J.Bridgewater
Threshold	96.0%	(Higher value represents better performance)	**Committee**	Trust Board

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	Wythenshawe, Trafford, Withington & Altrincham
NA	✓	✓	✗	NA	NA	✓
NA	97.0%	100.0%	89.7%	NA	NA	98.8%

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. SMH failed January with 2 breaches.

Actions

Actions taken as per the 62 day standard.

Progress

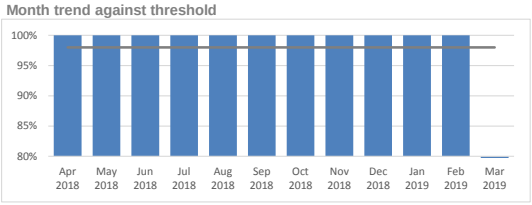
The Trust continues to achieve this standard

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



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	Wythenshawe, Trafford, Withington & Altrincham
NA	✓	NA	⊘	NA	NA	✓
NA	100.0%	100.0%	NA	NA	NA	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

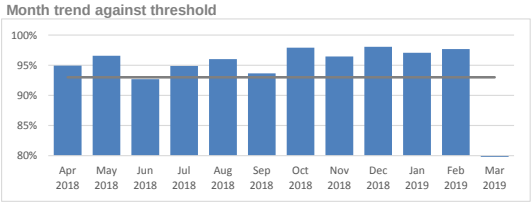
Actions taken as per the 62 day standard.

Cancer 2 Week Wait - Breast

MFT

Actual	97.4%	Quarterly	**Accountability**	J.Bridgewater
Threshold	93.0%	(Higher value represents better performance)	**Committee**	Trust Board

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	Wythenshawe, Trafford, Withington & Altrincham
NA	NA	NA	NA	NA	NA	✓
NA	NA	NA	NA	NA	NA	97.4%

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 achieved 98.1% in December, against National 88.1% (latest data)

Workforce and Leadership

P.Blythin

Core Priorities	✓	◇	✕	No Threshold
	5	0	6	3

Headline Narrative

All the arrangements for the new Group wide Clinical Mandatory training programme have been finalised and an extensive communication programme has commenced. The programme will launch on 1st April.

Workforce and Leadership - Core Priorities

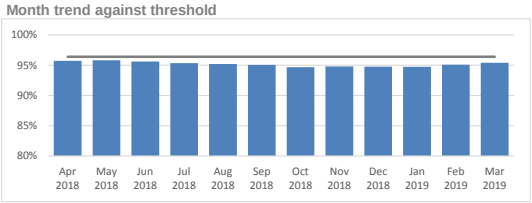
Attendance

MFT

Actual 95.4% Latest Period **Accountability** P. Blythin

Threshold 96.4% (Higher 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	Wythenshawe, Trafford, Withington & Altrincham
✓	✕	✕	✕	✕	✕	✕
96.4%	95.5%	95.5%	95.1%	94.0%	94.7%	94.7%

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 March has increased to 95.4% compared to the previous months figure (95.1%).

The attendance rate was slightly lower at the same point last year (March 2018) at 95.2%.

Meanwhile the latest figures released by NHS Digital show that for October 2018 the monthly NHS staff sickness absence for the whole of the North West HEE region was 5.0% (these figures include all provider organisations and commissioners). MFTs performance for the same period was 5.2%. Performance in the North West is significantly below that of the South East sector at 3.9%.

Actions

Work is underway to ensure Health and Wellbeing initiatives are focussed in areas where the biggest improvements can be made. The HWB programme for 2019/20 is currently in development.

In the Manchester Royal Infirmary a Workforce Performance (KPI) group has been established to understand the information that is available to managers within the hospital to monitor and improve key performance indicators such as sickness absence. As part of the actions from the MRI Workforce Performance (KPI) group an employee health questionnaire was sent to MRI employees which protected the anonymity of staff. Feedback from these questionnaires are going to be used to help inform actions to improve attendance within the hospital.

In Wythenshawe, Trafford, Withington and Altrincham (WTWA) sites there has been an emphasis on greater benefits realisation through Absence Manager system 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.
Actions plans have been put in place and are monitored via the Accountability Oversight Framework.

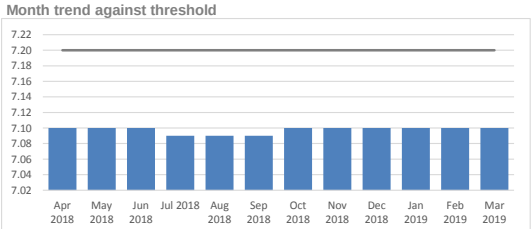
Engagement Score (quarterly)

MFT

Actual 7.10 Latest Period **Accountability** P. Blythin

Threshold 7.20 (Higher 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	Wythenshawe, Trafford, Withington & Altrincham
✕	✕	✓	✓	✕	✓	✕
7.00	7.00	7.30	7.20	7.00	7.40	7.10

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 full 2018 Staff Survey results have been published. As reported last month, there have been a number of significant national changes to the reporting of the staff survey results for 2018, including the replacement of the previous 5 point scale with a 10 point scale. The MFT Group staff engagement score is 7.1. This compares with a recalibrated staff engagement score for 2017 of 6.97 (rounded to 7.0 in national reporting).

Actions

The 2018 Staff Survey results provide staff engagement scores at Group and Hospital/MCS/Corporate level. These have now been disseminated across the Group, shared with staff via MFTinews, and presented to the Group Board. Priority actions at Group level for 2019-20 have been proposed, Hospitals/MCS are now sharing the results within their own areas and developing their staff engagement action plans for 2019-20. The Quarter 4 Pulse Survey closed on 10th March and the results will be available in early April.

> Board Assurance

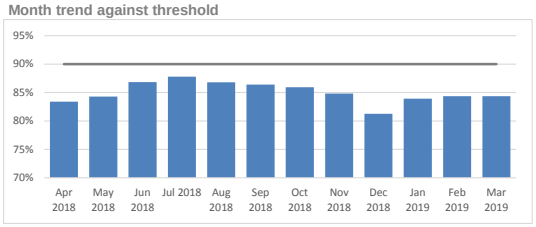
March 2019

Appraisal- non-medical

MFT

Actual	84.4%	Latest Period	**Accountability**	P. Blythin
Threshold	90.0%	(Higher 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	Wythenshawe, Trafford, Withington & Altrincham
✗	◇	✓	◇	✓	◇	◇
82.5%	85.9%	90.4%	88.7%	92.9%	88.3%	89.8%

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

Non Medical Appraisal compliance for the Group in March remained the same at 84.4%. 2 Hospitals/MCS are achieving target compliance.

Actions

All Hospitals / MCSs / Corporate Directorates are currently working to plans that were presented to the HR Scrutiny Committee last year and reviewed at the February Risk Management Committee. Monitoring also takes place through the AOF where hospitals/MCS present trajectories and action plans in place to achieve compliance.

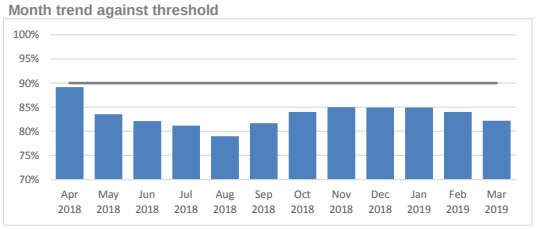
The new Appraisal process, paperwork and policy was launched in April.

Trust Mandatory Training - Clinical

MFT

Actual	82.2%	Latest Period	**Accountability**	P. Blythin
Threshold	90.0%	(Higher 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	Wythenshawe, Trafford, Withington & Altrincham
✗	◇	✗	◇	✗	✗	✗
81.4%	85.7%	82.7%	89.0%	79.0%	74.0%	80.0%

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

Compliance at the ORC decreased by 1.8% in March to 82.2%. No Hospitals nor the Corporate Division are achieving target compliance. At Wythenshawe compliance decreased by 0.3% to 81.1%
A new Clinical Mandatory training programme became effective across the Group from the start of the financial year. From April aggregate compliance against 6 of the 9 Level 2 and Level 3 Core Clinical subjects will be reported to the Board and from June reports will be based on aggregate compliance against all 9 subjects. Some of these subjects have previously not been reported as part of mandatory training and current compliance is significantly below target. All Hospital and Corporate Services teams have developed plans to ensure that target compliance will be achieved for all Level 2 and Level 3 Core Clinical subjects by 1st October.

Actions

A widespread communication plan has been delivered to ensure that all staff understand what the changes to the new programme are.
As well as monthly compliance reports continuing to be made available via eWIP a monthly tracker will be provided to all HRDs for all workforce competences to support the leadership teams in managing compliance.
A training video is also being developed to allow local OLM Administrators to run their own reports more frequently.

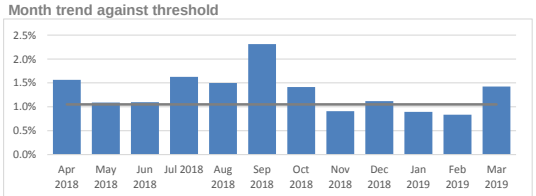
Monitoring also takes place through the AOF where hospitals/MCS present trajectories and action plans in place to achieve compliance

B5 Nursing and Midwifery Turnover (in month)

MFT

Actual	1.42%	Latest Period	**Accountability**	P. Blythin
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	Wythenshawe, Trafford, Withington & Altrincham
✗	✗	✗	✗	✓	NA	✗
1.70%	1.73%	1.12%	1.66%	0.00%	NA	1.13%

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 March 2019 is 1.42% against a monthly target of 1.05%. This is an increase in turnover from February 2019 at which the turnover was 0.84%.

Actions

A retention workshop was held with Directors of Nursing and HR in January 2019 focusing on Nursing and Midwifery Retention.
Retention Strategies have been developed by each Hospital/MCS and are monitored by the Directors of Nursing.

The strategies focus on the following work streams:-
- Divisional work streams focusing on wellbeing/staff focus groups/take a break
- Nursing and Midwifery extended induction for new starters
- Roll-out 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
- Band 5 rotation programmes have been introduced in RMCH, MRI and WTWA
- Focus on flexible working options
- Staff engagement and we're listening events within the hospitals/ MCS
- The development of an internal transfer scheme for Band 5 Registered Nurses

> Board Assurance

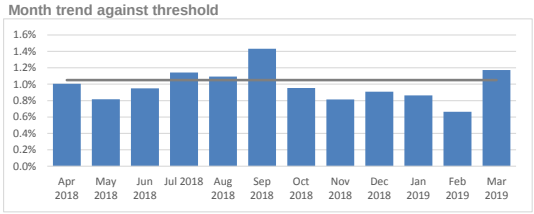
March 2019

Turnover (in month)

MFT

Actual	1.17%	Latest Period	**Accountability**	P. Blythin
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	Wythenshawe, Trafford, Withington & Altrincham
✗	✗	✗	✗	✓	✗	✓
1.22%	1.25%	1.47%	1.17%	0.88%	2.04%	0.87%

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

The single month turnover position for the Group has increased and now stands at 1.17% compared to 0.66% for the previous month.

The turnover rate was higher at the same point last year (March 2018) at 1.29%.

Actions

The Hospitals/MCS/Corporate Services continue to focus on staff turnover with regular staff engagement sessions, facilitating internal moves to prevent staff leaving the organisation.

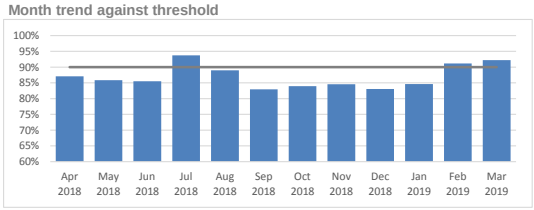
The Exit Questionnaire process is currently being aligned across all the hospitals. Staff leaving the Trust at Wythenshawe will complete exit questionnaires on the electronic Workforce Information portal (eWIP). This will create an improved reporting function at Wythenshawe for leaver information on eWIP.

Appraisal- medical

MFT

Actual	92.2%	Latest Period	**Accountability**	P. Blythin
Threshold	90.0%	(Higher 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	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	◇	✓	◇	◇	✓
96.3%	93.2%	86.9%	93.2%	89.7%	87.5%	92.5%

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

Key Issues

Medical Appraisal compliance increased by 1.1% in March to 92.2%. 4 Hospitals/MCS's are achieving target compliance.

Actions

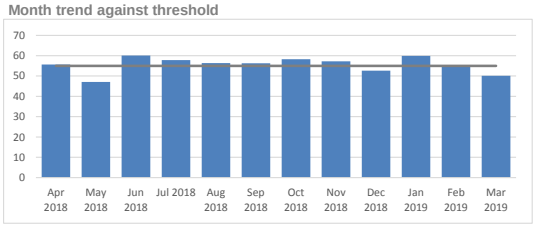
All Hospitals / MSCs / Corporate Directorates continue to deliver plans that were presented to the HR Scrutiny Committee last year and reviewed at the February Risk Management Committee. Monitoring also takes place through the AOF where hospitals/MCS present the trajectories and action plans in place to achieve compliance. Members of the Medical Director and Group Executive Director of HR & OD teams have put in place a number of actions to ensure that there are no anomalies in the reporting process.

Time to fill vacancy

MFT

Actual	50.1	Latest Period	**Accountability**	P. Blythin
Threshold	55.0	(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	Wythenshawe, Trafford, Withington & Altrincham
✓	✗	✓	✗	✗	✗	◇
45.8	59.2	48.6	72.5	86.9	119.0	55.2

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 reduced from 54.5 days and now stands at 50.1 days for March.

Actions

The Trust 'Time to Hire' for March 2019 (without Band 5 Nursing starts) is 50.1 working days, which has dropped by over 4 days from February figures and 8 days from January's figures which is a big leap forward for the team and divisions. There still ongoing work to do around streamlining processes and there has been a strong emphasis on the medical workforce as their overall time to hire is higher at 63.5 working days, which is due to the number of overseas doctors being recruited without a GMC registration as these appointments can take between 6-12 months as candidates have to obtain English exams, visa's and sponsorship for GMC.

An audit on recruitment processes is due to commence at the end of April 2019.

> Board Assurance

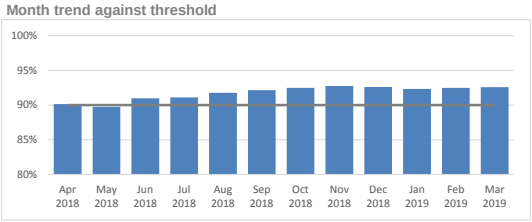
March 2019

Level 1 CSTF Mandatory Training

MFT

Actual	92.6%	Latest Period	**Accountability**	P. Blythin
Threshold	90.0%	(Higher 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	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✓	✓	✓	✗	✓
92.6%	91.3%	91.3%	96.7%	90.6%	87.4%	92.6%

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 March for the Group has seen the aggregate compliance for the 8 Level 1 Core subjects increase by 0.1% to 92.6%. All Hospitals/MCS and the Corporate Division are achieving target compliance. From April performance will be monitored against the aggregate compliance of all 11 Level 1 Core subjects. In March Group compliance for all 11 subjects was 91.4%

Actions

Although compliance has remained above target since June 2018, monthly compliance reports continue to be made available via eWIP and a monthly tracker will be provided to all HRDs for all workforce competences to support the leadership teams in managing compliance.

A training video is also being developed to allow local OLM Administrators to run their own reports more frequently. Monitoring also takes place through the AOF where hospitals/MCS present trajectories and action plans in place to achieve compliance.

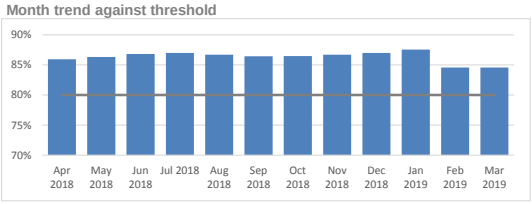
Agreement made at April Dental Management Board to apply immediate management focus to increase compliance. OD&T are providing a learning hub guide to the Dental management team in April.

Nurse Retention

MFT

Actual	84.6%	Latest Period	**Accountability**	P. Blythin
Threshold	80.0%	(Higher 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	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✓	✓	✓	NA	✓
84.6%	82.0%	88.4%	85.4%	86.7%	NA	85.1%

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

In March 2019, Nursing and Midwifery retention stands at 84.6% which is a slightly lower from February 2019 at which the retention rate was 86.6%. This rate remains above the threshold of 80%.

Actions

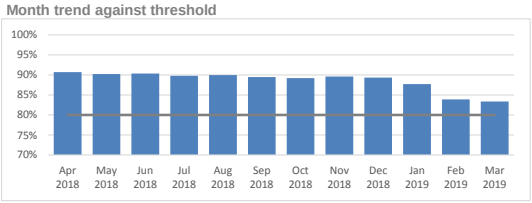
The retention threshold target for nursing and midwifery staff provides a strong indication of whether we are able to retain staff across the Trust and whether our polices, procedures and practices are supportive of the Trust being seen as a good place to work. The overall retention rate is good at 84.6%.

BME Staff Retention

MFT

Actual	83.4%	Latest Period	**Accountability**	P. Blythin
Threshold	80.0%	(Higher 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	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✓	✓	✓	✓	✓
84.9%	82.0%	86.8%	86.8%	85.4%	84.0%	82.8%

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

The Group is exceeding its retention 80% threshold for this indicator. The retention rate remains fairly consistent month on month at around 85%.

Action

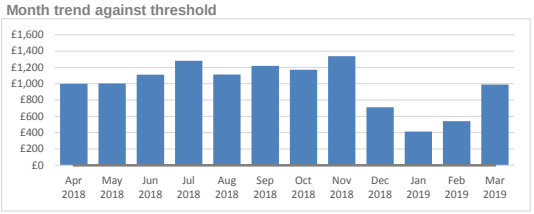
The Group continues to perform strongly on this indicator with Medicine (MRI), Research and Surgical Division (MRI) under the 80% threshold. Hospital Sites/MCSs and Functions are tracking this within their Accountability Oversight Framework and developing plans to address where negative gaps are being identified.

Medical Agency Spend

MFT

Actual	£989.5	Latest Period	**Accountability**	P. Blythin
Threshold	None	(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	Wythenshawe, Trafford, Withington & Altrincham
-	-	-	-	-	-	-
£16.9	£442.4	£63.3	£14.7	£71.4	£12.2	£367.7

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 March 2019 the total value of Medical and Dental agency staffing was £989.5.

Actions

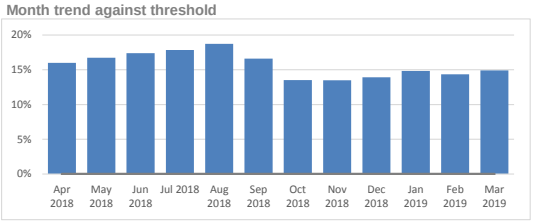
Hospitals are continuing to make improvements to their agency spend position, and weekly review meetings continue to take place. All agency workers have clear plans attached, with exit strategies where appropriate. The work to renegotiate the agency pay and commission rates continues.

Qualified Nursing and Midwifery Vacancies B5 Against Establishment

MFT

Actual	14.9%	Latest Period	**Accountability**	P. Blythin
Threshold	None	(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	Wythenshawe, Trafford, Withington & Altrincham
-	-	-	-	-	-	-
12.1%	16.1%	10.5%	7.9%	8.3%	NA	20.6%

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.

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

The majority of vacancies with Nursing and Midwifery are within the staff nurse (band 5) role. At the end of March 2019 there were 594.5 (14.9%) staff nurse/midwife/ODP (band 5) vacancies across the Trust Group. This is an increase from February 2019 when there was 572.1 wte vacancies.

Actions

There are 141 nurses and midwives expected to start before the end of June 2019 with a further 169 nurses with conditional job offers and whose appointments are being processed through the Trust recruitment process. The trust continues to recruit nurses from overseas. There is 46 international nurses expected to start in May 2019 with cohorts of approximately 30 nurses expected to arrive every 6 weeks for the rest of the year.

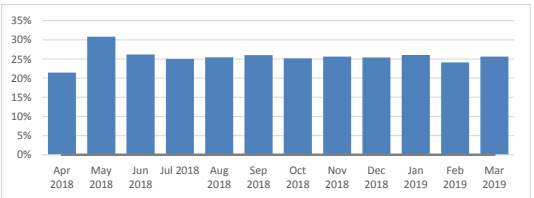
A Group Resourcing Plan has been developed including a schedule of recruitment events to support the recruitment strategies implemented across the Hospitals and MCS.

% BME Appointments of Total Appointments

MFT

Actual	25.6%	Latest Period	**Accountability**	P. Blythin
Threshold	None	(Higher 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	Wythenshawe, Trafford, Withington & Altrincham
-	-	-	-	-	-	-
28.6%	35.7%	20.0%	18.3%	44.0%	32.7%	28.0%

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

The data shows a slight improvement of over 1% from 24.1% to 25.6% from the reporting figure of last month; one in four appointments is of black and minority ethnic origin.

Actions

The Group figure is higher than the Greater Manchester black and minority ethnic population of almost 17% but lower than the Manchester black and minority ethnic population of over 30%. Hospital Sites/MCSs and Functions are tracking this within their Accountability Oversight Framework and developing plans to address where negative gaps are being identified.

Finance

A.Roberts

Core Priorities	✓	◇	×	No Threshold
	1	0	1	0

Headline Narrative

- Please see agenda item 5.2

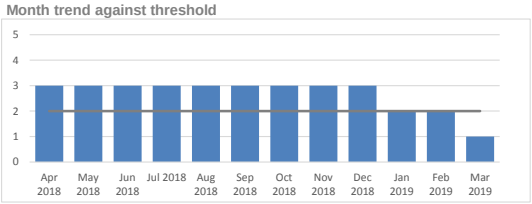
Finance - Core Priorities

Regulatory Finance Rating

MFT

Actual	1	Latest Period	**Accountability**	A.Roberts
Threshold	3	(Lower value represents better performance)	**Committee**	TMB and Board Finance Scrutiny Committee

Month trend against threshold

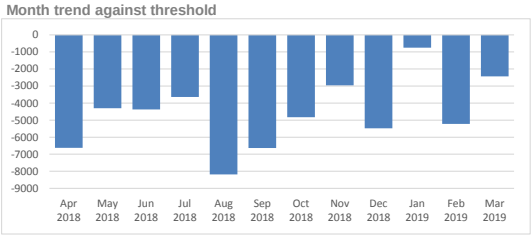


The regulatory finance rating identifies the level of risk to the ongoing availability of key services. A rating of 4 indicates the most serious risk and 1 the least risk. This rating forms part of NHSI's single oversight framework, incorporating five metrics:
- Capital service capacity
- Liquidity
- Income and expenditure margin
- Distance from financial plan
- Agency spend

Operational Financial Performance

Actual	-£55,440	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 the Chief Finance Officer's report for more detail.

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	Wythenshawe, Trafford, Withington & Altrincham
×	×	×	×	×	×	×

Strategy

Core Priorities	✓	◇	×	No Threshold
	1	2	0	0

Headline Narrative

The Trust is in the process of developing its Clinical Service Strategy. This will comprise an over-arching group service strategy and a series of individual clinical service strategies. The Clinical Service Strategy programme commenced in April 2018 and is expected to conclude in May 2019. The first version of the group service strategy has been approved by the Board and will be further iterated as the programme proceeds. Draft clinical service strategies are currently under development.
Annual plans are in place for all Hospitals / MCSs for 2018/19. The development of plans for 2019/20 has commenced.
All Hospitals / MCSs are making satisfactory progress towards the delivery of the strategic service development milestones in their Annual Plan.

Strategy - Core Priorities

Agreed 5-year strategy in place

MFT

Actual Amber **Accountability** D.Banks
Threshold **Committee** Group Management Board

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.

Green indicates that a strategy has been completed and approved by the Trust Service Strategy Committee
Amber indicates that a strategy is being developed but has not yet been 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	Wythenshawe, Trafford, Withington & Altrincham
◇	◇	◇	◇	◇	◇	◇

Agreed annual plan for 2018-19

MFT

Actual Green **Accountability** D.Banks
Threshold **Committee** Group Management Board

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 Group Management Board
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	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✓	✓	✓	✓	✓

Progress against delivery of service strategy milestones in annual plan

MFT

Actual **Accountability** D.Banks
Threshold **Committee** Group Management Board

Progress against the strategic development plans set out in the annual plan is monitored on a quarterly basis.

Green – consistent delivery against all milestones
Amber – delivery largely on track i.e. small number of milestones not being met or delivery slightly behind plan
Red – delivery of milestones not on track i.e. majority of milestones not being met or significantly behind 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	Wythenshawe, Trafford, Withington & Altrincham
◇	◇	◇	◇	◇	◇	◇

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Julia Bridgewater, Chief Operating Officer
Paper prepared by:	Lorraine Cliff, Acting Chief Transformation Officer
Date of paper:	24 April 2019
Subject:	TRANSFORMING CARE FOR THE FUTURE 2019/20 Annual Plan
Purpose of Report:	Indicate which by ✓ • Information to Note • Support • Accept • Resolution • Approval ✓ • Ratify
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)** The Board of Directors are asked to approve the Transformation Annual plan for 19/20 which are fully aligned to the OD, turnaround and financial strategies. The programme is flexible enough to adapt to strategic changes during the year. A quarterly report will be produced to inform the Board of progress and compliance.
Recommendations:	To note the content of the report
Contact:	Name: Lorraine Cliff, Acting Chief Transformation Officer Tel: 0161 701 5115

Manchester University
NHS Foundation Trust

Transforming Care for the Future

2019/20 Annual Plan and Commitments

Chief Transformation Officer
March 2019

Contents

Manchester University NHS Foundation Trust

Overview

The MFT Transformation Strategy was approved by the Interim Board of Directors on 19 September 2017 pending the formation of MFT on the 1st October 2017. Our ambition is to lead healthcare in the NHS and therefore we need to be in the top decile for quality in its broadest sense not only on outcomes and safety but patient and staff experience and operational efficiency.

As a result we aspire to be recognised for excellence in patient and staff experience and use of technology, facilities and strong leadership are enablers for staff to change. This is the key driver for our transformation programme and in 3 years' time through a culture of clinically led change we want to achieve:

Operational excellence across all hospitals and community services, alongside being recognised for excellence in quality, patient and staff experience

Fully integrated single hospital services

Effective partnerships with our Local Care Organisation, Devolution Manchester, Shelford Group and other key stakeholders

The aim of our transformation strategy is to ensure we:

- ✓ Continue to build upon and strengthen the transformation work already in place
- ✓ Continue to build the capability of staff to ensure a culture of continuous improvement
- ✓ Ensure we are making best use of existing resources and corporate teams to support improvement and support the clinical teams and divisions / hospitals in a coherent way
- ✓ Continue to co-ordinate projects to ensure lessons learnt are shared

The Transforming Care for the Future Programme objectives for the next 3 years are:

Culture for change	Continue to create the right culture across each Hospital and Division to deliver change through embedding the values and behaviours and leadership

Build Capability	Continue to build staff capability in leadership and change using a single methodology to support continuous improvement

Delivery	Through collaborative working achieve operational excellence and excellence in patient and staff experience which will continue to deliver efficiencies through transformational change, supporting the financial strategy

Governance	Comply with the governance process / PMO to ensure rigour to the work and expectations to achieve top decile for quality

The Roadmap

The 3 year road map within the Transformation Strategy outlines year 3 as going from good to great with a continuation of delivering and building on the integration benefits delivered in 2018/19.

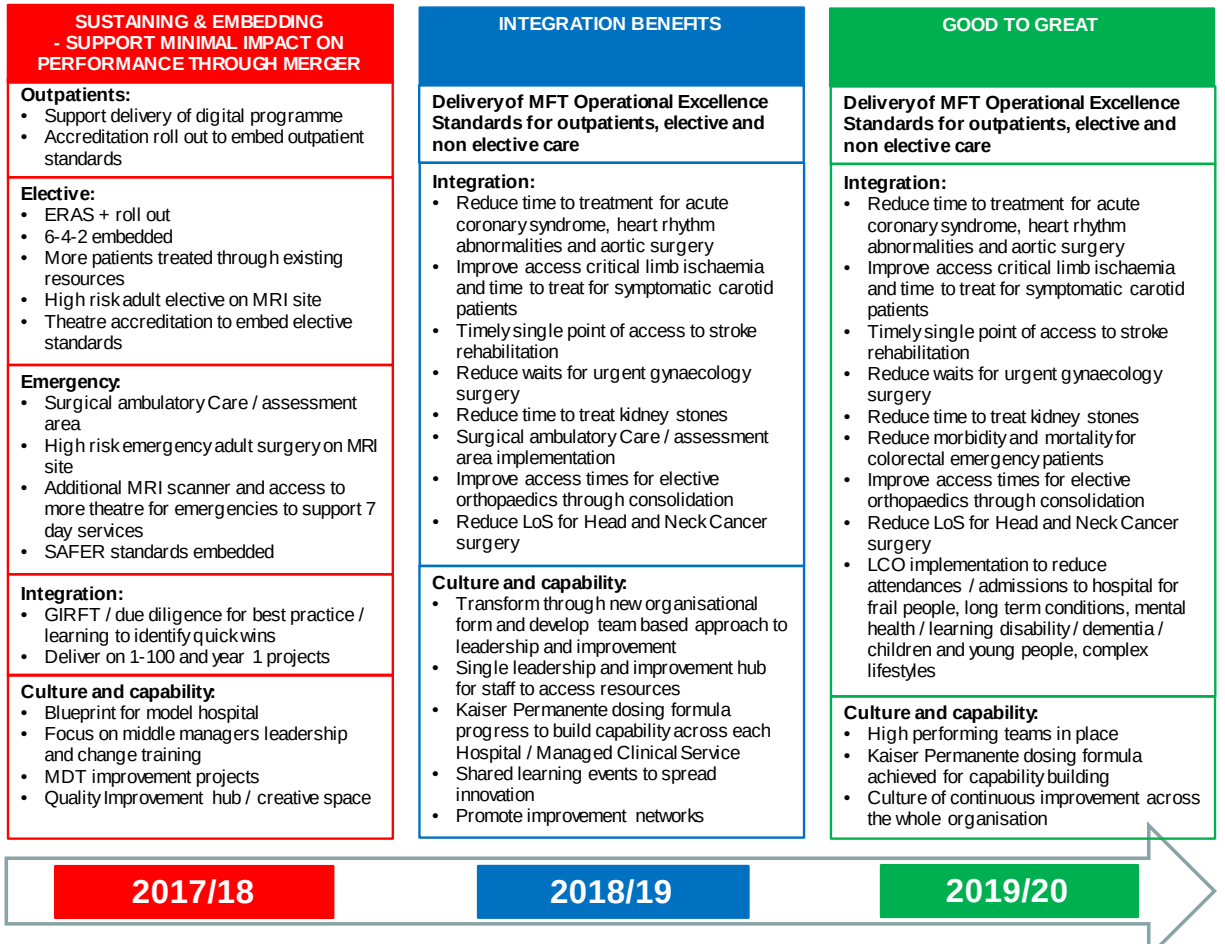
Following the creation of MFT in October 2017 the 2017/18 work programme focused on sustaining and embedding practices whilst ensuring minimal impact on performance through the merger.

During 2018/19 the focus was surrounding the delivery of the integration benefits agreed with commissioners through the Manchester Agreement, which consequently secured transformational funds. Under the decision rights it is the responsibility of Hospitals/MCSs to embed and sustain the MFT standards for outpatients, elective and non elective care, which has continued throughout the year but to varying degrees.

For 2019/20 The transformation resource will focus on the complex change work streams which will primarily be in the delivery of the integration benefits along with providing support across the Group to leverage and scale up good practice against delivery of the MFT Operational Excellence Standards.

This report outlines the timescales and commitments to deliver the 2019/20 transformation programme.

The next 3 year strategy is to be refreshed during the year to commence from 20/21 onwards.



Key Achievements for 2018/19

Manchester University NHS Foundation Trust

MFT Operational Excellence Standards rolled out across Wythenshawe & Withington with assessments and support carried out across all Hospitals/MCSs resulting in **£2m efficiency savings**

GIRFT GETTING IT RIGHT FIRST TIME

Exemplar site for process across MFT to drive improvements supported by Clinical Standard Groups

Urgent Care reviews carried out across MRI & Wythenshawe and joint review with Manchester Health Care Commissioners undertaken into the management of stranded patients

161 staff trained in improvement skills and **64 teams have been coached** through the Affina OD high performing teams programme

78 projects shared through Transform Together Shared Learning Events

Review of ENT processes and pathways to support **improvement in RTT** and impact in 19/20

Key Achievements for 2018/19

Manchester University NHS Foundation Trust

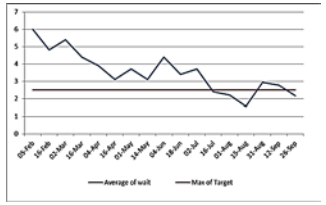
Achievement of Manchester Metrics and securing £11m of Greater Manchester Transformation Funds

Single Point of Access for Stroke implemented improving repatriation from hyper acute Stroke Units, providing more timely rehabilitation and reducing the amount of time patients spend away from their families

Orthopaedic equipment has been standardised across all sites **saving circa 600k**

Elective **lithotripsy** has been phased out at MRI with patients now booked at **Wythenshawe providing additional choice and a reduced waiting time**

Clinical Frailty Standards developed to harmonise frailty pathways across the Hospitals, improving the response and intervention by the acute frailty service and experience for patients



Additional urgent gynaecology surgery list introduced reducing the average waiting time for patients requiring that service **from over 4.5 to under 2.5 days**

New surgical ambulatory assessment unit at the MRI opened

Looking Ahead 2019/20

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Delivering the MFT Excellence Standards

Delivering against the MFT operational excellence standards is key in being able to meet activity plans and improve performance for 2019/20. Activity plans are predicted to deliver **an additional 54,000 outpatients, 11,000 electives** and meet an **increase in emergency demand** of 1,500 A&E attendances across the group. This will require **hospital efficiency targets,** set against national peer benchmarks, to be met for length of stay, DNAs and theatre utilisation. Following the publication of the **NHS Long Term plan** there will be a focus on supporting Hospitals to develop **new care models** to reduce the number of face to face outpatient appointments, along with improving streaming at the front door and increasing ambulatory care to support patient flow with focused transformation resource in the MRI. The Transformation Team will support Hospitals/MCSs in **sharing and scaling up improvement** projects as a priority for 19/20 whilst Hospitals/MCSs will continue to deliver against the operational excellence standards.

The **implementation of a new EPR system** phased from 20/21 across Hospitals will be the largest transformation programme the Trust has delivered. Ensuring the **organisational readiness** over the next 12-18 months will be a significant undertaking and Transformation will play a key role in supporting this. The Transformation team will also support the emerging programme on patient safety working along side the Group Medical Directors.

Integrated Care and Pathways to deliver Clinical Benefits

Continue to deliver the **integration benefits and the Manchester Agreement metrics,** resulting in a further £12m in transformation funds being received into the Trust. This will mean continuing to sustain the changes implemented in 18/19 along with the following:-

- Reducing time from referral to procedure for NSTEMI patients and reducing LoS
- Reducing Length of Stay for patients needing a pacemaker implant
- No patients to wait longer than 7 days for repatriation to a district stroke centre
- Increased usage of surgical ambulatory care at MRI

Creating the culture and Building Capability for Continuous Improvement

Now that Hospitals/MCSs have settled into their new structures, there is a need to **accelerate the building improvement capabilities** and using the Kaiser Permanent dosing formula, plans need to be developed to achieve these targets for training of staff in improvement methodologies. This will support the organisational readiness for a new electronic patient record system and the significant changes this will involve for staff and patients.

Key Message : Transforming pathways to improve patient experience and outcomes by supporting Hospitals/MCSs in delivering the access target, activity plans, financial stability and realising the integration benefits

.

Delivery of MFT Operational Excellence Standards

Manchester University NHS Foundation Trust

Over 1.6 million patients are seen across our outpatient settings and for many this is the only time they will come into contact with our services. This is why we are committed to improving our outpatient services to provide the best patient experience and have developed outpatient standards for all areas to work towards. Nationally it is recognised the outpatient model of care is obsolete to meet a growing demand and is a cornerstone of the NHS Long Term Plan with the ambition to digitalise and reduce face to face visits by a third. However, delivering on the basics is key enabler to this and Hospitals/MCSs will look to develop centralised booking to streamline processes.

Approximately 173,000 patients are treated electively across MFT and the NHS Constitution promises patients a limit on any wait for tests, outpatient care or planned operations. Timely referrals for treatment leads to better outcomes for patients. In order to improve care for our elective patients we have developed standards with clinical teams across the pathway to ensure that as soon as the decision is made to treat we have the most efficient and effective processes for pre-operative assessment, theatre listing and enhanced recovery.

Over 420,000 people attend our adult and children Emergency Departments every year. Emergency demand continues to rise and therefore we need to ensure our internal processes are efficient for patients through the delivery of our SAFER standards designed to improve patient flow. There is also the requirement to ensure collaborative working with key partners across Greater Manchester to manage patients as far as possible closer to home.

Hospitals / Managed Clinical Services are required under the decision rights to deliver and **embed the outpatient, elective and SAFER standards** in order to ensure the basics are in place to achieve operational excellence.

TRANSFORMATION TEAM OFFER AT GROUP LEVEL APRIL 19 – MARCH 20, WE WILL:

Objective 1:

✓ ensure best practice is shared across the Group through quarterly “Transform Together” events, sharing examples of improvement projects and ensuring individuals / teams gain recognition for their work. We will continue to support standards becoming "business as usual“ through Hospital / Managed Clinical Service Transformation Leads

Objective 2:

✓ ensure the outpatient, elective and SAFER standards are reviewed annual with clinical teams and patients and based on best practice, supported by technology resulting in reduced DNAs, improved theatre touch time and reduced length of stay. Provide the expertise to hospitals/MCSs in developing new care models to deliver against the NHS Long Term Plan for outpatients and urgent care, with targeted support in these areas for the MRI

Objective 3:

✓ scale up areas of best practice across the Group and ensure processes are standardised where appropriate providing tools, resources, case studies for staff through a single leadership and improvement programme

Objective 4:

✓ provide support working with informatics, OD&T and clinical services in preparing the organisation for a new electronic patient record (EPR) system

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Integrated Care and Pathways to deliver Clinical Benefits

A Post Transaction Implementation Plan (PTIP) was developed prior to the establishment of MFT and an element of this plan is the integration of clinical services. The Chief Transformation Officer will oversee the implementation through the Operational and Transformation Oversight Group and the Transformation Team resource will support clinical teams in delivery.

The business case identified **10 key clinical areas with significant patient benefits** through integration. Clear and robust plans have been developed and KPIs agreed to deliver the benefits over 3 years. This acknowledges the scale and complexity of the integration work, whilst ensuring quicks wins are realised. Now in year 2 the focus is on **continuing to sustain improvements made in 18/19 and deliver against the approved Manchester Agreement metrics.**

The **Integration Management Office** will track the progress against the benefits and this will contribute to the wider Single Hospital Benefits realisation process, with Hospitals/MCSs using the **WAVE system** to report progress and complete quality impact assessments.

Phase 1 and 2 of the Clinical Services Strategies has now been completed which affect services across WTWA and MRI. New governance arrangements have been put into place whereby the **Chief Executives of MRI & WTWA jointly chair a Service Integration Group** to hold the Senior Responsible Officers for each service to account for delivery. This joint approach will replace the existing programme board structure with the Operational and Transformation Oversight Group receiving progress reports and the **Integration Steering Group retaining overall accountability**. The clinical strategy work will continue to evolve and inform further service / integration reconfiguration and the transformation plans will adapt and align as required.

TRANSFORMATION TEAM OFFER AT GROUP LEVEL APRIL 19 – MARCH 20, WE WILL:

Objective 5:

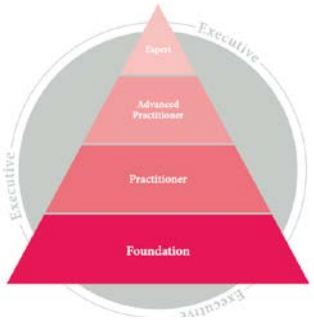
✓ ensure the patient benefits for year 2 are delivered in line with the KPIs and trajectory approved through the Manchester Investment Agreement

Objective 6:

✓ work with Hospitals/MCSs in delivering the phased implementation plans against the clinical service strategies

Objective 7:

✓ work with Finance and Turnaround to ensure the clinical benefits derive financial benefits as outlined in the Business Case and PTIP



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Creating the culture and build capability for continuous improvement

Successful transformation requires a prevailing culture that strives for improvement. A culture that is open about problems, receptive to change and committed to doing what is best for patients is a vital foundation for a successful and sustainable long-term transformation.

It is really important to **ensure staff possess the confidence and knowledge and skills to lead change**, as well as having the right number and level of people who are actively engaged and able to make improvements. Literature suggests it is helpful to have an explicit ambition for how many people should be skilled in improvement and without a considerable number of people with these explicitly recognised improvement skills transformational change will not be achieved.

As a result, it is important to ensure there is **investment in training in Improving Quality Programme (IQP), leadership and improvement skills** so that improvement capability is translated into Hospital Sites and Managed Clinical Services to ensure sufficient expertise to be able to effectively achieve the scale of improvement we are seeking.

Over the next year we will use **learning from global leaders** as outlined in the PTIP and the Kaiser Permanente formula for staff training to achieve a culture of continuous improvement.

The establishment of **Clinical Standards Groups** will continue to develop during the year to implement change at the patient interface, driven by data and information such as patient feedback, audit outcomes and key performance indicators at a local level. The **Getting It Right First Time (GIRFT) programme** will continue to be a feature throughout 19/20 with national visits continuing across services to identify opportunities to reduce variation in practice.

TRANSFORMATION TEAM OFFER AT GROUP LEVEL APRIL 18 – MARCH 19, WE WILL:

Objective 8:

- ✓ work with OD to ensure the high performing team principles and values and behaviours underpin the integration programmes of work which in turn will support and improve staff experience

Objective 9:

- ✓ continue to commission leadership and improvement courses to meet the needs of staff, working with those organisations with a lead role in improvement and innovation, such as NHS Improvement, AQuA, Haelo and Health Innovation Manchester

Objective 10:

- ✓ work with the Clinical Standards Groups (CSG's) and clinical teams to continue to generate ideas and translate into practice through reviewing new care models nationally and internationally and through established networks

Objective 11:

- ✓ Embed GIRFT recommendations and delivery into CSG and integration work programmes, to avoid duplication and maximise the benefits of sharing knowledge and learning

Key Outcomes Measures

Manchester University NHS Foundation Trust

	2018/19 Actual	Target 19/20 Shelford Upper Quartile	Stretch Target 19/20 Shelford Upper Decile
Patient Experience - overall view of inpatient services - patients feeling that they had a good experience (Inpatient Survey)	8.2 (2017 results)	8.2	8.7
Staff engagement - overall engagement score (Staff survey)	7.1	7.0	7.4
Mortality (SHMI) (HIVE)	93.0	<100.00	<100.00
Length of Stay (days) Elective Non-Elective (HIVE and HES data excluding zero days)	4.7 4.1 4.8	4.3 3.7 4.4	4.1 2.6 4.3
Theatre Touch Time (HIVE)	75.1%	84.7%	89.2%
Outpatient DNA New Follow	 11.0% 9.1%	 6.6% 8.1%	 3.8% 7.3%
Financial Impact of Integration (Turnaround team)	*£2m	£8m	£10m

* £11m Transformation Funds

These key outcome measures provide an MFT wide position and will be monitored through the Accountability Oversight Framework (AOF) at Hospital/MCS level where performance needs to shift and constitutional standards delivered.

Targets for 19/20 are set to achieve as a minimum Shelford upper Quartile with a stretch target to achieve upper decile.

In addition, a set of underpinning metrics will be developed which will track delivery against the NHS Long Term Plan specifically for:-

- Reduction in face to face outpatient appointments
- Increase in ambulatory care

Manchester Agreement Metrics

	Transformation area	Benefit Description	CMA Baseline Measure	Target	Implementation start date
2019/20	**Acute coronary syndrome**	Time to treatment for non-elective NSTEMI patients eligible for rapid access andiography	3.3 days	80% of patients treated on day or day after referral	01/04/2019
		LOS for non-elective NSTEMI patients who undergo angiography	Baseline TBC	Reduction of 1 day in median LOS	01/04/2019
	Heart Rhythm Abnormalities	Time to treatment for high risk heart rhythm patients seen between 1600 hrs on Friday to 0900 hrs on a Monday	Baseline TBC	80% of eligible patients to undergo bradycardia pacemaker implantation on the same day or day after admission	01/04/2019
	Cardiac surgery	Time from angiography to CABG surgery for all NSTEMI patients	Baseline TBC	80% of patients to have CABG within 10 days of angiography performed	01/04/2019
	Vascular Surgery	Reduced time to treatment	Baseline TBC	20% improvement	01/04/2020
		Improved access to non-elective procedures and investigations	Baseline TBC	25% improvement	01/04/2020
	Stroke	Timely single point of access to stroke specialist rehabilitation	N/A	85%	01/10/2018
		Ensuring a maximum waiting time for patients awaiting repatriation	N/A	0	01/10/2018
	General surgery	Implementation of ambulatory care for general surgery patients at MRI	0	15%	01/10/2018
		Reduced morbidity and mortality for colorectal emergency patients	Baseline TBC	Reduction of 150 patients	01/04/2020
	Elective orthopaedics	Reduced cancellations of elective surgery	6.5% cancellation rate	1% cancellation rate	01/04/2019
		Improved RTT performance	80%	92%	01/04/2019
	Head and neck cancer surgery	Reduced LOS	11.7 days	8.4 days	01/04/2020

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Our Year Ahead

	Delivery of MFT Operational Excellence Standards	Integration	Culture Change, Capability Building & Standardisation

Quarter 1	• Support MRI Transformation programme of work including:-
	  • Commence joint programme with LCO, MSCC and Hospitals on Complex Discharge Planning
	  • Implement virtual ward and ambulatory care projects as part of the MRI patient flow programme
	  • Complete RTT improvement programme in ENT at the MRI
	  • Commence training on FourEyes ENT scheduling tool in ENT as pilot site
	  • Support development of plans for centralised booking at the MRI
	• Support St Mary's in developing a continuous improvement programme in Gynaecology across outpatients, theatres, ambulatory care, EGU
	• Support MREH outpatient team to deliver service improvements, implementing trust outpatient standards
	• Review of Trafford theatres and develop set of options for maximising capacity
		• Implement joint coronary rhythm management rota
		• Begin regular monitoring of cardiac KPIs
		• Develop proposal for consistent 5 day TIA service
		• Begin reporting of the Manchester Agreement metrics relating to the single point of access
		• Review the scope of the T&O programme board and launch new workstreams
		• Complete the phasing work associated with the wave 1 strategic moves and establish programme governance arrangements
		• Launch community and secondary integration projects relating to respiratory services
		• Urology programme to oversee the transfer of cystectomies from MRI to Wythenshawe
			• Share Learning through Transform Together Event, focusing on projects to scale up and publish case studies
			• Launch new curriculum for building capability
			• Support Hospitals in developing training plans
			• High Performing Team Coaching and accreditation
			• Implement Single Improvement Hub
			• Support 'tackling poor behaviours' initiative
			• Evaluate Transform Together projects and identify opportunities to scale up and spread
			• Model for improvement programme
			• Facilitation of GIRFT visits: Renal, cardiology, breast surgery and update to Clinical Advisory Committee

Quarter 2	• Implement initial phase of outpatient booking centralisation at the MRI • Roll out of first wave of virtual clinics at MRI • Roll out of RTT improvement programme to other MRI services • Outpatient clinic letter standards drafted for Clinical Advisory Group approval • Continue to support REH in delivering against outpatient standards • Support Gynaecology in reviewing outpatients, EGU, ambulatory care pathways	• Evaluate progress against Manchester Agreement • Audit of programme documentation to uphold process and reporting standards, and continuous improvement • Begin implementation of the wave 1 strategic moves • Implement first phase of the TIA improvement programme • Urology programme to oversee the transfer of nephrectomies from MRI to Wythenshawe	• Share Learning through Transform Together Event • Quarterly staff pulse check • Transformation team development session to deliver continuous improvement • Facilitation of GIRFT acute and general medicine specialty visits • Assessment of GIRFT actions, implementation and benefits report to Clinical Advisory Committee • Support implementation of clinical standards via CSG's: surgical consent, WHO checklist, cardiothoracic GIRFT recommendations, pulmonary embolism pathway

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Our Year Ahead

	Delivery of MFT Operational Excellence Standards	Integration	Culture Change, Capability Building & Standardisation
Quarter 3	• Evaluate impact of outpatient improvement plans • Virtual model roll out across the group • Host Shelford Network event • Development of opportunity packs for Hospitals to develop 20/21 plans • Implement frailty assessment unit at MRI	• Evaluate progress against Manchester Agreement • Begin formal reporting of the Manchester Agreement KPIs relating to cardiac services • Evaluation of stroke repatriation single point of access initiative • Continue implementation of the wave 1 strategic moves	• Share Learning through Transform Together Event focused on NHS Change Day • Quarterly staff pulse check • Draft capacity training specification for 2020/21 • GIRFT update to Clinical Advisory Committee • Support implementation of clinical standards via CSG's: surgical length of stay, ED pathway
Quarter 4	• Review standards against good practice and refresh where necessary with patients and staff • Evaluate progress against the work programme and agree 2020/21 plan • Hospital Capacity Plans	• Develop 20/21 plans based on the opportunity pack data and accountability oversight framework • Evaluate progress against Manchester Agreement • Audit of programme documentation to uphold process and reporting standards, and continuous improvement • Begin formal reporting of the Manchester Agreement KPIS relating to surgical ambulatory care • Continue implementation of the wave 1 strategic moves	• Share Learning through Transform Together Event • Evaluate 19/20 capability programme • Quarterly staff pulse check • GIRFT paediatric general surgery regional visit • Support development of CSG annual planning

This programme of work will be developed throughout the year in regards to supporting the organisational readiness of the new EPR System, once the procurement phase is completed by Autumn 2019.

APPENDIX 1 - REVIEW OF 2018/19 DELIVERABLES

		Objective	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19
Delivery of MFT Operational Excellence Standards	1	Ensure best practice is shared across the Group through quarterly "Transform Together" events, sharing examples of improvement projects and ensuring individuals / teams gain recognition for their work	✓ Transform Together Shared Learning Event held 28 June 2018	✓ Lessons Learnt from Urgent Care Reviews shared across MRI & Wythenshawe Hospitals	✓ MFT took part in FabChange 70 Event sharing improvement projects nationally with 45 case studies live streamed during the 70 hours	✓ Transform Together Shared Learning event held 4th March focusing on Transform Together Charitable Funds projects ✓ Frailty focus week held across MFT to raise awareness and launch frailty standards
	2	Ensure the outpatient, elective and SAFER standards are based on best practice, supported by technology resulting in reduced DNAs, improved theatre touch time and reduced length of stay. We will ensure the standards are reviewed annually with clinical teams and patients	✓ Outpatient Standards launched across Wythenshawe & Withington ✓ Refreshed Elective Standards ratified through Quality Committee	✓ Digitalising outpatients simulation exercise carried out ✓ Table top exercise completed across all Hospitals against the elective standards ✓ SAFER review undertaken as part of Urgent Care Reviews across MRI and WTWA with focus on board rounds	✓ MFT took part in the national benchmarking exercise for outpatients and a dashboard has been produced by Deloitte which was released at the end of December via Model Hospital ✓ Audit against Outpatient Standards undertaken ✓ MRI has launched "SAFER, better, together" to roll out the SAFER standards across the hospital and WTWA relaunched SAFER standards in October ✓ Review of endoscopy services at the MRI undertaken with recommendations supporting the patient flow transformation programme	✓ MRI Outpatient engagement session held with staff ✓ Support the MRI in the commencement of an Outpatient Improvement Programme ✓ Refresh of Outpatient programme providing support to MRI and REH ✓ Audit against Elective Standards undertaken ✓ Diagnostic review of elective pathway and theatres in St Mary's and support to implement good practice processes
	3	Scale up areas of best practice across the Group and ensure processes are standardised where appropriate providing tools, resources, case studies for staff through a single leadership and improvement programme	✓ Improvement framework in place across MRI ✓ Review of urgent care pathways across Wythenshawe undertaken with recommendations forming a patient flow transformation programme	✓ Leadership & Improvement framework approved ✓ Review of urgent care pathways across MRI undertaken with recommendations supporting the patient flow transformation programme	✓ Process to embed GIRFT across MFT recognised by the National Director for Clinical Quality and Efficiency as an exemplar approach, following presentation to GIRFT Regional Director and Clinical Champion	✓ Transformation network held on Outpatients to identify areas to scale up and work collectively on developing virtual model of care ✓ Review of outpatient booking processes carried out across the group identifying best practice and opportunities to share ✓ Progress report on urgent care review recommendations ✓ Joint Review with MHCC into the management of stranded patients across MFT
	4	Monitor Group progress through the Accountability Oversight Framework (AOF) measures and accreditation scores	✓ Operational excellence standards monitored through the AOF on a monthly basis ✓ Areas identified for audit of Outpatients across MFT to complement the outpatient accreditation programme	✓ Use of Resources (UoR) Clinical Service metrics monitored through the AOF ✓ Audit of MFT Standards across all Hospitals to review progress and governance	✓ Detailed assessment of progress against the Use of Resources (UoR) Clinical Service metrics with Directors of Operations	✓ Contributed to UoR assessment with NHSI 30 January ✓ Analytical review of AOF scoring differential to form the basis of Clinical Standards Group work programmes

APPENDIX 1 - REVIEW OF 2018/19 DELIVERABLES

		Objective	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19
Integrated Care and Pathways to deliver Clinical Benefits	5	✓ Ensure the patient benefits for year 1 are delivered in line with the KPIs and trajectory approved through the Manchester Investment Agreement	✓ Tracking of benefits undertaken through programme boards and reported to the Operational & Transformation Oversight group	✓ Dashboard developed to track progress	✓ Contributed to Single Hospital Service Year 1 report and PTIP update	✓ All KPIs in the Manchester Agreement have been achieved for 18/19 ✓ Metrics reviewed with MHCC for relevance with some changes agreed
	6	✓ Ensure implementation of the first phase of the general surgery Healthier Together consolidation	✓ Successful recruitment of 4 General Surgeons	✓ Implementation of ambulatory care for general surgery patients at MRI	✓ Implementation of ambulatory care for general surgery patients at MRI	✓ Business case for sector resource completed and submitted to GM
	7&9	✓ Work with OD to ensure the high performing team principles and values and behaviours underpin the integration programmes of work which in turn will support and improve staff experience	✓ Commencement of phased Group-wide roll-out of Affina OD programme ✓ Cohort 1 High Performing Team Coaching and accreditation delivered April 2018	✓ MFT Values & Behaviours framework launched and shared through programme boards ✓ 63 staff going through Affina Team Coach training programme	✓ 6 staff fully accredited Affina coach status ✓ 32 teams are now being coached through the Affina OD programme	✓ Team journey embedded within Transformation Team to improve the support provided to other teams across the Group – incorporated into ongoing team development sessions
	8	✓ Work with Finance and Turnaround to ensure the clinical benefits derive financial benefits as outlined in the Business Case and PTIP	✓ Endoscopy due diligence completed May 2018 ✓ MFT Frailty Standards agreed with clinical teams ✓ Review of Cardiac Services completed June 2018 ✓ Development of Acute Coronary Syndrome pathways protocol ✓ Options paper developed for Head & Neck ✓ Options appraisal for Orthopaedics elective activity at Trafford drafted	✓ Presentation to Greater Manchester (GM) Partnership and Manchester Health & Care Commissioning (MHCC) with progress on year 1 benefits ✓ Stroke single point of access agreed and implemented from 1st October ✓ Continuing to deliver against Manchester Agreement Metrics for Urology Lithotripsy Service and Gynaecology emergency list	✓ Worked with Turnaround, Hospital/MCS level opportunity packs have been developed triangulating benchmark, GIRFT, Model Hospital data to identify the financial opportunities for 2019/20 ✓ Working with the strategy team to understand capacity impacts of the wave 1 clinical service strategies including efficiency opportunities	✓ Review of MRI and Trafford endoscopy service completed with recommendations for improvements and opportunities for working with Wythenshawe ✓ Worked with Turnaround to develop an integrated urology service review pack which will now roll out to other services in wave 1 of the clinical strategy

APPENDIX 1 - REVIEW OF 2018/19 DELIVERABLES

		Objective	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19
Creating the culture and build capability for continuous improvement	10	✓ Continue to commission leadership and improvement courses to meet the needs of staff, working with those organisations with a lead role in improvement and innovation, such as NHS Improvement, AQuA, Haelo and Health Innovation Manchester	✓ Launched new curriculum for building capability with AQUA – May 2018 ✓ Supported Hospitals in developing training plans	✓ 130 staff trained in improvement methodologies ✓ Training Plans developed for Hospitals ✓ NACs programme Cohort 12 underway, 75 clinical leaders on programme	✓ 161 staff trained staff trained in improvement methodologies, an increase of 31 during Q3. ✓ 21 clinicians have graduated from the Newly Appointed Consultants (NACs) programme Cohort 11, Cohort 12 is underway with 22 participants and overall 241 have been through the NACs programme to date.	✓ Cohort 13 of the NACs programme underway with 24 participants ✓ Evaluation of 19/20 AQUA improvement training undertaken and 2019/20 Curriculum developed with AQUA
	11	✓ Work with the clinical standards groups and clinical teams to continue to generate ideas and translate into practice through reviewing new care models nationally and internationally and through established networks	✓ Supported the launch of the Clinical Standards Groups inaugural event, developing our local approach to implementing standardised cross-site patient experience and outcomes ✓ Researched and produced a comprehensive governance framework and approach to how the Group should embed GIRFT to deliver the maximum benefits	✓ Produced governance framework for Clinical Standards Groups, including collection and prioritisation of standardisation opportunities, and project management approach – presented to and ratified at Clinical Advisory Committee ✓ Organised and attended ENT GIRFT national clinical lead visit ✓ GIRFT governance framework presented to and ratified by the Clinical Advisory Committee	✓ Facilitated secondary launch for confirmed core team members of Clinical Standards Groups, and provided key data to support the construction of annual work programmes. ✓ Facilitated Hospital Medical Director reviews to obtain formal ownership of GIRFT recommendations by respective Clinical Leads. ✓ Organised and attended Endocrinology, Emergency Medicine and Radiology GIRFT national clinical lead visits	✓ Annual Clinical Standards Groups work programmes produced and submitted to Clinical Advisory Committee for ratification ✓ Hospital Dentistry GIRFT national clinical lead visit ✓ Presented MRI theatre productivity successes at NHSI national event as part of their Trust support offer development session ✓ GIRFT assessment of progress against actions undertaken to identify and report successful implementation and outcomes

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Julia Bridgewater, Chief Operating Officer
Paper prepared by:	Lorraine Cliff, Acting Chief Transformation Officer
Date of paper:	24 April 2019
Subject:	TRANSFORMING CARE FOR THE FUTURE 18/19 Quarter 4 Progress Report
Purpose of Report:	Indicate which by ✓ • Information to Note ✓ • Support ✓ • Accept • Resolution • Approval • Ratify
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)** The report provides progress against the Transforming Care for the Future 18/19 plan and commitments to achieve the top decile for quality - clinical outcomes, safety, patient experience, staff engagement and operational efficiency measures
Recommendations:	The Board are asked to note and support the MFT Transforming Care for the Future Programme 18/19 Quarter 4 report.
Contact:	Name: Lorraine Cliff, Acting Chief Transformation Officer Tel: 0161 701 5115

Agenda Item 8.2.2

Manchester University
NHS Foundation Trust

Transforming Care for the Future

2018/19 Quarter 4 Report

Lorraine Cliff, Acting Chief Transformation Officer
April 2019

Contents

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NHS Foundation Trust

Overview

Manchester University NHS Foundation Trust

The MFT Transformation Strategy was approved by the Interim Board of Directors on 19 September 2017 pending the formation of MFT on the 1st October 2017. Our ambition is to lead healthcare in the NHS and therefore we need to be in the top decile for quality in its broadest sense not only on outcomes and safety but patient and staff experience and operational efficiency.

As a result we aspire to be recognised for excellence in patient and staff experience and use of technology, facilities and strong leadership are enablers for staff to change. This is the key driver for our transformation programme and in 3 years' time through a culture of clinically led change we want to achieve:

Operational excellence across all hospitals and community services, alongside being recognised for excellence in quality, patient and staff experience

Fully integrated single hospital services

Effective partnerships with our Local Care Organisation, Devolution Manchester, Shelford Group and other key stakeholders

The aim of our transformation strategy is to ensure we:

- ✓ Continue to build upon and strengthen the transformation work already in place
- ✓ Continue to build the capability of staff to ensure a culture of continuous improvement.
- ✓ Ensure we are making best use of existing resources and corporate teams to support improvement and support the clinical teams and divisions / hospitals in a coherent way.
- ✓ Continue to co-ordinate projects to ensure lessons are shared .

The Transforming Care for the Future Programme objectives for the next 3 years are:

	Culture for change	Continue to create the right culture across each Hospital and Division to deliver change through embedding the values and behaviours and leadership
	Build Capability	Continue to build staff capability in leadership and change using a single methodology to support continuous improvement
	Delivery	Through collaborative working achieve operational excellence and excellence in patient and staff experience which will continue to deliver efficiencies through transformational change, supporting the financial strategy
	Governance	Comply with the governance process / PMO to ensure rigour to the work and expectations to achieve top decile for quality

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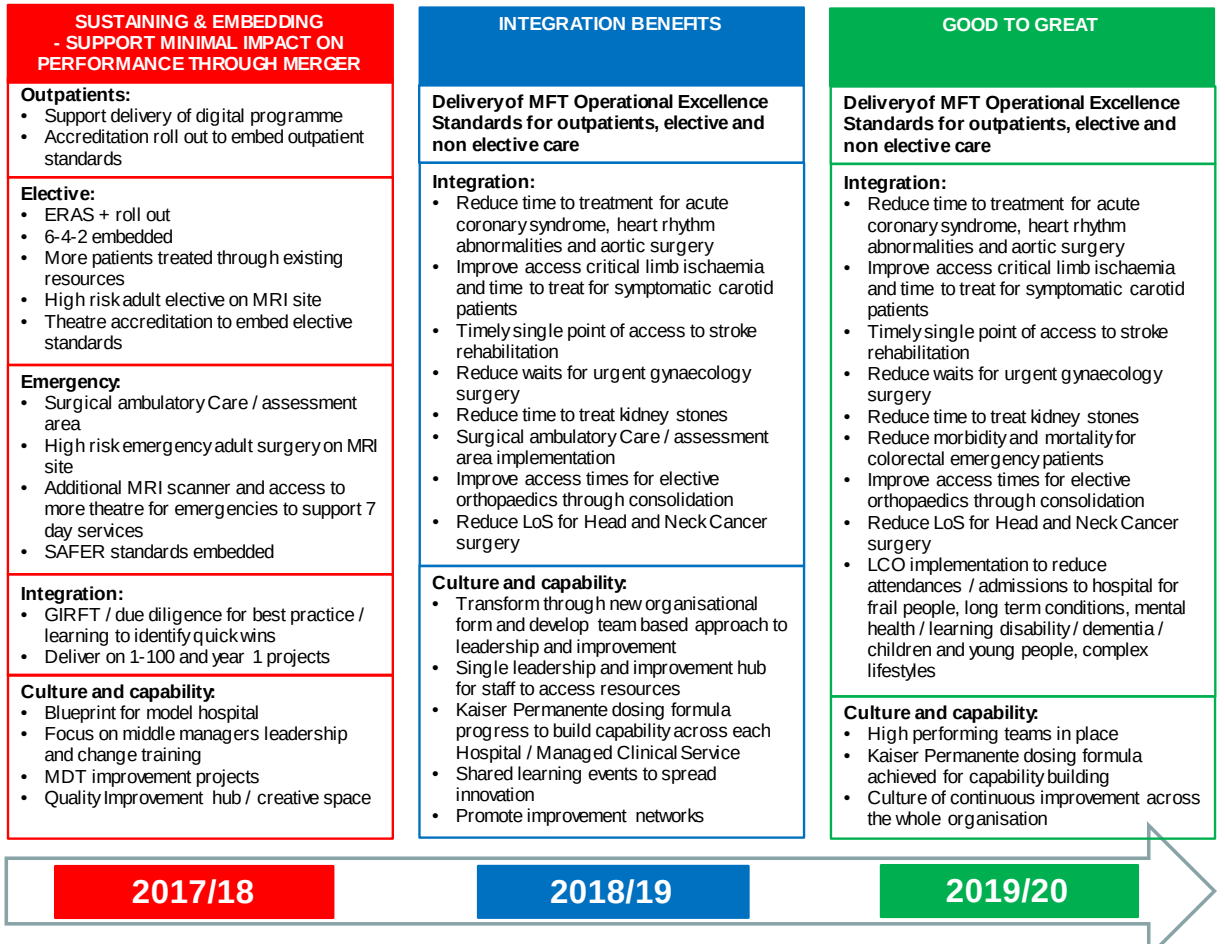
The Roadmap

The 3 year road map within the Transformation Strategy outlined year 2 as delivering integration benefits and going from “good” to “great” in year 3.

During 2018/19 the focus will be to deliver 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.

The transformation resource will focus on the complex change work streams which will primarily be in the delivery of the integration benefits.

This report outlines the timescales and commitments to deliver the integration programmes of work.



Summary of Q4 Progress against agreed objectives

	Objective	Q4 Progress
1	Ensure best practice is shared across the Group through quarterly "Transform Together" events, sharing examples of improvement projects and ensuring individuals / teams gain recognition for their work.	✓ Transform Together shared learning event held 4th March with 11 projects showcased and 80 attendees. The event focused on projects supported through the Transform Together Charitable fund
2	Ensure the outpatient, elective and SAFER standards are based on best practice, supported by technology resulting in reduced DNAs, improved theatre touch time and reduced length of stay. We will ensure the standards are reviewed annually with clinical teams and patients	✓ Assessment against the MFT Elective Standards carried out across Hospitals/MCSs to identify areas of good practice to share and areas to focus. ✓ Refresh of the Elective, Non-Elective and Outpatient Programme Initiation Documents for 19/20 and shared with Hospitals/MCSs ✓ Assessment of progress against the MRI & WTWA Urgent Care review recommendations carried out ✓ Task & Finish Group established and workshop held to develop MFT principles for outpatient clinic letters
3	Scale up areas of best practice across the Group and ensure processes are standardised where appropriate providing tools, resources, case studies for staff through a single leadership and improvement programme	✓ Assessment against all 280 Transform Together projects undertaken to theme up and identify opportunities to spread and scale up ✓ Frailty focus week to launch Frailty Standards across MFT carried out w/c 25th February ✓ Review undertaken on the Referral To Treatment (RTT) pathways within ENT services
4	Monitor Group progress through the Accountability Oversight Framework (AOF) measures and accreditation scores	✓ Supported the preparation for the Use of Resources (UoR) assessment In January providing evidence on Clinical Service metrics with Directors of Operations
5	Ensure the patient benefits for year 1 are delivered in line with the KPIs and trajectory approved through the Manchester Investment Agreement	✓ Tracking of benefits undertaken through programme boards and reported to the Operational & Transformation Oversight group
6	Ensure implementation of the first phase of the general surgery Healthier Together consolidation	✓ Surgical ambulatory care model continues to be implemented at MRI learning from Wythenshawe
7	Work with Organisational Development (OD) to ensure the high performing team principles underpin the integration and engagement with staff and patients throughout the process	✓ 64 multidisciplinary staff trained to deliver Affina Team Coaching programme , with 6 fully accredited ✓ 47 team leaders are now being coached through the Affina OD programme
8	Work with Finance and Turnaround to ensure the clinical benefits derive financial benefits as outlined in the Business Case and Post Transaction Implementation Plan (PTIP)	✓ Working with Turnaround, Hospital/MCS level opportunity packs have been developed triangulating benchmark, GIRFT, Model Hospital data to identify the financial opportunities for 2019/20 ✓ Capacity modelling undertaken to understand the impact of the wave 1 clinical service strategies including efficiency opportunities presented to the Board.
9	Continue to commission leadership and improvement courses to meet the needs of staff, working with those organisations with a lead role in improvement and innovation, such as NHS Improvement, AQuA, Haelo, Health Innovation Manchester	✓ 220 staff trained in improvement methodologies , an increase of 59 during Q4. ✓ Cohort 13 of the Newly Appointed Consultants (NACs) programme commenced in Q4, with cohort 12 also in progress. The total number of consultant attending or attended this programme is 265.
10	Work with the Clinical Standards Groups (CSGs) and clinical teams to continue to generate ideas and translate into practice through reviewing new care models nationally and internationally and through established networks	✓ Annual programmes of work for each CSG have been approved by the Clinical Advisory Committee held in February 2019. A vlog has been created to educate all staff in the purpose and focus of Clinical Standards Groups. Hospital Dentistry GIRFT visit took place

MFT Operational Excellence Standards

Manchester University NHS Foundation Trust

OUR COMMITMENTS FROM JANUARY – MARCH 2019, WE WILL:

Objective 1:
Ensure best practice is shared across the Group through quarterly "Transform Together" events, sharing examples of improvement projects and ensuring individuals / teams gain recognition for their work. We will continue to support standards becoming "business as usual" through Hospital / Managed Clinical Service Transformation Leads

Objective 2:
Ensure the outpatient, elective and SAFER standards are based on best practice, supported by technology resulting in reduced DNAs, improved theatre touch time and reduced length of stay. We will ensure the standards are reviewed annually with clinical teams and patients

Objective 3:
Scale up areas of best practice across the Group and ensure processes are standardised where appropriate providing tools, resources, case studies for staff through a single leadership and improvement programme

Objective 4:
Monitor Group progress through the Accountability Oversight Framework (AOF) measures and accreditation scores

8 Processes proven to improve performance and patient experience

Function	MRI	Wyth	Trafford	REH	RMCH	Dental	St Mary's
Follow up waiting lists							
Directly bookable slots via e referral							
Booking with choice							
Partial booking							
2 way text reminders							
Targetted telephone reminders							
Outsourced printing and sending							
Dedicated booking function							

RAG - Not in place, partially in place, fully embedded

PROGRESS DURING QUARTER 4:

During Q4 an assessment against the MFT Operational Excellence standards for Outpatients and Electives has been undertaken.

Across Outpatients progress has been made on offering patient choice and minimising cancellations at short notice due to the roll out of the electronic referral system in April 2018. The recent assessment demonstrated areas of good practice, shared learning and identified 8 processes that were proven to improve performance and experience for patients.

However there remains a number of common challenges across Hospital/MCSs, these are as follows:-

- **Standardised letters & providing clear information:**
- **Communication**: Patients across MFT sites felt they were not notified of waiting times in clinic
- **Clinic Delays:** delays in clinic were identified as a common issue
- **Clinic Letter 5 day turnaround**: The majority of areas were reported to be over the 5 day turnaround performance
- **Casenote availability at time of appointment**: Although progress is being made through the Medical Records Improvement Programme, casenote availability was highlighted as an on-going issue

Outpatients has gained a national focus and is a cornerstone of the recently published NHS long-term plan with a commitment that services will be designed to achieve a reduction by a third of face to face outpatient visits. With this in mind the Outpatient Transformation Programme is being refreshed, responding to the findings from the latest assessment and Hospitals/MCSs will deliver through their improvement boards with focused support from Transformation in the MRI and St Mary's.

Tracking the impact is measured through **did not attends (DNAs)** which is monitored through the Accountability Oversight Framework. The year end position overall has shown an **improved performance against 17/18 from 10.1% to 9.7%**. Improvements have been seen in Ophthalmology and MRI surgical specialties**.** Wythenshawe continues to be our exemplar site with an overall DNA performance of 8.8%.

MFT Operational Excellence Standards

Manchester University NHS Foundation Trust

OUR COMMITMENTS FROM JANUARY – MARCH 2019, WE WILL:

Objective 1:
Ensure best practice is shared across the Group through quarterly "Transform Together" events, sharing examples of improvement projects and ensuring individuals / teams gain recognition for their work. We will continue to support standards becoming "business as usual" through Hospital / Managed Clinical Service Transformation Leads

Objective 2:
Ensure the outpatient, elective and SAFER standards are based on best practice, supported by technology resulting in reduced DNAs, improved theatre touch time and reduced length of stay. We will ensure the standards are reviewed annually with clinical teams and patients

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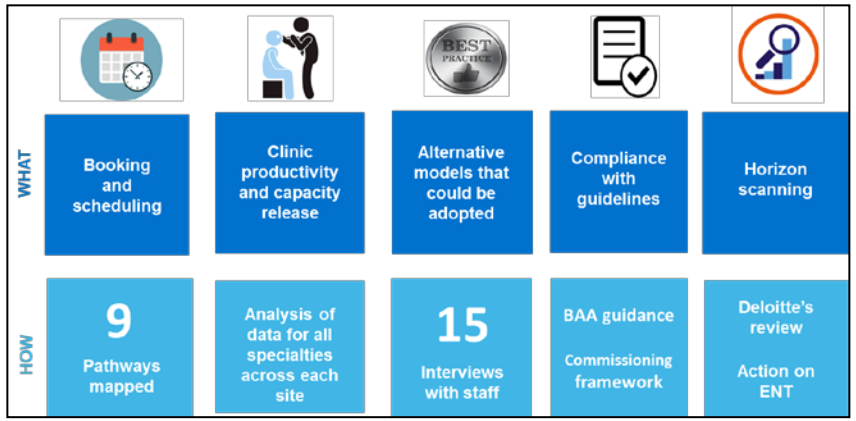
Scale up areas of best practice across the Group and ensure processes are standardised where appropriate providing tools, resources, case studies for staff through a single leadership and improvement programme

Objective 4:
Monitor Group progress through the Accountability Oversight Framework (AOF) measures and accreditation scores



Review of ENT Pathways

PROGRESS DURING QUARTER 4:

An assessment against the elective standards was carried our during February. Areas of good practice were identified with 6-4-2 scheduling processes being embedded across all Hospitals, Surgery School and Enhanced Recovery after Surgery programmes across MRI and Wythenshawe were well embedded to improve the outcomes for patients undergoing high risk surgery.

However, there were a number of challenges and common areas of focus:-

- **Consent in clinic** – variation of compliance
- **Compliance with 'Golden Patient' processes**
- **Readiness of patients on the ward** – number of instances where Theatres experience delays due to patients not being ready to be sent for
- **Discretionary list changes** – numerous occasions where lists changes occurred due to reasons including bed capacity, surgeon preference, equipment availability
- **Cancellations due to Pre-op Assessment**

The elective transformation programme has been refreshed and Hospitals/MCSs are revising plans to deliver against the standards. The Transformation team are providing focused support to St Mary's to deliver a programme of continuous improvement working with clinical and operational teams in Gynaecology to improve theatre productivity.

Tracking the impact is measured through Theatre Touch times which is monitored through the Accountability Oversight Framework. During 18/19 progress has been variable across Hospitals with RMCH, REH and TGH improving on their performance, however overall MFT position has not improved with MRI, Wythenshawe, St Mary's and UDH reporting a deteriorated position during Q4.

The team have undertaken a review of the ENT referral to treatment (RTT) pathways across the MRI and have developed a 30,60,90 day action plan with the aim to improve access targets and experience for patients.

MFT Operational Excellence Standards

Manchester University NHS Foundation Trust

OUR COMMITMENTS FROM OCTOBER– DECEMBER 2018, WE WILL:

Objective 1:
Ensure best practice is shared across the Group through quarterly "Transform Together" events, sharing examples of improvement projects and ensuring individuals / teams gain recognition for their work. We will continue to support standards becoming "business as usual" through Hospital / Managed Clinical Service Transformation Leads

Objective 2:
Ensure the outpatient, elective and SAFER standards are based on best practice, supported by technology resulting in reduced DNAs, improved theatre touch time and reduced length of stay. We will ensure the standards are reviewed annually with clinical teams and patients

Objective 3:
Scale up areas of best practice across the Group and ensure processes are standardised where appropriate providing tools, resources, case studies for staff through a single leadership and improvement programme

Objective 4:
Monitor Group progress through the Accountability Oversight Framework (AOF) measures and accreditation scores

Craig Parson receiving the Trophy from our Chairman

A **Transform Together shared learning** event was held in March where 11 projects were showcased from across Hospitals/MCSs. The event was opened by Vanessa Gardener, Chief Transformation Officer and our Chairman, Kathy Cowell, with over 80 staff members in attendance. As usual staff voted on their favourite project with the winner receiving a trophy. This time the trophy was awarded to Craig Parson, Organisational Development Manager who has developed an **e-learning package for staff on improvement skills**.

PROGRESS DURING QUARTER 4:

To support the work on **patient flow** across the group in February the Transformation team completed an assessment of progress against the urgent care review recommendations carried out at Wythenshawe and MRI in the summer 2018. This showed that of the 51 recommendations made 24 (47%) had been implemented with a further 21 (41%) in progress. Further areas of focus and recommendations were identified. At the same time a rapid review was carried out with RMCH to identify good practice, areas of focus and recommendations.

Following on from the urgent care assessments a rapid review was carried out with MHCC into the processes for managing **stranded patients** at the MRI and Wythenshawe hospitals. This focused on the systems and processes at each site and the reasons for the recent increases in long stay patients on both sites. Following on from this work a more detailed piece of work is being carried out with Greater Manchester Health & Social Care Partnership (GMHSCP) using their recently ratified '**System Wide Discharge Model and Standards'** document. This will become a system wide transformation programme with the adult acute sites and the Local Care Organisation (LCO).

The Transformation team has continued to support the implementation of the **Patient Flow Programme (Safer, Better, Together) at the MRI**. In the last quarter this has included

- embedding of board rounds across all wards
- support with the implementation of a new consultant of the week rota in orthopaedics
- development of options for a virtual ward model
- improvements in diagnostic testing in Emergency Department

SAFER. BETTER. TOGETHER.

The has resulted in more patients being discharged earlier in the day with 17% of all discharges in February taking place before midday, an increase of 5% compared to January.

Integrated Care and Pathways to deliver Clinical Benefits

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OUR COMMITMENTS FROM OCTOBER– DECEMBER 2018, WE WILL:

Objective 5:
ensure the patient benefits for year 1 are delivered in line with the KPIs and trajectory approved through the Manchester Investment Agreement

Objective 6:
ensure implementation of the first phase of the general surgery Healthier Together consolidation

Objective 7:
work with Organisational Development (OD) to ensure the high performing team principles underpin the integration and engagement with staff and patients throughout the process

Objective 8:
work with Finance and Turnaround to ensure the clinical benefits derive financial benefits as outlined in the Business Case and PTIP

PROGRESS DURING QUARTER 4:

The delivery of the **integration** programme has continued through quarter 4 and achievement against the Manchester metrics has been sustained for urology lithotripsy service and waits for urgent gynaecology surgery.

The integration workstreams have been supported by the publication of the **first wave of clinical strategies.** The findings and recommendations of the clinical strategies have been presented to programme boards and integration groups and have informed the development of the work plans for 19/20. Working with strategy the transformation team have undertaken the **capacity modelling** to understand the impact of the wave 1 clinical service strategies, which was presented to Group Management Board in February.

Progress in each of the workstreams is summarised below:

Cardiac

- High and medium risk **rapid access Acute Coronary Syndrome pathway** has been implemented at both sites reducing the time taken for patients to have their angiogram and reduced the length of stay for this group of patients
- **Project nurse** funded by the Greater Manchester Transformation fund
- A new **weekend rota** has been agreed in heart rhythm management and will start from 1st April. This new rota will ensure that urgent patients receive a pacemaker implantation within 24 hours regardless of which site they present to
- The aortic surgeons from both cardiac centres have been working together to develop a **single point of referral** for patients with acute problems which went live in Q4

Integrated Care and Pathways to deliver Clinical Benefits

NHS Manchester University NHS Foundation Trust

Urology

- Progress has been made in developing the **future model of care** for urology in line with the strategy wave 2 process.
- The initial **merger benefits** have been sustained that have resulted in a reduced time to treatment for kidney stone removal from 60 days to 0 and increased choice of treatment from 0.5 days to 3 days
- Plans developed for the **transfer of bladder and kidney cancer surgery** from MRI to Wythenshawe in Q1 & Q2 19/20
- Urology **service line review** developed with Turnaround to support the development of a single service

Respiratory

- Developed plans in response to the publication of the **lung clinical strategy** focusing on areas of commonality and mutual benefit for Wythenshawe and MRI.
- Plans are being developed for an **integrated community service** and joint working around specific respiratory service areas that cross secondary and tertiary care

Orthopaedics

- A new **consultant of the week** rota has been implemented at the MRI
- Procurement savings have increased up to **£500k**

General Surgery

- New **on call proposals** and **pelvic floor model** have been agreed
- **Surgical ambulatory care** model continues to be implemented at MRI learning from Wythenshawe

Frailty

- Successful **frailty focus week** in February.
- **Emergency laparotomy pilot** has gone live at MRI and Wythenshawe as part of a national QI initiative
- Nearly 100% compliance for **Rockwood screening** at Wythenshawe, MRI & Trafford in the Pre-op assessment session
- **Online frailty training package** funded and designed

Stroke

- Stroke single point of access for repatriation has **reduced breaches and waiting times** for patients (no patients waited over 72 hours in March)
- Bed management on the stroke ward at MRI has improved with **more stroke patients in the right bed**
- **Transient Ischemic Attack (TIA) clinic** improvement project has begun which will deliver an **equitable high quality service** across MFT

Creating the Culture and build capability for continuous improvement for Change

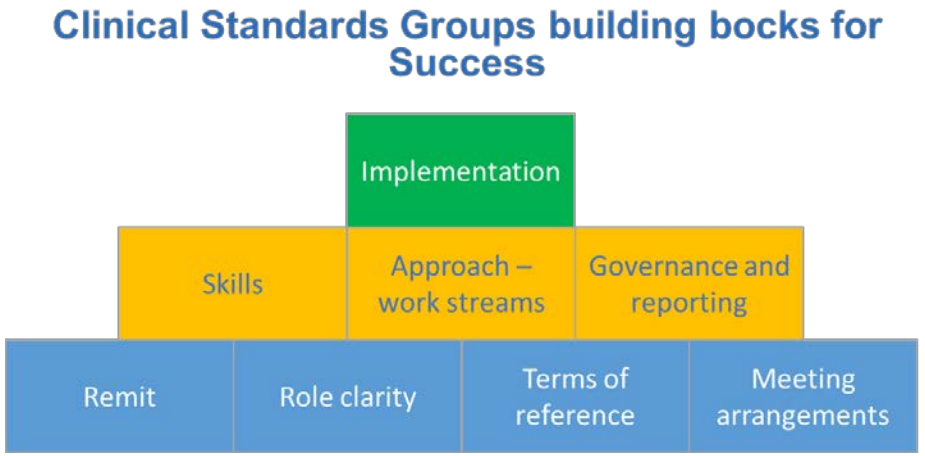
Manchester University NHS Foundation Trust

OUR OBJECTIVES FROM JANUARY - MARCH 2019, WE WILL:

Objective 9:
work with OD to ensure the high performing team principles and values and behaviours underpin the integration programmes of work which in turn will support and improve staff experience

Objective 10:
continue to commission leadership and improvement courses to meet the needs of staff, working with those organisations with a lead role in improvement and innovation, such as NHS Improvement, AQuA, Haelo, Health Innovation Manchester

Objective 11:
work with the clinical standards groups and clinical teams to continue to generate ideas and translate into practice through reviewing new care models nationally and internationally and through established networks



Core elements of Clinical Standard Group's success

PROGRESS DURING QUARTER 4:

The **Getting It Right First Time (GIRFT)** national programme continues, and in Q4 a **visit to the Dental Hospital** took place to share the benchmarked position of the organisation with regard to Hospital Dentistry. The session was well attended and we await the subsequent report and recommendations.

The work of the **Clinical Standards Groups** (CSG's) is gathering momentum and each group has clear direction with regard to its initial programmes of work. A vlog has been produced to enable the Clinical Leads to describe their areas of focus, to help staff to understand and appreciate how the groups can be successful in ensuring our patients receive similar standards of experience, care and clinical outcomes, regardless of the location of their visit.

A **new improvement hub** to support collaboration and learning is being developed which will be launched with the new MFT intranet site during Q1.

The **2019/20 AQuA training offer** has been agreed in principle, which sets out to support the organisation in delivering a minimum volume of staff who are trained in change methodologies. Details of courses available to staff will be displayed within the new improvement hub intranet site.

Work continues with the Organisational Development (OD) team to roll out the high performing team principles and 6 members of the Transformation Team are trained as Affina OD coaches and are supporting teams through the process. A quarterly meeting of staff trained as Affina OD coaches took place and is a support and development network to help coaches to improve their service offering to current and future team leaders.

A formal presentation was given to the national and regional NHSI theatre productivity teams to share our learning and to help them to construct their support offer for the benefit of all trusts. The key message was to ensure cultural change is at the forefront of improvement, and the ability to be involved in shaping the NHSI agenda and approach means that we are able to spread our own message regarding the importance of maximising both culture and capability in a concurrent and complementary manner.

Key Outcomes Measures

Manchester University NHS Foundation Trust

Metric	2018/19 Plan Shelford Upper Quartile	2018/19 Actual
Patient Experience - overall view of inpatient services - patients feeling that they had a good experience (Inpatient Survey)	8.2	8.2 (2017 results)
Staff engagement - overall engagement score (Staff survey)	7.0	7.1
Mortality (SHMI) (HIVE)	<100.00	93.0
Length of Stay (days) Elective Non-Elective (HIVE and HES data excluding zero days)	4.3 3.7 4.4	4.7 4.1 4.8
Theatre Touch Time (HIVE)	84.7%	75.1%
Outpatient Did Not Attend (DNA) New Follow	 6.6% 8.1%	 11.0% 9.1%
Financial Impact of Integration (Turnaround team)	£8m	*£2m

* Includes £11m transformation funds following delivery of the Manchester Agreement Metrics

RAG rating compared to 18/19 Deterioration, partial progress, achieved target

Manchester Metrics

	Area	Benefit Description	Baseline	Target	Actual
2018/19	Urgent gynaecology surgery	Reduced waits for urgent gynaecology surgery	3.3 days	2.5 days	2.17 days
	Kidney stone removal	Reduced time to treatment	60 days	0 days	0 days
		Increased choice of treatment	0.5 days	3 days	3 days

Key Message

Progress has been made but this has been slow and during 19/20 the pace needs to be stepped up to deliver the required efficiency targets

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Peter Blythin, Group Executive Director of Workforce and Corporate Business.
Paper prepared by:	Greg Shaw, SHS Business Manager
Date of paper:	13th May 2019
Subject:	Progress report on the Manchester Single Hospital Service.
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration of Risk against Key Priorities:	Failure to deliver the Manchester Single Hospital Service Programme effectively will potentially 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, Group Executive Director of Workforce and Corporate Business Tel: 0161 701 0190

1. Purpose

1.1. The purpose of this paper is to provide an update for the Board of Directors on the Single Hospital Service (SHS) Programme.

2. Background

2.1. The proposal to establish a Single Hospital Service in Manchester forms an integral part of the Manchester Locality Plan. Building on the work of the independent Single Hospital Service Review, led by Sir Jonathan Michael, the SHS Programme has been operational since August 2016.

2.2. The Programme is being delivered through two linked projects. Project One, the creation of MFT through the merger of Central Manchester University Hospitals NHS Foundation Trust (CMFT) and University Hospital of South Manchester NHS Foundation Trust (UHSM), was completed on 1st October 2017.

2.3. 'Project Two' is the proposal for North Manchester General Hospital (NMGH) to transfer from Pennine Acute Hospital NHS Trust (PAHT) to MFT.

3. Integration (Project One)

Benefits Management Approach

3.1. The established Integration Management Office (IMO) within the Single Hospital Service Team has set up robust tracking / monitoring structures and processes to ensure that the organisation effectively delivers the planned merger benefits and is able to clearly evidence the impact. Processes have also been instituted to identify and track a series of additional emergent benefits enabled by the merger.

3.2. In March 2018, the IMO met all work stream leads to confirm which planned merger benefits were actively being delivered / anticipated to be delivered through integration projects. Following this process a consolidated list of confirmed and emergent benefits was produced, including details of timescales, ownership and suggested measures for each individual benefit. Each benefit was also categorised by the high level benefit areas identified in the Sir Jonathan Michael Review.

3.3. Delivery of all identified benefits is tracked by the IMO to ensure they are successfully realised as planned. This is critical given the expected length of time it will take to realise some of the key benefits and the need to evidence their success to key stakeholders both within and outside of the organisation.

Governance Arrangements for Delivery

3.4. Operational responsibility for ensuring the delivery of integration benefits sits with the Integration Steering Group (ISG), chaired by the Executive Director of Workforce and Corporate Business. In this context, the ISG continues to be a useful forum for connecting the work of the Strategy, Workforce, Transformation and Single Hospital Service Teams to ensure all work is harnessed to ensure sensible delivery.

3.5. An additional forum chaired by the Chief Executives of Manchester Royal Infirmary (MRI) and Wythenshawe, Trafford, Withington and Altrincham (WTWA) is being established to oversee delivery of the MRI and WTWA integration portfolios. This group will hold each service area to account for the duration of their integration programmes. Delivery progress will continue to be tracked by the IMO and shared with the Operations and Transformation Oversight Group, Hospital/Managed Clinical Service Chief Executive Forum and monitored by the ISG. The Group Executive Director Team will continue to receive briefings and formal reports will be submitted to the Board of Directors on a regular basis.

Assurance on the Approach to Benefits Management

3.6. An internal audit of the Post Transaction Integration Plan (PTIP) and the approach to merger benefits management was conducted by the Trust's Internal Auditors in March 2019. The audit reviewed the strength and effectiveness of the Trust's approach to managing, tracking and reporting on merger integration related benefits.

3.7. The audit awarded the Trust's benefits management approach a rating of "Significant Assurance with Minor Improvements Required". This indicates that the system is well designed and applied.

Ongoing Development of the Benefits Management Approach

3.8. In response to the audit, the IMO developed an action plan to strengthen the approach to benefits management. This has been agreed by ISG and is being implemented.

3.9. The IMO is also applying a revised benefits management approach to all integration related work streams and projects.

3.10. To ensure relentless attention to benefit realisation a comprehensive integration benefit review is scheduled for June 2019.

3.11. Delivery of a wide range of integration benefits is underway across the organisation. This information is set out in the 2019/20 Transformation Annual Plan and Q4 (2018/19) Report. These documents provide an insight into the breadth of benefits being delivered across the Trust.

4. Proposed Acquisition of North Manchester General Hospital (NMGH)

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

4.2. The transaction process is being managed under the auspices of the national NHS I Transaction Guidance with oversight provided by a Transaction Board established at the end of November 2017. The Board, of which MFT is a member, is chaired by Jon Rouse, Chief Officer Greater Manchester Health & Social Care Partnership (GMH&SCP).

Strategic Case

4.3. The Board of Directors received the Strategic Case for consideration and subsequently approved it for onward submission to NHS I on 13th March 2019. The final Strategic Case was submitted to NHS I on 29th March 2019.

4.4. Salford Royal Foundation Trust (SRFT) also submitted its Strategic Case on 29th March 2019 regarding the acquisition of the remaining Pennine Acute Hospitals Trust (PAHT) sites.

4.5. Following the submission of the Strategic Cases, NHS I colleagues have commenced their review of the documents. This process is anticipated to last approximately six weeks after which feedback will be provided by NHS I.

Due Diligence and Disaggregation

4.6. Due Diligence activities remain underway. Significant progress has been made with IM&T Due Diligence with work commencing over the coming weeks. Other areas of due diligence such as clinical, equipment and workforce remain on track.

4.7. Processes to engage directly with NMGH staff remain in place and MFT attendance at bi-monthly NMGH 'team talks' continues to be well received. The SHS Team meet monthly with the NMGH Care Organisation Management Team and have also been invited to present at a variety of senior leader's meetings on the site.

4.8. Positive engagement with Healthwatch Manchester, Oldham, Bury and Rochdale has also recently taken place.

5. Conclusions

5.1. Integration work is progressing well aimed at realising patient benefits and creating new efficiencies. The ISG continues to oversee the robust tracking and delivery of a number of organisational and patient benefits associated with the merger.

5.2. The importance of post-merger integration notwithstanding, MFT remains committed to fully establishing the Manchester Single Hospital Service by transferring NMGH to MFT at the earliest practicable opportunity. On this basis, MFT will continue to engage with all key stakeholders and in particular, work with Greater Manchester Health and Social Care Partnership in its role in overseeing the plan to dissolve Pennine Acute Hospitals NHS Trust.

6. Recommendations

6.1. The Board of Directors is asked to note the progress of the Single Hospital Service Programme.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Adrian Roberts, Chief Finance Officer
Paper prepared by:	Ursula Denton, Group Director of Finance
Date of paper:	26th April 2019
Subject:	Financial Performance for 2018/19
Purpose of Report:	Indicate which by ✓ • Information to Note • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration of Risk against Key Priorities:	Maintaining financial stability for both the short and medium term
Recommendations:	Hospitals/MCSs took specific further actions during the fourth quarter, to secure stronger, more consistent delivery of the required results. Follow up discussions continue to be held between the Group CFO, Group COO and Hospital CEOs and leadership teams to ensure that progress is maximised and any delay factors are systematically tackled and removed.
Contact:	Name: Adrian Roberts Tel: 0161 276 6992

Executive Summary

1.1	**Delivery of financial Control Total**	The financial performance for the year was **a bottom line surplus** (on a control total basis excluding Provider Sustainability Fund) **of £7.5m** (0.5**%** of operating income). At Hospital level, run-rate financial performance continued to fall short of plans with very limited aggregate improvement delivered across the fourth quarter overall. This level of underlying financial performance means that the Trust is taking a deficit run rate of £50m into 2019/20. Whilst all hospitals have evidenced strong delivery plans towards fully addressing this deficit run rate in 2019/20, robust delivery needs to be demonstrated from the beginning of April 2019, to adequately assure the Trust's continuing financial sustainability. The Trust over achieved by £19.6m against its overall 2018/19 Control Total set by NHS Improvement, through a substantial number of non-recurrent benefits which arisen in-year. This has enabled significant further access to the PSF incentive fund, which provides critical additional financing capacity towards funding the existing, prioritised 2019/20 capital programme.
1.2	**Run Rate**	Sustained improvement in Hospital financial results is required as we move into the new financial year.
1.3	**Remedial action to manage risk**	Hospitals/MCSs took specific further actions during the fourth quarter, to secure stronger, more consistent delivery of the required results. Follow up discussions continue to be held between the Group CFO, Group COO and Hospital CEOs and leadership teams to ensure that progress is maximised and any delay factors are systematically tackled and removed.
1.4	**Cash & Liquidity**	As at 31st March 2019 the Trust had a cash balance of £154.6m.
1.5	**Capital Expenditure**	The Capital Plan for 2018/19 was £74.0m. Capital expenditure in the year was £54.3m, with significant slippage against a range of Property and Estates schemes.

Financial Performance

Income & Expenditure Account for the period ended 31st March 2019

		Year to date - Month 12				
	Annual Plan	Year to date budget	Variance from budget	Variance as % of budget	Variance to Month 11	Year to date Actual
INCOME	£'000	£'000	£'000	%	£'000	£'000
Income from Patient Care Activities						
A and E	45,379	45,379	521		474	45,900
Non-Elective (includes XBD's)	263,388	263,388	3,328		2,388	266,716
Elective (includes Day Case & XBD's)	213,805	213,805	-2,984		-3,253	210,821
Out-Patients (includes First & Follow up)	173,805	173,805	736		733	174,541
Other NHS Clinical Income	474,771	474,771	16,347		10,644	491,118
Community Services (includes LCO)	103,421	103,421	-1,397		-1,255	102,024
Drugs (excludes Blood Products)	105,319	105,319	-4,714		-3,433	100,605
Sub -total Income from Patient Care Activities	**1,379,888**	**1,379,888**	11,836	0.9%	6,298	**1,391,724**
Private Patients/RTA/Overseas(NCP)	8,135	8,135	1,627		1,614	9,762
Total Income from Patient Care Activities	**1,388,023**	**1,388,023**	13,463	1.0%	7,912	**1,401,486**
Training & Education	61,163	61,163	1,068		-704	62,231
Research & Development	55,629	55,629	2,121		1,215	57,750
Misc. Other Operating Income	123,294	123,294	-8,003		-12,320	115,291
Other Income	**240,086**	**240,086**	-4,814	-2.0%	-11,809	**235,272**
Total Income	**1,628,109**	**1,628,109**	8,649	0.5%	-3,897	**1,636,758**
EXPENDITURE						
Pay	-929,700	-929,700	-24,560	-2.6%	-18,162	-954,260
Non pay	-635,817	-635,817	27,964	4.4%	25,224	-607,853
Total Expenditure	**-1,565,517**	**-1,565,517**	3,404	0.2%	7,062	**-1,562,113**
EBITDA Margin (excluding PSF)	**62,592**	**62,592**	12,053	19.3%	3,165	**74,645**
Interest, Dividends and Depreciation						
Depreciation	-30,226	-30,226	3,539		3,366	-26,687
Interest Receivable	443	443	1,995		311	2,438
Interest Payable	-41,138	-41,138	129		130	-41,009
Dividend	-3,755	-3,755	1,917		557	-1,838
Surplus/(Deficit) on a control total basis	**-12,084**	**-12,084**	19,633	162.5%	7,530	**7,549**
Surplus/(Deficit) as % of turnover						**0.5%**
PSF Income	**44,931**					**66,892**
Non operating Income						**3,157**
Depreciation - donated / granted assets						**-753**
Impairment						**-50,060**
	32,847					**26,785**

Operating Unit Performance against breakeven measures

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 12)		Comparative position as at month 11	Control total (YTD)	Variance to control total	
£000s					£000s	%	£000s	£000s	£000s	£000s
2,797	-1,984	-2,921	-440	Clinical & Scientific Support	-2,548	-1.1%	-1,956	1,500	-4,048	224,661
2,285	7,300	608	-2,713	Facilities, Research & Corporate	7,480	2.9%	3,423	0	7,480	258,241
836	3,612	-1,969	-968	Manchester LCO	1,511	1.6%	2,239	1,444	67	94,452
2,881	-11,372	-3,329	-28,132	MRI	-39,952	-11.2%	-36,204	-23,900	-16,052	355,291
596	967	195	-5,514	REH / UDH	-3,756	-4.8%	-3,544	-3,000	-756	78,545
1,119	-1,613	-915	0	RMCH	-1,409	-0.6%	-1,174	1,500	-2,909	227,166
523	-665	-304	-3,256	Saint Mary's Hospital	-3,702	-2.3%	-3,043	-1,800	-1,902	164,246
892	-2,843	1,884	-12,997	WTWA	-13,064	-3.3%	-12,748	-11,900	-1,164	398,972
11,929	**-6,598**	**-6,751**	**-54,020**	**Trust position**	**-55,440**	**-3.1%**	**-53,007**	**-36,156**	**-19,284**	**1,801,574**

Key Run Rate Areas

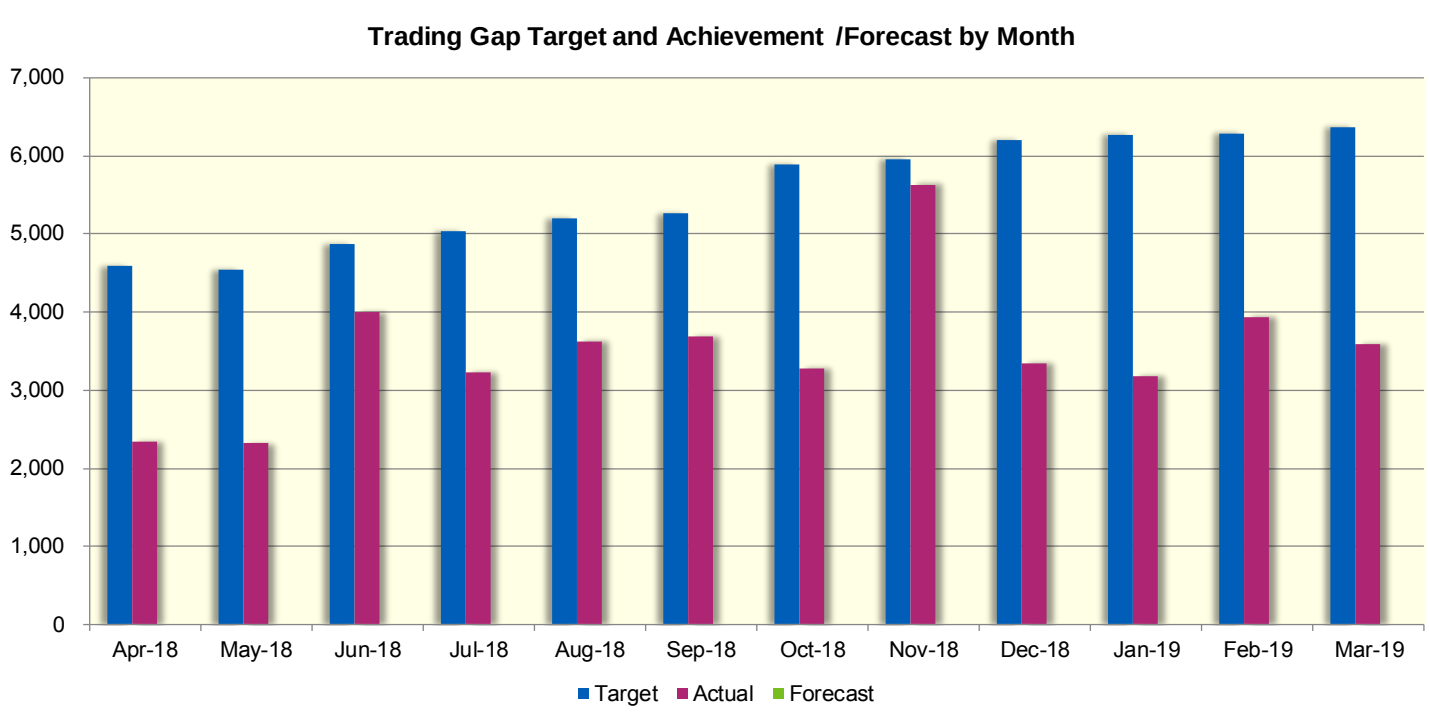
1. 2018/19 Trading Gap challenge

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	2,259	2,371	112	105%	2,259	2,371	112	105%
Blood Management	14	4	(10)	30%	14	4	(10)	30%
Contracting & income	7,794	6,917	(877)	89%	7,794	6,917	(877)	89%
Hospital Initiatives	6,544	7,226	682	110%	6,544	7,226	682	110%
Length of stay	50	23	(27)	0%	50	23	(27)	46%
Outpatients	1,782	1,423	(359)	80%	1,782	1,423	(359)	80%
Pharmacy and medicines management	1,881	2,030	150	108%	1,881	2,030	150	108%
Procurement	5,294	3,655	(1,640)	69%	5,294	3,655	(1,640)	69%
Theatres	2,862	1,984	(879)	69%	2,862	1,984	(879)	69%
Workforce - medical	5,917	4,273	(1,644)	72%	5,917	4,273	(1,644)	72%
Workforce - nursing	1,738	1,439	(300)	83%	1,738	1,439	(300)	83%
Workforce - other	769	1,185	416	154%	769	1,185	416	98%
Full year effect of prior year schemes	9,476	9,476	(0)	100%	9,476	9,476	(0)	100%
Unidentified	20,146	0	(20,146)	0%	20,146	0	(20,146)	0%
Grand Total	**66,525**	**42,006**	**(24,519)**	**63%**	**66,525**	**42,006**	**(24,519)**	**63%**

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%



Narrative:

The year-to-date Trading Gap position includes £8.9m of non-recurrent items. The split across the months of the year is outlined below:

April - £470k
May - £361k
June - £1,170k
July - £689k
August - £427k
September - £864k
October - £370k
November - £1,630k
December - £499k
January - £481k
February - £1,159k
March - £771k

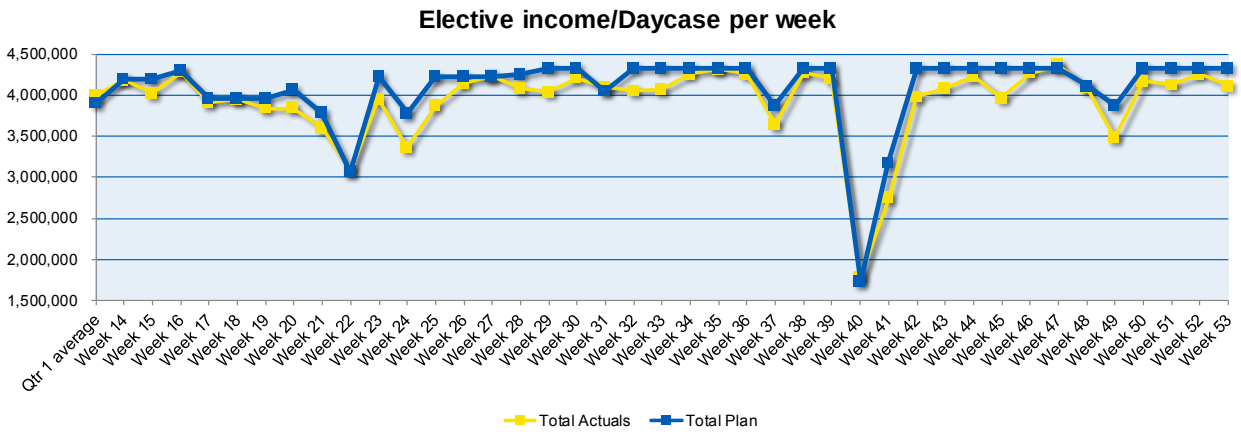
2. Agency spend by Hospital / MCS

Staff Group	YTD M1-12 £'000s	Average M1-6 £000's	Average M7-9 £000's	Average M10-12 £000's
Consultant	-4,813	-452	-438	-258
Career Grade Doctor	-558	-48	-52	-38
Trainee Grade Doctors	-6,878	-685	-571	-352
Registered Nursing Midwifery	-8,341	-772	-637	-601
Support to Nursing	-1,630	-137	-150	-117
Allied Health Professionals	-1,647	-177	-93	-103
Other Scientific and Theraputic	-2,087	-177	-206	-135
Healthcare Scientists	-1,544	-164	-81	-105
Support to STT / HCS	-976	-89	-106	-41
Infrastructure Support	-1,106	-85	-90	-113
Grand Total	**-29,580**	**-2,786**	**-2,424**	**-1,863**

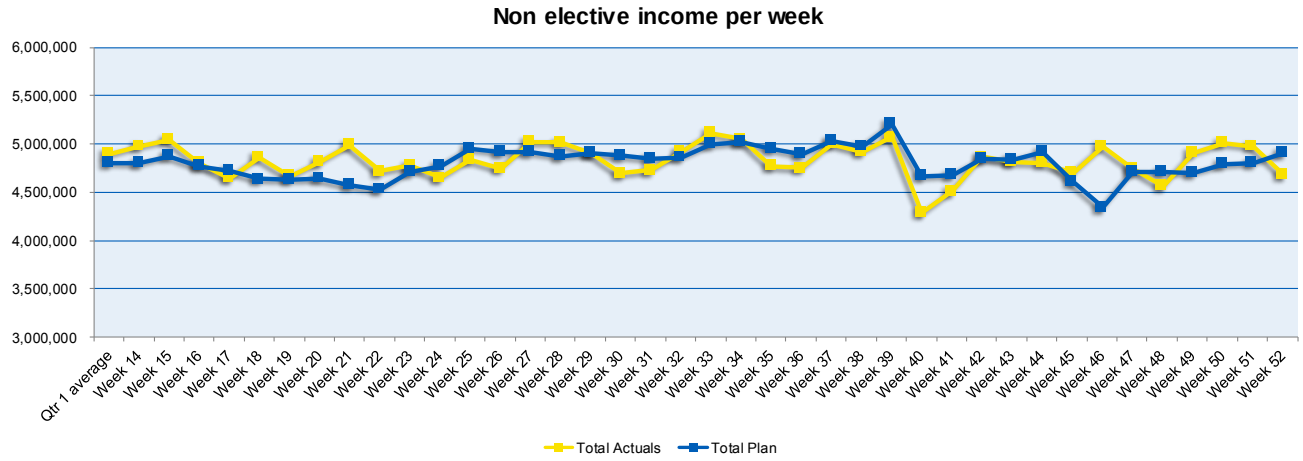
Hospitals / MCS	YTD M1-12 £'000s	Average M1-6 £000's	Average M7-9 £000's	Average M10-12 £000's
Clinical & Scientific Support	-4,395	-444	-301	-271
Manchester LCO	-602	-47	-44	-61
MRI	-9,694	-924	-859	-524
REH / UDH	-1,286	-111	-117	-89
RMCH	-1,763	-144	-157	-142
Saint Mary's Hospital	-420	-36	-30	-38
WTWA	-9,381	-899	-697	-632
Corporate	-1,800	-164	-179	-101
Research	-239	-17	-40	-5
Total	**-29,580**	**-2,786**	**-2,424**	**-1,863**

Trust Total	Agency spend M1- 12 (£000)	Agency ceiling M1- 12 (£000)	Difference (£000)	% Above Ceiling
	-29,580	**-26,524**	**-3,056**	**11.5%**

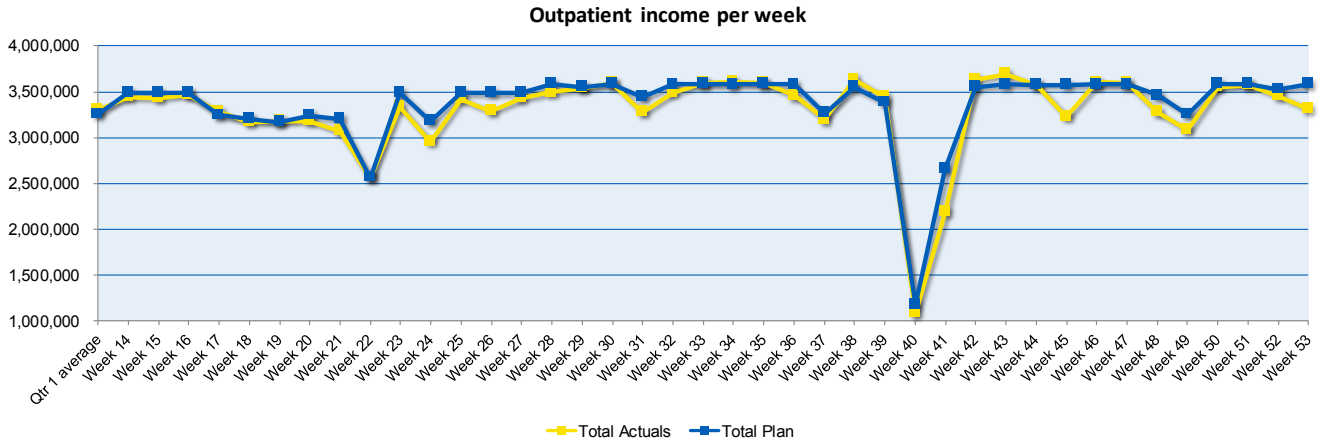
2. Elective / Daycase income: March 2019



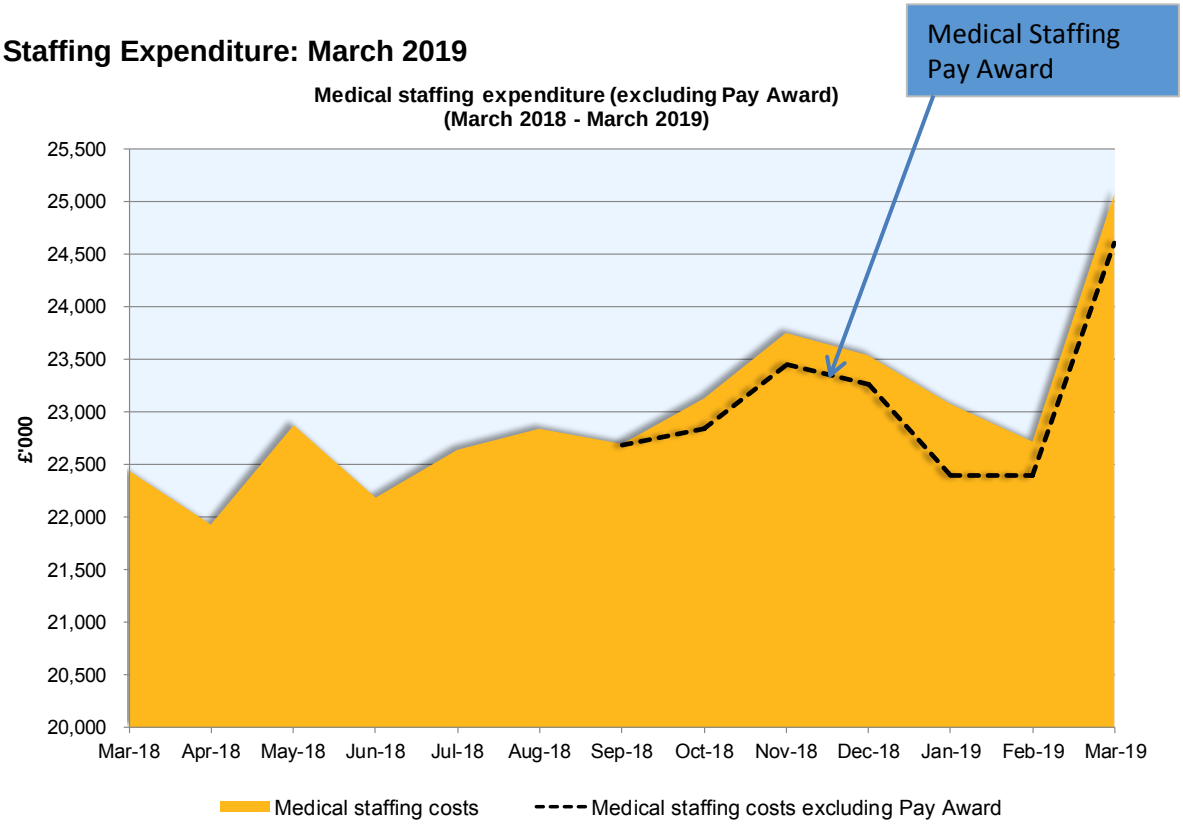
3. Non-Elective income: March 2019



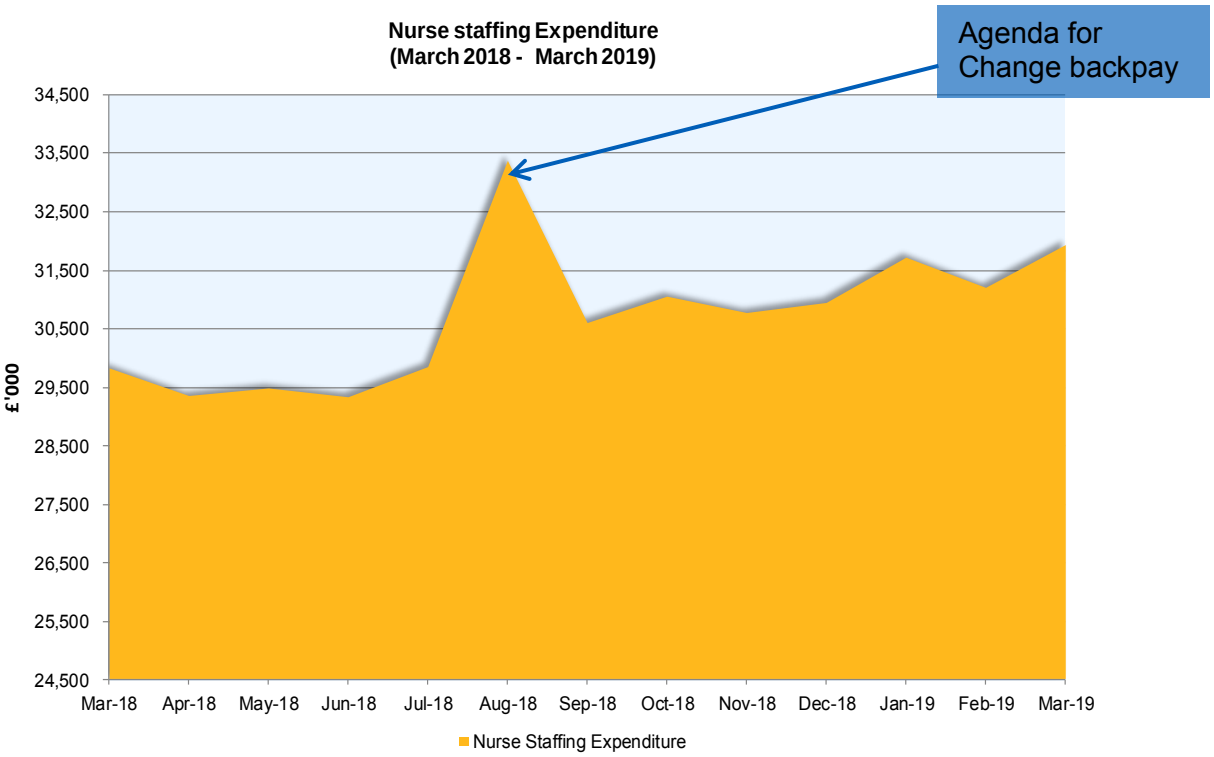
4. Outpatient income: March 2019



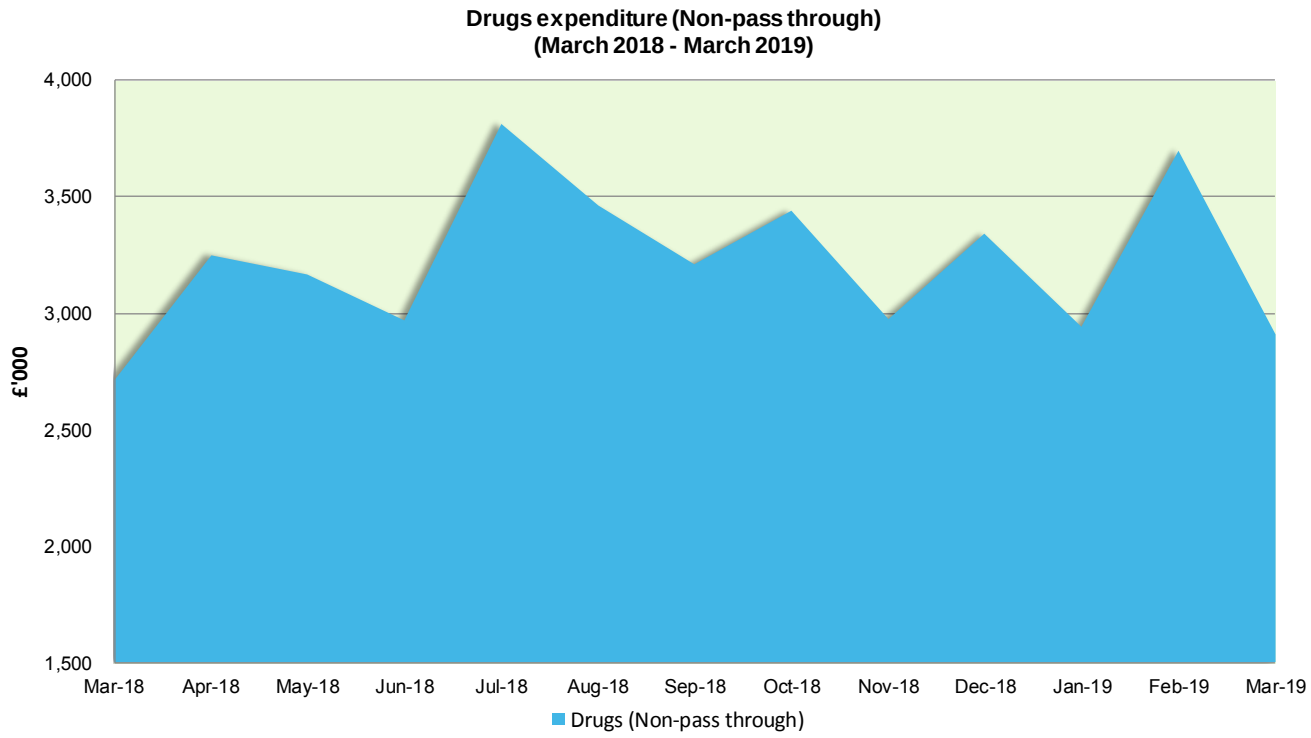
6. Medical Staffing Expenditure: March 2019



7. Nurse staffing Expenditure: March 2019



8. Prescribing Drugs: March 2019



NHS Improvement's KPIs

	Annual Plan		*Actual*	
	Metric	*Level*	*Metric*	*Level*
Liquidity ratio	0.2	2	12.1	1
Capital servicing capacity	1.6	3	2.2	2
I&E Margin	2.0%	1	4.4%	1
I&E margin: Distance to financial plan	0.0%	1	2.4%	1
Agency spend Metric - above / (below) the agency ceiling	8.1%	2	11.5%	2
Use of Resource (UOR) metrics - Level 1 being highest		**2**		**1**

Narrative:

Under the Use of Resource (UOR) metrics, the Trust achieves an overall level 1.

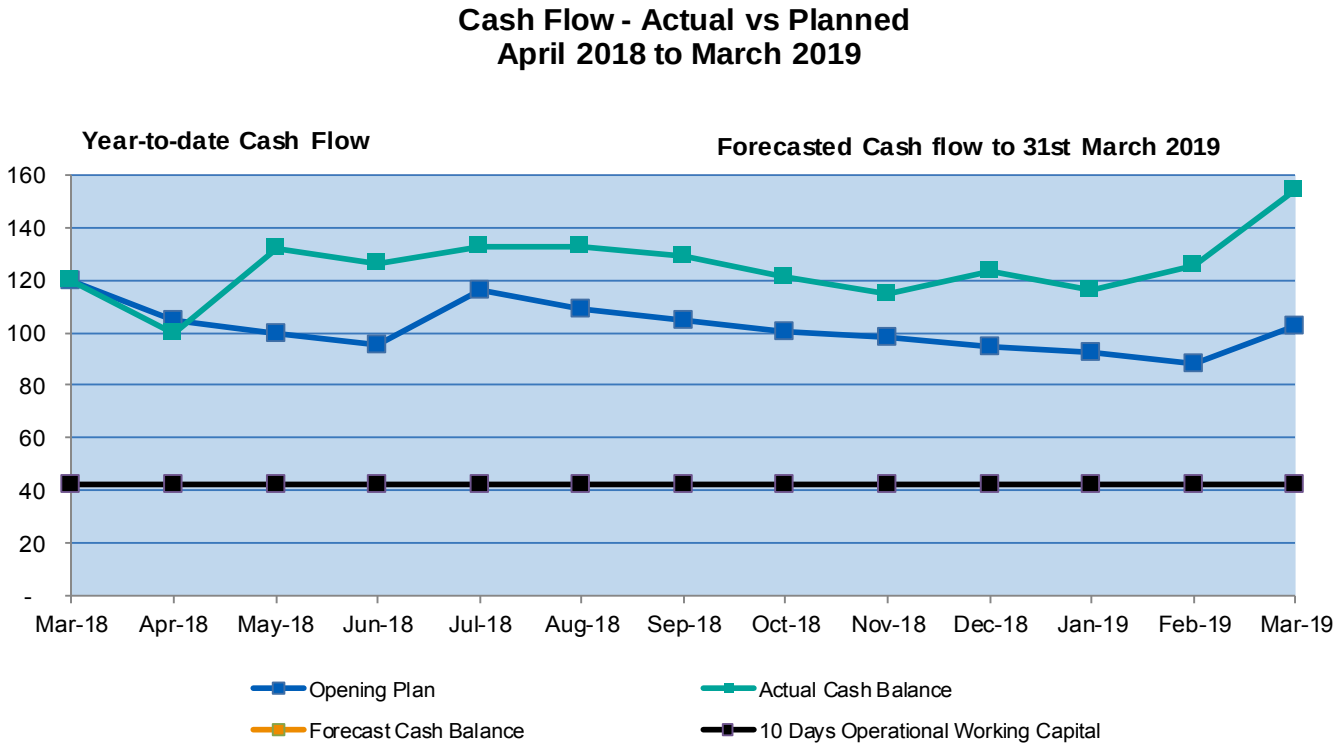
Only one element is driving an adverse variance to the plan submitted to NHSI:

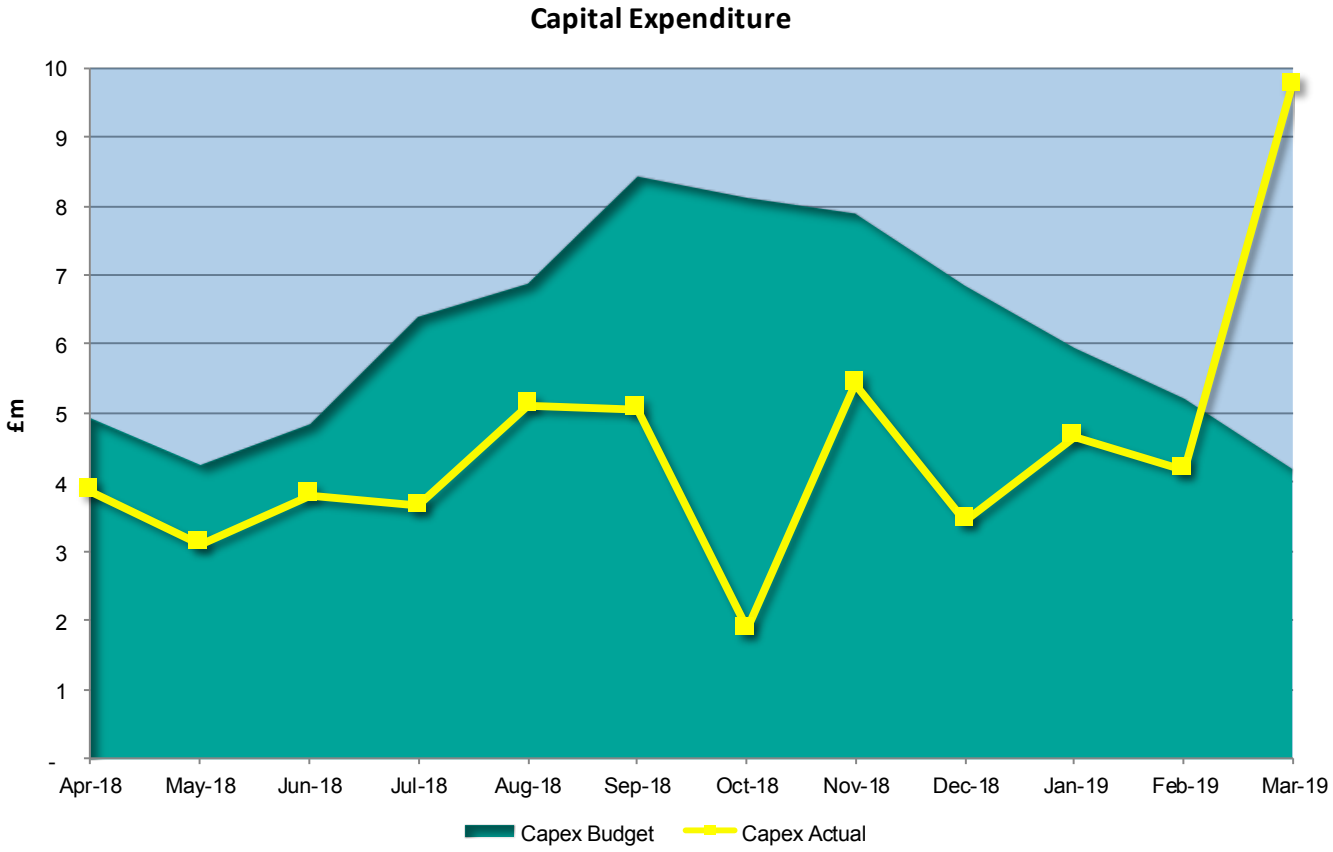
- Agency spend – since October, monthly average expenditure on agency staff has decreased by over £0.5m. This is an improvement compared to months 1-6 where the Trust exceeded its ceiling by 26%.

Balance Sheet

	Opening Balance Sheet 01/04/2018 £000	Actual Year to Date 31/03/2019 £000	Movement in Year to Date £000
Non-Current Assets			
Intangible Assets	4,397	4,120	(277)
Property, Plant and Equipment	617,672	594,723	(22,949)
Investments	866	2,513	1,647
Trade and Other Receivables	5,591	4,969	(622)
Total Non-Current Assets	**628,526**	**606,325**	**(22,201)**
Current Assets			
Inventories	17,026	16,462	(564)
NHS Trade and Other Receivables	90,505	83,467	(7,038)
Non-NHS Trade and Other Receivables	41,863	45,467	3,604
Other Current Assets	0	0	0
Non-Current Assets Held for Sale	210	210	0
Cash and Cash Equivalents	119,896	154,563	34,667
Total Current Assets	**269,500**	**300,169**	**30,669**
Current Liabilities			
Trade and Other Payables: Capital	(9,497)	(4,242)	5,255
Trade and Other Payables: Non-capital	(154,265)	(171,403)	(17,138)
Borrowings	(22,286)	(19,780)	2,506
Provisions	(23,052)	(15,858)	7,194
Other liabilities: Deferred Income	(22,635)	(20,400)	2,235
Other Liabilities: Other	0	0	0
Total Current Liabilities	**(231,735)**	**(231,683)**	**52**
Net Current Assets	**37,765**	**68,486**	**30,721**
Total Assets Less Current Liabilities	**666,291**	**674,811**	**8,520**
Non-Current Liabilities			
Trade and Other Payables	(2,601)	(2,600)	1
Borrowings	(423,858)	(407,793)	16,065
Provisions	(7,251)	(8,815)	(1,564)
Other Liabilities: Deferred Income	(5,252)	0	5,252
Total Non-Current Liabilities	**(438,963)**	**(419,208)**	**19,755**
Total Assets Employed	**227,328**	**255,603**	**28,275**
Taxpayers' Equity			
Public Dividend Capital	203,291	204,780	1,489
Revaluation Reserve	45,408	45,408	(0)
Income and Expenditure Reserve	(21,371)	5,415	26,786
Total Taxpayers' Equity	**227,328**	**255,603**	**28,275**
Total Funds Employed	**227,328**	**255,603**	**28,275**

Cash flow and capital expenditure





Scheme	Annual Plan £'000	Spend YTD at 31st Mar 2019 £'000
Property and Estates schemes		
Helipad	5,246	945
Diabetes Centre	1,849	22
Emergency Department - Wythenshawe	5,548	5,619
MRI ED redevelopment	3,992	1,094
RMCH ED redevelopment	1,000	0
Property & Estates Schemes - Compliance Work	18,534	14,805
Property & Estates Schemes - Development	11,862	3,905
Property & Estates - sub-total	**48,031**	**26,390**
IM&T schemes		
Electronic Patient Records (EPR)	2,100	1,198
IM&T Rolling Programme	1,555	1,360
IM&T Strategy	7,949	8,965
IM&T - sub-total	**11,604**	**11,523**
Equipment rolling replacement programme	**6,904**	**8,726**
PFI Lifecycle	**7,500**	**7,636**
Total expenditure	**74,039**	**54,275**

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Darren Banks, Group Executive Director of Strategy
Paper prepared by:	Caroline Davidson, Director of Strategy
Date of paper:	26 April 2019
Subject:	Strategic Development Update
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • 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 updates in relation to: ▪ National level o Planning Round for 2019/20 o NHS Long Term Plan o Alignment of NHS England and NHS Improvement ▪ Greater Manchester level o Cancer Board and Annual Report o GM Improving Specialist Care Programme ▪ Local level o Service Strategy Development o Trafford Community Services.
Contact:	Name: Darren Banks, Group Executive Director of Strategy Tel: 0161 276 5676

1. Introduction

The purpose of this paper is to update the Board of Directors in relation to strategic issues of relevance to MFT.

2. National Issues

NHS Long Term Plan

The NHS Long Term Plan was published in January 2019. It set out proposals for:

- Making sure everyone gets the best start in life
- Delivering world-class care for major health problems, and
- Supporting people to age well.

The plan is to be delivered through:

- Doing things differently - giving people more control over their own health and care, increasing service provision in the community and encouraging NHS organisations to work with local partners to plan and deliver services which meet the needs of their communities.
- Preventing illness and tackling health inequalities through eg helping people stop smoking, overcome drinking problems and avoid Type 2 diabetes
- Backing the workforce - training and recruiting more professionals and making the NHS a better place to work
- Making better use of data and digital technology – providing access to services and health information through apps, providing better access patient records for staff, and planning and delivering services based on the analysis of patient and population data.
- Getting the most out of taxpayers' investment in the NHS – increasing efficiency.

Local health systems were tasked with developing their own strategies for taking forward the ambitions set out in the Long-Term Plan. Greater Manchester Health and Social Care Partnership has now developed and submitted its Operational Plan for turning the Long-Term Plan into local action across Greater Manchester.

Alignment of NHS England and NHS Improvement

Further to the appointment of Bill McCarthy as the North West Regional Director, he is now appointing his senior leadership team. Under the new arrangements Jon Rouse, Chief Officer of the GMH&SC Partnership will report directly to the NW Regional Director.

Planning Round 2019/20

The final version of the MFT 2019/20 Operational Plan was submitted to NHS I/E on 3 April 2019 prior to the deadline of 4 April 2019.

The MFT internal business planning round has completed. Each Hospital / MCS has developed their plan for 19/20. An over-arching MFT Annual Plan is being developed.

3. Greater Manchester Issues

GM Cancer Board

Following a review of progress against the GM Cancer Plan proposals to update the arrangements supporting the operation and organisation of the GM Cancer Board have been agreed. The Board will take a clearer and direct role in overseeing the delivery of the GM Cancer Plan and the cancer elements of the NHS Long Term Plan, with its agenda driven by the key priorities set out in these documents.

There will be joint chairs; a Provider CEO (The Christie) and a Local Authority CEO (Oldham LA). The Board will ensure that links are maintained, and where necessary enhanced, with the Joint Commissioning Board, Primary Care, Local Care Organisations and other representative groups to ensure that the Cancer programme is properly connected to all elements of the GM delivery system.

GM Cancer Annual Report

The GM Cancer Annual Report is about to be published. It sets out progress made across GM on the cancer agenda during 2018/19. It highlights a number of the initiatives pioneered by MFT including the development of the Haematological Cancer Diagnostic Partnership, the CURE programme for stopping smoking and the development of the lung health check programme to screen for lung cancer at an early stage.

Improving Specialist Care Programme

It has been agreed that paediatric medicine will be an in-scope specialty for the Improving Specialist Care programme.

4. MFT Issues

Service Strategy Development

Overarching group service strategy

The overarching Group Service Strategy was approved by the Board of Directors in November 2018. The document has been circulated to the Council of Governors and is being circulated to key external stakeholders for comment.

The document will remain a 'live' working document until completion of Waves 2 and 3, and the Managed Clinical Services (MCS) strategies. It will be updated in May to reflect any feedback received and to capture the outputs from the whole programme and re-presented to the Board in July 2019.

Clinical Service Strategies

Waves 1, 2 and 3 cover the services spanning WTWA and MRI. The wave 1 and 2 service strategies have now been approved by the Board. Wave 3 has commenced. It includes Orthopaedics, Infectious Diseases, Burns and Plastics' Breast and Rehabilitation.

The development of the Managed Clinical Services (Children's, Saint Mary's, Eye and Dental) strategies is on-going. They are planned to be complete by mid-April and to be presented to the Board in May and July 2019.

The proposals outlined in all of the strategies are at a formative stage and we are now about to engage with commissioners on the next steps.

Trafford Community Services

Following confirmation that MFT has been chosen as the preferred provider for Trafford Community Services, we are in discussion with Trafford CCG and Pennine Care NHS Foundation Trust about the due diligence process.

5. Actions / Recommendations

The Board of Directors is asked to note the updates in relation to:

- National level
  - Planning Round for 2019/20
  - NHS Long Term Plan
  - Alignment of NHS England and NHS Improvement

- Greater Manchester level
  - Cancer Board and Annual Report
  - GM Improving Specialist Care Programme

- Local level
  - Service Strategy Development
  - Trafford Community Services.

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:	May 2019
Subject:	Manchester Local Care Organisation Update
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration of Risk against Key Priorities:	Leading on the development and implementation of integrated care.
Recommendations:	The Board of Directors are asked to note the contents of this paper.
Contact:	Name: Tim Griffiths Tel: 07985448165

1. Introduction

1.1 This report provides an update from Manchester Local Care Organisation to Board of Directors. It covers the following:

- System resilience and escalation;
- New care models;
- Development at neighbourhood level;
- Communications and Engagement;
- Freedom to Lead;
- MLCO governance and audit; and,
- CQC

2. System Resilience and Escalation

2.1 As per previous updates to Board, MLCO continues to work with Manchester University NHS Foundation Trust (MFT) and partners such as Manchester City Council and Greater Manchester Mental Health NHS Foundation Trust to support the alleviation of current acute flow pressures. This work became one of MLCO's key delivery priorities for 2018/19.

2.2 The work which has largely focused on the pressures at the Manchester Royal Infirmary, with the MLCO senior leadership including significant input from Glyn Syson (Assistant Director Adult Social Care) working closely with colleagues to expedite the movement and discharge of patients from an acute bed to the most appropriate community setting. As of mid-March this programme of work had supported the discharge of 164 patients who account for an accumulated length of stay of circa 16,900 days.

2.3 Responsibility for delivering this work on an ongoing basis has now transferred to the MRI Director of Operations, who has mobilised a robust internal escalation process with operational teams.

3. New Care Models

3.1 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 is threefold and a detailed update is provided against each of the programmes:

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

<u>Integrated Neighbourhood Teams</u>

3.2 As previously advised, following an initial consultation period, MLCO has been actively progressing with an external recruitment process to recruit to 12 INT Lead posts. Following interview processes in November 2018 and February 2019 all of the posts have been recruited into – nine have taken up role with the remaining three due in post by the end of June.

3.3 In addition to the leadership roles outlined above, MLCO is also in the process of confirming the rest of the INT leadership quintet. In terms of the GP Leads, it has been agreed that these posts will undertake two sessions a week as part of this role, increasing from the one session a week that is currently in place. All of the GP Leads are in place and underwent a two-day leadership session, aligned to the overarching INT development plan, in November 2018. Work is underway to clarify the impact on this role with the advent of Primary Care Networks (PCN) and the requirements for each PCN to appoint a Clinical Director. The LCO has commenced a discussion with practices through the Federations and MHCC to ensure existing INTs can and are aligned to the emerging PCNs. Practices are required to submit their plans to develop PCNs to MHCC by 15th May 2019.

3.4 In regards to the remaining roles, the majority of these have now been recruited to. There are six Mental Health Leads who have been assigned two neighbourhoods each. The 12 Nursing Leads have been confirmed and are in the process of being allocated neighbourhoods and the Social Care Leads recruitment process is currently ongoing.

3.5 MLCO is currently working to finalise its neighbourhood operating model, neighbourhood governance arrangements, and accountability and assurance arrangements. This should be in place by the end of Q1.

Manchester Community Response

3.6 Manchester Community Response (MCR) is a seven-day service that provides community based intermediate care, reablement and rehabilitation services to patients. These are often older people, after leaving hospital or when they are at risk of being sent to hospital. These services offer an interface between hospitals and where people live, working across the health and social care system. It is an evolution of the highly-effective North Manchester Community Assessment and Support Service. The main component parts of the MCR model are Crisis Response, Discharge to Assess services, bed and home based intermediate care and reablement. An update on the mobilisation of these services and some associated activity to date is provided below.

Crisis Response

3.7 The Crisis Response Team supports patients who need urgent support at home, but who do not need to be admitted to hospital. The team accept referrals from North West Ambulance Service (NWAS) and is being mobilised across the city. The team provides urgent assessments and interventions for people who have a health or social care crisis, to support people to remain at home while the crisis situation is addressed.

3.8 The Crisis Response service in Central Manchester went live on 5th November 2018. Although implemented ahead of schedule, due to staffing and recruitment issues only the amber pathway element of the service is operational, with the whole becoming operational in March 2019. Work is ongoing with the North West Ambulance Service to increase the referrals and usage of this service further.

3.9 The Crisis Response service launched in part in South Manchester, 3rd December 2018. The community referral element of the model was launched, with the aim to operationalise the whole model by March 2019, subject to recruitment. The service is currently operational 7 days a week from 08:30 to 18:30, accepting three out of the four available pathways.

Discharge 2 Assess

3.10 Discharge 2 Assess (D2A) helps people home from hospital, quickly and safely. The essence of the approach is that the person, once medically optimised, leaves hospital and is assessed for their ongoing needs in their home or other place of residence. The aim is to reduce unnecessary delays in discharge when people could be back at home or in a more appropriate place to receive ongoing assessment, short term interventions and support from community teams. Funding has been provided to design, implement and roll-out D2A across the entire city.

3.11 The rollout of Discharge to Assess has commenced in both North and South Manchester. The service commenced in North Manchester in May 2018 and South Manchester in September 2018. Similarly, to other care models, there have been recruitment challenges, which have influenced the roll out of the service. Staff continue to be recruited into the teams to deliver the required capacity as quickly as possible.

High Impact Primary Care

3.12 High Impact Primary Care (HIPC) continues to be mobilised across the City of Manchester with a HIPC team based in three neighbourhoods, which span across each of the localities. This service is a vital component of local care organisation models and is supported by international evidence in terms of having a positive impact on population health, specifically for those at high risk of admission to acute and secondary care.

3.13 There are numerous patient case studies being collected and shared, demonstrating the quality impact of the service on patients' lives. In terms of quantitative activity data, information has been provided below. From an activity perspective, the service is having a demonstrable impact on the cohort of patients, with the cost of emergency activity reducing by 65%. 75% of the patients discharged from HIPC have had no further emergency activity since discharge. HIPC met its performance targets in both November and December.

3.15 An overview of performance in regards to new care models and system escalation is provided at Appendix One.

3.16 MHCC developed an interim report regarding HIPC's progress against the development requirements set out in the October review, which was considered by MHCC Executive. It has been agreed in principle to expand the service to 6 neighbourhoods and expand the cohort to the top 5% risk cohort over a further 2 year contract period. The proposal from MHCC is to focus the expansion of the service on the remaining 3 neighbourhoods in North Manchester. A revised service model and expansion plan is in development for the July 2019 Business Case Committee's approval.

4. Development at neighbourhood level

4.1 The 12 neighbourhoods are the principal building blocks of MLCO and the volume and intensity of work to date reflects that. To support the development and production of MLCO Business Plan for 19/20, MLCO has now developed 12 neighbourhood plans.

4.2 As of 13th March all 12 of the plans had been received, and they are now subject to review with the intention of the content driving, in part, the MLCO Business Plan for 2019/20.

4.3 The plans are comprehensive, with the content built from the neighbourhood meetings over the last 12 months. They provide a clear picture of the population in each neighbourhood and outline the key priorities that each neighbourhood will aim to focus on. They are a key document for the development of our neighbourhoods during 19/20 and the teams will be supported to develop the plans to ensure they are reflective of all the work in each place.

4.4 The Nesta 100 day challenge launched across four neighbourhoods in April 2019. In getting to this stage two planning and design workshops were held with leaders from across the Manchester system in January and March 2019. Coaching development for the seven local coaches took place in March.

4.5 The four neighbourhoods are outlined below and will focus on tackling a key issue in their area ranging from social isolation to mental health in over 50's:

- Miles Platting, Newton Heath, Moston and City Centre
- Cheetham and Crumpsall
- Chorlton, Whalley Range and Fallowfield
- Wythenshawe, Bagueley, Sharston and Woodhouse Park

5. Communication and engagement

5.1 MLCO is currently undertaking a significant amount of work to support the delivery of our adult social care improvement programme. This includes the development of a comprehensive communications strategy which started with the first adult social care forum taking place at the end of March. Almost 100 staff attended to hear about the improvement plan and updates on work around integration. Feedback has been positive.

5.2 MLCO is currently mobilising a programme of work to develop the core communication activity for the INTs. A communications plan template has been developed that outlines the core offer we want for all INT's. This affords a degree of flexibility and allows for significant customisation to ensure the teams are able to respond to local needs – in addition to the 12 neighbourhood plans it is our intention to have 12 accompanying neighbourhood communication plans.

5.3 As part of MLCO's on-going engagement work a session with PPAC around neighbourhood plans has been arranged for mid-April. This will support MLCO to develop the core engagement offer we want each INT to undertake.

5.4 As one of the many steps we need to take to further integrate our health and social care staff we have rolled the 'pulse survey' to all MLCO deployed staff. For the first time this will provide us with some key insights into how our workforce feel as an integrated workforce. It is expected that results will become available in May 2019.

6. Freedom to Lead II

6.1 MLCO's second Freedom to Lead (F2L) event took place on 24th April 2019 at Gorton Monastery. It followed our first F2L event in September which brought together 210 staff from across MLCO's deployed health and social care teams to talk about vision, plans for the future and learn about key areas of work.

6.2 F2L II built on this and focused on sharing priorities for year 2 of MLCO and beyond. It was the first opportunity to share the developing MLCO business plan with staff. The programme allowed teams to introduce all of the new roles in the city, provide workshop sessions on planning and working together across the integrated team and features a panel discussion around communities of interest in Manchester including representatives from faith, ethnic, disability, homeless, young, older and carers groups in the city to support staff in thinking how they can effectively work with these groups.

6.3 Over 200 MLCO staff and partners attended Freedom to Lead 2 - our second MLCO staff conference. Taking place in the heart of the community at Gorton Monastery, F2L2 had a focus on planning for our second year of operation as well as celebrating the progress made in year one. Staff took part in an interactive workshop to develop the Yr 2 neighbourhood plans and a question time panel made up of representatives from Manchester community leaders including the VCSE sector, faith groups, homelessness support, disability support and younger people's mental health allowed staff to explore how MLCO can develop work with communities of interest in the city. There was also a focus on some of the new roles in health and care sector in the city to encourage joint working.

6.4 Feedback from the day was extremely positive and planning will take place with our staff steering group for F2L3 later in the year. Outputs from the day will be shared with colleagues who were unable to attend.

7. Care Quality Commission

7.1 As Board will be aware, MLCO, along with the rest of Manchester Foundation Trust, were subject to regulatory inspection in October 2018. This came only six months after the launch of the organisation. The review focused on five key business areas:

- Community health services for adults;
- Community health services for children and young people;
- Community health inpatient services;
- Community end of life care; and,
- Community dental services.

7.2 In March MLCO, as part of MFT, received their report which offered an overall rating of GOOD. MLCO was rated good across all five of the domains: Well-led; Caring, Safe, Effective, and Responsive.

7.3 Out of 30 assessed domains, MLCO was assessed as being good in 29 of them, with only one domain being assed as requires improvement; responsiveness in community health services for children and young people.

8. Roadmap and Phase 2 update

8.1 Significant progress has been made through the continued discussions with partners on the MLCO roadmaps for 2019/20. Board are reminded that the roadmaps set out how MLCO will develop in 2019/20.

8.2 Board are advised that In April MLCO Partnership Board supported the phasing proposals that were put forward, through 2019/20 and become responsible for the delivery of c£287m of services.

8.3 Whilst MFT will still need to undertake appropriate due diligence in regards to the budgets and contracts that will transfer, it was agreed that at the point of transfer, the operational management of these services will be MLCO. For commissioned health services, this would mean that these contracts will formally pass to the lead contractor as part of the agreed hosting arrangements, again overseen by MLCO. This a huge step forward and supports Manchester to deliver on the ambitions of the locality plan.

8.4 The services and budgets that were agreed to transfer to the management of MLCO in October 2019 included Continuing Healthcare and Learning Disability Healthcare. This will enable MLCO to more effectively meet the needs of the some of the most vulnerable residents within our city, ensuring that we can support people closer to home, and provides us with the opportunity to fully integrate provision for those with learning disabilities across the city.

8.5 Importantly it was also agreed that in excess of £21m worth of primary care contracts will transfer to MLCO including Out of Hours' Provision, Seven-day Access, and Primary Care Standards. The support of both Manchester Health and Care Commissioning and Manchester Primary Care Partnership in making this happen again demonstrates the proactive and positive commitment of colleagues to realise the ambition of MLCO. It was agreed that these contracts will transfer no later than October 2019.

8.6 In regards to Adult Social Care it was agreed that by October 2019 ASC services (including residential and nursing care, home care, extra care and sheltered housing) will fall under the leadership of the Director of Adult Social Services hosted within MLCO. These contracts will not transfer to the lead contractor (MFT) due to previously discussed legal and technical challenges (including VAT).

8.7 The transfer of numerous public health budgets will support MLCO and the city to deliver its population health plan and place prevention at the core of what MLCO will deliver both within neighbourhood and across Manchester.

8.8 Whilst acknowledging that mental health contracts will not move in 2019/20 it has been acknowledged that embedding mental health teams within the neighbourhood offer is critical to the success off the neighbourhood delivery model. To support this, it was agreed to develop a clear integration plan between Greater Manchester Mental Health Trust and the MO for mental health provision with Integrated Neighbourhood Teams, High Impact Primary Care, and Urgent Care for 2019/20, and also to co-design the commissioning of mental health provision in Manchester. Again, this is a positive step and builds on the work that has been undertaken between commissioners and the respective teams of from Greater Manchester Mental Health Trust and MLCO.

9. MLCO Business Plan 2019/20

9.1 Work on the Business Plan has been ongoing during the winter. As described previously, we have 12 neighbourhood business plans, business plans from the 3 localities, social care and children's services all being finalised.

9.2 We are currently working on producing a 'plan on a page' for each of the 12 neighbourhoods, for the three community health directorates, for social care and for children's community health services. These are expected to be finalised during May 2019.

9.3 A corporate overarching business plan will also be produced alongside these, which will be available to all Partner organisations. This is summarised below:

- Our aims and priorities for 19/20 and how they will be delivered;
- The scope of our responsibilities in our second year;
- What we delivered during our first year and how that informs our second year of operation;
- The financial plan for 19/20;
- Our approach to develop the longer term vision and approach of MLCO towards 2028;
- The risks and challenges we face and how we will work to address them.

9.4 This will include:

- Approved financial settlement for MLCO during 2019/20, prior to any contract shifts that may happen in 2019/20;
- Contractual KPIs for the range of current services from within the MLCO;
- Management of performance;
- Workforce approach;
- Organisational development approach; and,
- Clinical and organisational governance and any changes we are planning to make; an

9.5 Given the above, it was agreed by MLCO Partnership Board that an overarching high level Business Plan for MLCO be presented at its next meeting (scheduled for May 2019). This will include the full set of overarching neighbourhood, community service, social care and children's community service plans.

11. Recommendations

11.1 Board is asked to note the content of this report.

MLCO peformance and updates at a glance

March 2019

Manchester Local Care Organisation

Leading local care, improving lives in Manchester, with you

High Impact Primary Care (HIPC)

Three pilot HIPC programmes across the city providing GP led, integrated community care to most vulnerable residents who are high users of other services.

- 743 residents enrolled in HIPC and working with teams in the pilots
- Significant reductions in use of other services by users
- Almost 12% lower secondary costs and 30% reduction in length of stay in hospital for HIPC users who have needed hospital care whilst in the programme.

High Impact Primary Care

3 neighbourhood pilots in the city

743 people enrolled in HIPC by March 2019

With outcomes including

↓ **11.6%** lower secondary care costs for HIPC users who've needed hospital care

↓ **29.2%** reduction in length of stay in hospital for those users

Source: January MLCC performance report

Escalation and patient flow support

Joint work with team at Manchester Royal Infirmary to support discharge of super stranded patients medically fit for discharge back to community settings with right support.

- Programme of work since August 2018
- Ongoing identification of super stranded and stranded patients and coordination work to expedite discharge
- Joint health and social care approach through MLCO team
- Over 160 patients successfully discharged with combined length of stay of almost 16,900 bed days
- Contributed to average MRI length of stay reducing by around five days.

As at close of project on 15 March 2019

164 super stranded and stranded patients discharged

with a combined length of stay in hospital of

16,900 days

Contributing to a reduction of around five days in average inpatient length of stay at MRI .

Manchester Community Response (MCR)

Umbrella for six programmes of work including Community Crisis Response, Discharge to Assess, Reablement and others that provide short term care to help prevent hospital admission/expedite discharge.

- Central Manchester crisis response team launched Nov 2018 to take NWAS amber pathway referrals
- South Manchester crisis response team launched Dec 2018 to provide community referrals (acute, GP and social care) - have extended their hours of operation from March 2019
- Discharge to Assess programmes running in North and South
- Citywide Community IV business case approved for launch Summer 2019

Central Community Crisis Response Nov-Feb

209 accepted amber referrals from NWAS

177 patients treated in community and avoided A&E/admission

South Community Crisis Response team Dec- Feb

108 referrals accepted from GPs/urgent care and treated in community

Integrated Neighbourhood Teams (INTs)

12 neighbourhood teams, co-locating health and social care services around populations of 30k to 50k residents. Each team has leadership including overall lead and GP, nursing, social care and mental health leads.

- Recruitment to final three of 12 overall leads complete end Feb. Six INT leads now in post in their neighbourhoods, others joining soon
- All 12 GP leads in place as well as nurse and mental health leads
- Estates work to complete hub bases for each INT progressing with six complete and others underway/in negotiation
- Didsbury East and West, Burnage and Chorlton Park INT has been an early implementer at Withington Community Hospital since November 2018.

Early work from **Didsbury East & West, Burnage and Chorlton Park INT** early implementer has found:

\+ improved communication between health and social care teams

\+ better understanding of roles, speeding up of assessments and more joint visits

= **better coordinated care for local residents**

Powered by:

NHS Manchester University NHS Foundation Trust

NHS Greater Manchester Mental Health NHS Foundation Trust

Manchester City Council

Manchester Health & Care Commissioning

A partnership between Manchester City Council and NHS Manchester CCG

The Manchester Primary Care Partnership

MANCHESTER HOSPITALS NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Professor Cheryl Lenney, Group Chief Nurse
Paper prepared by:	Sarah Corcoran, Director of Clinical Governance
Date of paper:	22nd April 2019
Subject:	CQC Inspection and Response Update
Purpose of Report:	Indicate which by ✓ • Information to Note • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration of Risk against Key Priorities	Quality, safety, experience, research, innovation and teaching
Recommendations	The Board of Directors are asked to approve the recommendations set out in 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 March 2019 detailing the progress of the CQC comprehensive inspection of the Manchester University NHS Foundation Trust. The Trust was awaiting the final results at the time of the meeting.

1.2. The inspection was carried out within the first 12 months of our merger to create MFT. The inspection was the largest comprehensive inspection ever carried out in the NHS by the CQC. The Trust was visited by over 120 inspectors over a 6 week period.

1.3. This paper sets out further progress to date.

2. Final Report - Ratings Outcome

2.1. The Trust received an overall rating of **GOOD.**

2.2. The final report was received on 13th March 2019 and was published on 19th March 2019 The ratings are detailed in appendix A, the overall summary is presented below:

Group Level Well-led	**Good**					**Good**
	SAFE	**EFFECTIVE**	**CARING**	**RESPONSIVE**	**WELL LED**	
OVERALL GROUP	**Good**	**Good**	**Outstanding**	**Good**	**Good**	**Good**

3. Final Report – Summary Findings

3.1. The report narrative includes very positive commentary about the services and also details areas where improvement is required. It is of note that the main areas identified as requiring improvement were identified as risks as part of the pre inspection submission to the CQC and the majority of those areas are also detailed on the Trust risk register.

3.2. It is of particular note that:

- For MFT overall, the ratings for the key lines of enquiry (the way in which they measure services) are extremely positive. The Trust is assessed in 5 areas; *Caring* was rated as '**Outstanding'** and *Safe, Effective, Responsive and Well-led* were rated as **'Good'**

- Two hospitals were rated as **Outstanding:** Manchester Royal Eye Hospital and the University Dental Hospital of Manchester.

- Two MFT-wide services, Adult Critical Care and Child and Adolescent Mental Health Services, were rated as **Outstanding**

- There were **24 individual indicators** rated as **outstanding** for individual key lines of enquiry across the Group.

Royal Manchester Children's Hospital **Key Line/s of Enquiry**

- Core Service **Surgery** Caring and Responsive
- Core Service **End of Life Care** Caring
- Core Service **Outpatients** Caring

Manchester Royal Eye Hospital

- Core Service **Surgery** Effective, Caring, Responsive & Well led
- Core Service **Outpatients** Caring and Well led

University Dental Hospital Manchester

- Core Service **Surgery** Safe, Effective and Well led

Wythenshawe Hospital

- Core Service **Critical Care** Caring and Responsive
- Core Service **Children and Young People** Responsive
- Core Service **End of Life Care** Caring

Manchester Royal Infirmary

- Core Service **Critical Care** Caring and Well led

Saint Mary's Hospital

- Core Service **Neonates** Caring

Child and Adolescent Mental Health Services

- Core Service **Community Services** Effective, Caring, Responsive & Well led

- Six hospitals were rated '**Good'.** These are:
  - Wythenshawe Hospital
  - Royal Manchester Children's Hospital
  - Saint Mary's Hospital
  - Trafford Hospital
  - Withington Community Hospital
  - Altrincham Hospital.

- The Manchester Local Care Organisation was rated '**Good'**; a significant achievement as the MLCO had been established for six months at the time of inspection.

- The Manchester Royal Infirmary was rated as **Requires Improvement.** However, within the MRI, Critical Care was rated as '**Outstanding**', End of Life Care and Medicine were rated as '**Good'** and. Caring was also rated as '**Good'** reflecting the way in which staff demonstrated kindness and compassion when caring for patients.

3.3. The rating for the Trust provides patients and families with significant assurance about the quality of care they can expect to receive from MFT, whether that is in one of our hospitals, the community or in their home.

3.4. It is a credit to all of our staff that one year after the largest merger in the NHS the Trust has received an overall '**Good'** rating with many '**Outstanding**' features. It really is a significant achievement and provides the Trust with a solid foundation on which to move to '**Outstanding**' in the future.

3.5. The CQC have provided a detailed commentary on areas of outstanding practice and areas for improvement. Group wide headlines are noted at table 1.

Table 1

Outstanding Practice	Areas Requiring Improvement
High level of leadership experience, capability, capacity and integrity	The health record
Outstanding ratings for 'caring' across many areas	Maintenance and management of medical equipment
A mostly positive response to the merger and new arrangements	Mandatory training compliance
A good safety culture with high levels of reporting and strong evidence of learning	Compliance with some clinical protocols such as the World Health Organisation Safety Checklist for surgery
Many examples of learning from complaints	Staffing in the Emergency Departments at MRI, Wythenshawe Hospital and Trafford Hospital
A compelling vision at core service and strategic level	Staffing in some other areas of the Trust
Clear statement on vision and values well understood by staff	Patients could not always access treatment in a timely way
Clear roles and responsibilities and sound systems to support good governance	Appraisal rates
Effective systems for the management of risk	Manchester Royal Infirmary – Urgent and Emergency Services, Surgery and Outpatients
Staff consistently stated that finance did not take priority over patient safety	Wythenshawe Hospital – Urgent and Emergency Services
Good examples of staff engagement	Trafford Hospital – Urgent and Emergency Services
Medicines were mainly managed well and stored safely	Withington Community Hospital - Outpatients
The environment was mostly clean	
Infection rates are low	
Care was effective and based on evidence / best practice	
MDT working evident across most areas	

3.6. Following this inspection the CQC will re-inspect services on the basis of the Trust's previous ratings and the latest information they have to decide which services to inspect alongside an annual inspection of the well-led key question. The maximum intervals for re-inspection are:

- one year for core services rated as inadequate
- two years for core services rated as requires improvement[1]
- three and a half years for core services rated as good
- five years for core services rated as outstanding

The CQC will take into account the Trust's own assessment of the quality of its core services. If the organisation is of the view that services have improved, the CQC may re-inspect on request.

4. **Next Steps**

4.1. A detailed internal and external communications plan was agreed and implemented. This included messages from the Chief Executive, Group Executives and Hospital/MCS leadership teams.

[1] Manchester Royal Infirmary – Urgent and Emergency Services, Surgery and Outpatients
Wythenshawe Hospital – Urgent and Emergency Services
Trafford Hospital – Urgent and Emergency Services
Withington Community Hospital - Outpatients

4.2. An action plan in response to the report was submitted on the 22nd April 2019 and will be overseen by a time limited CQC Inspection Response Group. This group will be chaired by the Chief Nurse, and will report to the Group Quality and Safety Committee on remedial action being undertaken and provide assurance to the Quality and Performance Scrutiny Committee. Governance structures (detailed at fig. 1) will hold Hospitals/MCS to account on completion of actions which will be risk assessed and prioritised accordingly.

4.3. The terms of reference are set out at appendix B. The group will:

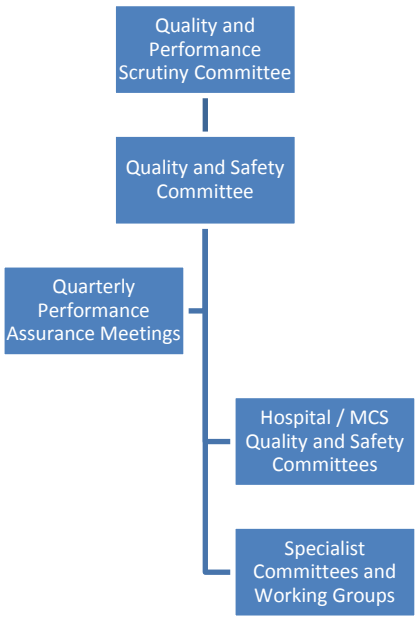
4.3.1. Oversee the MFT Group response to the 2018 CQC Comprehensive Inspection
4.3.2. Ensure a rapid response to any regulatory breaches
4.3.3. Provide assurance to the Board of Directors, via the Quality and Safety Committee and Quality and Performance Scrutiny Committee, that all identified risks are being addressed
4.3.4. Ensure that the response is aligned with 2019/20 work plans and other related strategy documents

4.4. In addition quarterly Performance Assurance Meetings will be chaired by the Chief Nurse who will oversee an in-depth review with Hospital / MCS / MLCO and Corporate Teams on progress against the plan and assurance evidence on outcomes. A report will be provided to the Quality and Safety Committee and any issues escalated if necessary.

5. The Chair of the Q&PSC or any of the Non-executive Directors may request specific areas of scrutiny are presented through the Group scrutiny committees.

5.1. It should be noted that a number of actions have already been undertaken in response to feedback at the time of inspection and the draft report. This includes a focus on mandatory training and improvements to equipment maintenance rates.

Fig 1



5.2. All core services rated as requiring improvement will develop an additional plan to prepare for their unannounced inspection within the next 2 years.

6. Recommendations

6.1. The Board of Directors is asked to approve the steps set out in section 4.

Appendix A

Part 1 - Manchester University NHS Foundation Trust CQC Ratings Summary

Hospital / MCS	Key Lines of Enquiry					Overall
	Safe	Effective	Caring	Responsive	Well-Led	
Wythenshawe Hospital	Good	Good	Outstanding	Requires Improvement	Good	**Good**
Manchester Royal Infirmary	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	**Requires Improvement**
Royal Manchester Children's Hospital	Good	Good	Outstanding	Good	Good	**Good**
Saint Mary's Hospital	Good	Good	Outstanding	Good	Good	**Good**
Manchester Royal Eye Hospital	Good	Outstanding	Outstanding	Outstanding	Outstanding	**Outstanding**
University Dental Hospital Manchester	Outstanding	Outstanding	Good	Requires Improvement	Outstanding	**Outstanding**
Trafford General Hospital	Good	Good	Good	Good	Good	**Good**
Withington Community Hospital	Good	Good	Good	Good	Good	**Good**
Altrincham Hospital	Good	Not rated	Good	Good	Good	**Good**
Manchester Local Care Organisation	Good	Good	Good	Good	Good	**Good**
Child and Adolescent Mental Health Services	Good	Outstanding	Outstanding	Outstanding	Outstanding	**Outstanding**

Group Level Well-led	**Good**					**Good**
OVERALL GROUP	**Good**	**Good**	**Outstanding**	**Good**	**Good**	**Good**

Part 2 - Hospital / MCS Detail

Manchester Royal Infirmary

	Safe	Effective	Caring	Responsive	Well-Led	Overall
Urgent and Emergency Services	RI	RI	Good	RI	RI	**RI**
Medical Care (including older people's care	Good	Good	Good	Good	Good	**Good**
Surgery	RI	RI	Good	RI	RI	**RI**
Critical Care	Good	Good	Outstanding	Good	Outstanding	**Outstanding**
End of Life Care	Good	Good	Good	Good	Good	**Good**
Outpatients	RI	Not rated	Good	RI	Good	**RI**
Overall	**RI**	**RI**	**Good**	**RI**	**RI**	**RI**

Wythenshawe Hospital

	Safe	Effective	Caring	Responsive	Well-Led	Overall
Urgent and Emergency Services	RI	RI	Good	RI	Good	**RI**
Medical Care (including older people's care	Good	Good	Good	RI	Good	**Good**
Surgery	Good	Good	Good	Good	Good	**Good**
Critical Care	Good	Good	Outstanding	Outstanding	Good	**Outstanding**
Maternity Services	Good	Good	Good	Good	Good	**Good**
Services for Children and Young People	Good	Good	Good	Outstanding	RI	**Good**
End of Life Care	Good	Good	Outstanding	Good	Good	**Good**
Outpatients	Good	Not rated	Good	Good	Good	**Good**
Overall	**Good**	**Good**	**Outstanding**	**RI**	**Good**	**Good**

Royal Manchester Children's Hospital

	Safe	Effective	Caring	Responsive	Well-Led	Overall
Urgent and Emergency Services	RI	Good	Good	Good	Good	**Good**
Medical Care	Good	Good	Good	Good	Good	**Good**
Surgery	Good	Good	Outstanding	Outstanding	Good	**Outstanding**
Critical Care	Good	Good	Good	Good	Good	**Good**
Transition Services	Good	Good	Good	Good	Good	**Good**
End of Life Care	Good	Good	Outstanding	Good	Good	**Good**
Outpatients	Good	Good	Outstanding	Good	Good	**Good**
Overall	**Good**	**Good**	**Outstanding**	**Good**	**Good**	**Good**

Trafford General Hospital

	Safe	Effective	Caring	Responsive	Well-Led	Overall
Urgent and Emergency Services	Good	RI	Good	Good	RI	**RI**
Medical Care (including older people's care)	Good	Good	Good	Good	Good	**Good**
Surgery	RI	Good	Good	Good	Good	**Good**
Services for Children and Young People	Good	Good	Good	Good	Good	**Good**
End of Life Care	Good	Good	Good	Good	Good	**Good**
Outpatients	Good	Not rated	Good	Good	Good	**Good**
Overall	**Good**	**Good**	**Good**	**Good**	**Good**	**Good**

Saint Mary's Hospital

	Safe	Effective	Caring	Responsive	Well-Led	Overall
Maternity	Good	Good	Good	Good	Good	**Good**
Neonatal Services	Good	Good	Outstanding	Good	Good	**Good**
Overall	**Good**	**Good**	**Outstanding**	**Good**	**Good**	**Good**

Manchester Royal Eye Hospital

	Safe	Effective	Caring	Responsive	Well-Led	Overall
Surgery	Good	Outstanding	Outstanding	Outstanding	Outstanding	**Outstanding**
Outpatients	Good	Not rated	Outstanding	Good	Outstanding	**Outstanding**
Overall	**Good**	**Outstanding**	**Outstanding**	**Outstanding**	**Outstanding**	**Outstanding**

University Dental Hospital Manchester

	Safe	Effective	Caring	Responsive	Well-Led	Overall
Surgery	Outstanding	Outstanding	Good	RI	Outstanding	**Outstanding**
Overall	**Outstanding**	**Outstanding**	**Good**	**RI**	**Outstanding**	**Outstanding**

Manchester Local Care Organisation

	Safe	Effective	Caring	Responsive	Well-Led	Overall
Community Health Services for Adults	Good	Good	Good	Good	Good	**Good**
Community Health Services for Children and Young People	Good	Good	Good	RI	Good	**Good**
Community Health Inpatient Services	Good	Good	Good	Good	Good	**Good**
Community End of Life Care	Good	Good	Good	Good	Good	**Good**
Community Dental Services	Good	Good	Good	Good	Good	**Good**
Overall	**Good**	**Good**	**Good**	**Good**	**Good**	**Good**

Withington Community Hospital

	Safe	Effective	Caring	Responsive	Well-Led	Overall
Surgery	Good	Good	Good	Good	Good	**Good**
Outpatients	Good	Not rated	RI	RI	RI	**RI**
Overall	**Good**	**Good**	**Good**	**Good**	**Good**	**Good**

Altrincham Hospital

	Safe	Effective	Caring	Responsive	Well-Led	Overall
Outpatients	Good	Not rated	Good	Good	Good	**Good**
Overall	**Good**	**Not rated**	**Good**	**Good**	**Good**	**Good**

Child and Adolescent Mental Health Services

	Safe	Effective	Caring	Responsive	Well-Led	Overall
Child and Adolescent Mental Health Wards	Good	Good	Good	Good	Good	**Good**
Specialist Community Mental Health Services for Children and Young People	Good	Outstanding	Outstanding	Outstanding	Outstanding	**Outstanding**
Overall	**Good**	**Outstanding**	**Outstanding**	**Outstanding**	**Outstanding**	**Outstanding**

Appendix B

MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

CQC Inspection Response Group (CIRG)

TERMS OF REFERENCE

1. CONSTITUTION

1.1. The Quality and Safety Committee has established a time limited working Group, CQC Inspection Response Group (CIRG).

2. MEMBERSHIP

Chief Nurse (Chair)
Group Medical Director (Deputy Chair)
Director of Clinical Governance
Group Deputy Chief Nurse
Group Chief Pharmacist
Group Deputy Director of Workforce and OD
Group Director of Corporate Services/Trust Secretary
Group Director of Estates
Group Head of Clinical Governance Chief Executive Clinical Scientific Service

Corporate Directors as required

3. ATTENDANCE AT MEETINGS

3.1. The Committee may require the attendance of any Trust employee or agent of the Trust.

3.2. A quorum shall consist of four members including as a minimum the Chief Nurse or the Medical Director.

4. FREQUENCY OF MEETINGS

4.1. Every month and at other times as may be necessary

5. OVERVIEW

5.1. To oversee the MFT Group response to the 2018 CQC Comprehensive Inspection
5.2. To ensure a rapid response to any regulatory breaches
5.3. To provide assurance to the Board of Directors, via the Quality and Safety Committee that all identified risks are being addressed
5.4. To ensure that the response is aligned with 2019/20 work plans and other related strategy documents

6. SCOPE AND DUTIES

6.1. To provide an assurance to the Quality and Safety Committee that risks of all types are identified within the CQC report, and are controlled to an acceptable level, and to advise the Quality and Safety Committee on significant risks that need further escalation.

7. To further provide assurance to the Quality and Performance Scrutiny Committee

7.1. To develop and agree a format for action planning in response to the CQC recommendations

7.2. To ensure those actions are aligned with other strategic plans and documents

7.3. To oversee, through regular meeting and review of assurance narrative / indicators the implementation and effectiveness of actions planned

7.4. To ensure Group wide communication of learning and improvements made

7.5. To ensure an effective mechanism for escalating issues to the appropriate Committee and the Board Assurance Framework.

7.6. To receive a report on progress from each Hospital/MCS and relevant corporate teams on progress with action implementation

7.7. To complete all actions required and support Group wide progress to an overall rating of OUTSTANDING

8. RELATIONSHIPS AND REPORTING

8.1 The CIRG summary report shall be considered at the next Quality and Safety Committee

8.2 The Committee report shall be considered when required by the Quality and Performance Scrutiny Committee.

8.3 The Committee may request formal reports from any other Trust Committees when relevant.

8.4 The Committee will work closely with Hospital/MCS Quality and Safety Committees and other groups to provide assurance to the Group Quality and Safety Committee that there has been an effective response to the recommendations made.

9. AUTHORITY

9.1. The Committee is empowered to examine and investigate any activity within the Trust pursuant to the above scope and duties.

10. KEY PERFORMANCE INDICATORS

10.1. These terms of reference will be measured against the following key performance indicators;

10.1.1. The provision of a report to each Quality and Safety Committee and Quality and Performance Scrutiny Committee
10.1.2. Completion of the Group wide response to the CQC recommendations detailing measurable and achievable actions within a defined timescale
10.1.3. Presentation of the response detail in the Annual Report for 2019/20
10.1.4. 75% attendance by all required members and attendees

These Terms of reference and continuation of the group will be reviewed by March 2020 or earlier if required

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Professor Cheryl Lenney, Group Chief Nurse
Paper prepared by:	Karen Meadowcroft, Corporate Director of Nursing Debra Armstrong, Assistant Chief Nurse
Date of paper:	April 2019
Subject:	Quarter 4 Complaints Report, Financial Year 2018/19
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
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 January 2019 – 31st March 2019

1. Executive Summary

1.1. Members of the Group Board of Directors are asked to note the Quarter 4, 2018/19 complaints report for Manchester University NHS Foundation Trust (MFT), covering the period 1st January 2019 – 31st March 2019.

1.2 This report provides an overview of the Complaints and PALS performance for Quarter 4, 2018/19. Due to new reporting capabilities to refresh and cleanse previous data, the data provided in this report for the periods prior to the current quarter (Quarter 4) may differ slightly to the data presented in previous reports.

1.3 During Quarter 4, 2018/19, work continued to integrate the Trust's complaints functions and develop a single set of performance metrics. This has enabled comparisons to be made between the Hospitals/MCS and MLCO across the Group. A fundamental part of the integration has involved the reporting alignment of formal complaints and PALS concerns to Hospitals/MCS and the MLCO.

1.4 During Quarter 4, 2018/19 there was a total of 1,753 PALS concerns received. This compares to 1,494 concerns received in Quarter 3; is a 17.3% increase in concerns compared to Quarter 3, 2018/19. Numerically this is an increase of 259 PALS concerns.

1.5 During Quarter 4, 2018/19, there were a total of 409 new formal complaints received. This compares to 333 new formal complaints received in Quarter 3, 2018/19; which is a 22.8% increase in formal complaints compared to Quarter 3, 2018/19. Numerically this is an increase of 76 formal complaints. There continues to be a natural seasonal variation of complaint numbers received on a monthly basis (see section 2.7) which has ranged from 78 (December) to 165 (March) complaints received in 2018/19 at Group level. The Assistant Chief Nurse continues to monitor the variation closely.

1.6 The largest numerical increases in the number of complaints received in Quarter 4 were within Manchester Royal Infirmary (MRI) with an increase of 31 (36%) and Wythenshawe, Trafford, Withington and Altrincham (WTWA) with an increase of 24 (26.7%) complaints received. The largest decrease in the number of complaints received was within Clinical Scientific Services (CSS), with a reduction of 6 (25%) in Quarter 4, 2018/19, compared to the number of complaints received in Quarter 3, 2018/19. Additional support has continued to be provided to MRI from the corporate team during Quarter 4, 2018/19.

1.7 The total number of complaints closed in Quarter 4, 2018/19 was 351, whilst this is a decrease (negative) of 98 cases compared to 449 complaints closed in Quarter 3, 2018/19 which is reflective of seasonal variation and specifically the lower number of complaints received in Quarter 3, 2018/19, specifically the month of December 2018 when 78 complaints were received.

1.8 During Quarter 4, 2018/19 there was a notable decrease (positive) in the number of complaint responses, resolved over 41 days, compared to the number of complaint responses resolved at over 41 days in Quarter 3, 2018/19, was a reduction of 49 cases (a positive 4.2% reduction).

1.9 The NHS Complaint Regulations (2009) stipulate that complaints must be acknowledged in writing no later than 3 working days following receipt of the complaint. The Trust achieved 99.6% compliance with this Key Performance Indicator during Quarter 4, 2018/19. The one acknowledgement breach was due to human error at the triage stage of the formal complaint process.

1.10 In accordance with the agreed schedule, the Complaints Scrutiny Group, which is chaired by a Non-Executive Director, met twice during Quarter 4, 2018/19. CSS and WTWA (Medicine) each presented a case at the January 2019 meeting and the University Dental Hospital of Manchester (UDHM) and Manchester Royal Eye Hospital (MREH) each presented a case at the March 2019 meeting. The learning identified from the cases presented is detailed in Section 5 of this report.

1.11 Improvements in the Complaint and PALS management processes are described in the report with future quality improvements identified.

1.12 The Group Board of Directors is asked to note:

- The information within the report which demonstrates whilst the number of PALS concerns and Formal Complaints received in Quarter 4 has increased the timeliness of responding to complainants has significantly improved.
- The ongoing integration and development of the complaints system during Quarter 4, 2018/19 and the targeted support from the corporate team provided to improve performance.

2. Overview of Quarter 4, 2018/19 Performance

PALS

2.1 During Quarter 4, 2018/19 there was an increase in PALS concerns with 1,753 PALS concerns being received, compared to 1,494 in Quarter 3, 2018/19. This is a 17.3% increase in concerns compared to Quarter 3, 2018/19 and is numerically an increase of 259 PALS concerns.

2.2 As appropriate and in agreement with the complainant, PALS concerns can be escalated to formal complaints or formal complaints de-escalated to PALS concerns. There were 19 PALS cases escalated for formal investigation during Quarter 4, 2018/19 this is an increase when compared to the 9 PALS cases escalated during Quarter 3, 2018/19. Cases are predominantly escalated due to the complexity of the complaint received and following discussion and agreement with the complainant advising that formal investigation should be undertaken. Conversely three formal complaint cases were de-escalated during Quarter 4, 2018/19; this compares to 11 cases de-escalated during Quarter 3, 2018/19.

2.3 As in previous reports the Hospital/MCS with the highest number of PALS concerns received during Quarter 4, 2018/19 was WTWA with 608 cases (34.7%), followed by MRI with 479 cases (27.3%) of the PALS cases received. Whilst the higher number of PALS concerns received by WTWA and MRI partially reflects the level of activity in these Hospital/MCS's, this is an increase of 18% and 19.1% respectively compared to the number of PALS concerns received by WTWA and MRI in Quarter 3. To support the Hospital/ MCS senior management teams to understand the increase in the number of PALS concerns received the corporate team commenced providing quarterly thematic PALs reports to WTWA and MRI from Quarter 4. Initial data analysis has identified 'Outpatient Appointment Delay / Cancellation' and 'Communication' as the most common Themes from PALS concerns received at both WTWA and MRI. The information provides the Hospital teams the detail to identify focussed areas for improvement. The MFT Transformation Team have a programme of support across all Outpatient Services to deliver improvements in outpatient care.

2.4 The majority of PALS concerns during Quarter 4, 2018/19 related to outpatient areas, which accounted for 1,428 (81.5%) of the 1,753 contacts received. This compares to 1,129 (75.6%) of concerns raised during Quarter 3, 2018/19 relating to the Outpatient areas.

2.5 **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 1, 2018/19		Quarter 2, 2018/19		Quarter 3, 2018/19		Quarter 4, 2018/19	
Days to Close	Number of Cases Resolved Within Timeframe	Percentage of Cases Closed Within Timeframe	Number of Cases Resolved Within Timeframe	Percentage of Cases Closed Within Timeframe	Number of Cases Resolved Within Timeframe	Percentage of Cases Closed Within Timeframe	Number of Cases Resolved Within Timeframe	Percentage of Cases Closed Within Timeframe
0-7	922	76.3%	126	72.0%	1177	77.5%	1189	71.8%
8-14	247	20.4%	313	23.0%	314	20.7%	444	26.8%
15+	40	3.3%	63	5.0%	28	1.8%	22	1.3%

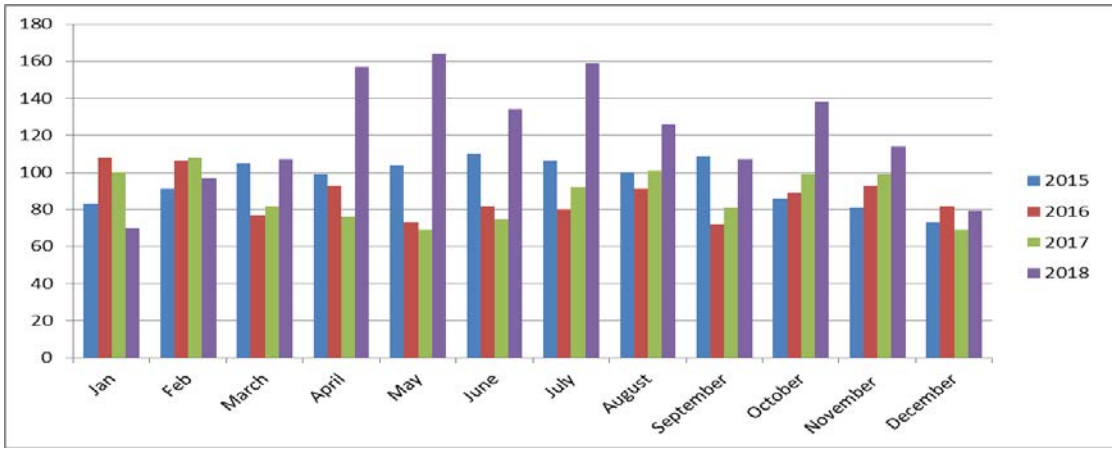
2.6 In Quarter 4, 2018/19 the number of cases taking longer than 14 days to close reduced (positive) from 28 (1.8%) in Quarter 3 to 22 (1.3%) of all cases. At the beginning of Quarter 2, 2018/19 a new process was implemented for the escalation of all PALS cases over 12 days. All cases are now escalated to the PALS Manager on day 12 and this earlier escalation process has been successful in reducing the time to resolve PALS concerns.

New Formal Complaints

2.6 During Quarter 4, 2018/19, there were a total of 409 new formal complaints received. This compares to 333 in Quarter 3, 2018/19, 392 received in Quarter 2, 2018/19 and 455 received in Quarter 1, 2018/19. This represents a 22.8% increase in formal complaints (increase of 76 in number) when compared to Quarter 3, 2018/19. There continues to be a natural seasonal variation of complaints received on a monthly basis which has ranged from 78 (December) to 165 (March) complaints received in 2018/19 at Group level. The Assistant Chief Nurse continues to monitor the variation closely. Work will continue in Quarter 1, 2019/20 to report this variation by Hospital/ MCS and MLCO to allow proactive management by the Hospital/ MCS and MLCO senior teams based on expected volumes of complaints, whilst improvement programmes are underway to reduce the overall number of complaints.

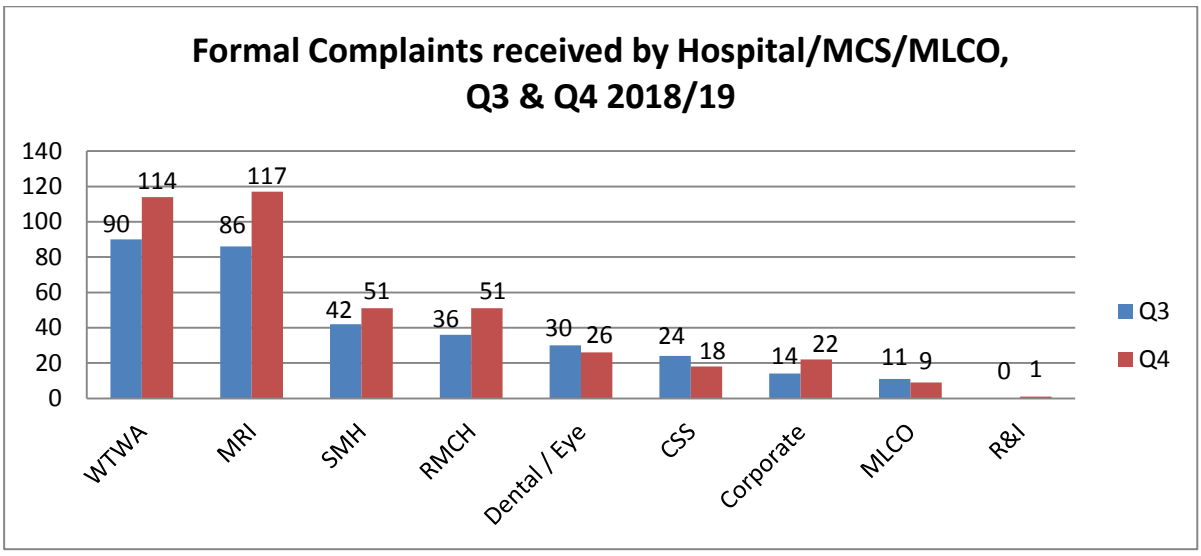
2.7 **Graph 1** demonstrates the concept of seasonal variation with figures from the former CMFT for the period of 2015-17 and MFT for the period of 2017/18 which demonstrates the consistent decrease in complaints in December which affects Quarter 3 data and further decreases in January to March which is reflected in Quarter 4 data.

Graph 1: compares the total number of new formal complaints received by former CMFT for 2015-17 and MFT for the period of 2017/18 by month to illustrate the concept of seasonal variation.



2.8 **Graph 2** compares the total number of new formal complaints received by Hospital/MCS/MLCO in Quarter 3 and Quarter 4, 2018/19.

Graph 2: Total number of Formal Complaints Received by Hospital/MCS/MLCO



2.9 During Quarter 4, 2018/19 MRI received the most complaints (117). This represents an increase of 31 (36%) cases compared to Quarter 3, 2018/19. The largest decrease in the number of complaints received from Quarter 3 to Quarter 4, 2018/19 was at CSS which had a reduction of 6 cases (25%). The MRI team continue to be supported by the Corporate Nursing team.

2.10 Compared to Quarter 3, 2018/19 Corporate Services experienced an increase of 8 (57.1%) complaints received in Quarter 4, 2018/19 and WTWA experienced an increase of 24 (26.7%). The complaints received by Corporate Services were categorised across 10 themes predominantly the concerns related to car parking. There were no specific Themes identified in the increased number of complaints received by WTWA. 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.

2.11 During Quarter 4, 2018/19, there were 131 new complaints made relating to inpatient services and 184 relating to outpatient services. For inpatient services, this represents an increase of 21 cases (19.1%) compared to Quarter 3, 2018/19 and for outpatient services, this represents an increase of 29 cases (18.7%) compared to Quarter 3, 2018/19. The area with the highest number of outpatient complaints for Quarter 4, 2018/19 was WTWA with a total of 38 of the 184 received (20.65%). Themes identified for inpatient services were general medical care and communication failure with patient/relative and themes for outpatient services were appointment delay and treatment/procedure delay/failure.

2.12 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 99.6% compliance with this key performance indicator (KPI) during Quarter 4, 2018/19 compared to 99.5% in Quarter 3, 2018/19 and 100% in Quarter 2, 2018/19. The one acknowledgement breach in Quarter 4 was due to human error at the triage stage of the formal complaint process. Further work continues to review and strengthen the Trust's Complaint Triage process to ensure complaint correspondence is prioritised.

Current Complaints

2.13 In accordance with the NHS Complaint Regulations (2009) the Trust has identified complaint response timescales as; 25 working days, 26-40 working days and 41 days and above. The performance against these timescales is monitored.

2.14 In accordance with the Trust's Complaint Triage process timescales are discussed and agreed with the complainant in three broad timeframes, as follows:

- 25 working days, normal response timeframe
- 40 working days, highly complex case response timeframe
- 60 workings days, highly complex case involving multiple organisations, High Level Investigations (HLIs), Independent/External reviews and HR investigations response timeframe

2.15 The accountability for complaints management and monitoring has been fully devolved to the Hospital/MCS and the MLCO Chief Executives and since Quarter 1, 2018/19 performance is monitored at a Group level via the AOF.

2.16 At the end of Quarter 4, 2018/19 there was 230 open formal complaints compared to 217 unresolved at the end of Quarter 3, 2018/19. This is a 6% increase (negative) at the end of Quarter 4, compared to the end of Quarter 3 2018/19; equating to 13 more open complaints. The open complaints comprised 159 which had been registered between 0-25 days, 34 between 26-40 days, (14 of which were in planned and agreed timescale with the complainant) and 37 had been registered for 41 or more days, (15 of which were in planned and agree timescale with the complainant).

2.17 There were 37 cases unresolved at 41 or more days at the end of Quarter 4, 2018/19 compared to 46 complaints at the end of Quarter 3, 2018/19. This represents a 19.56% decrease (positive) in over 41 day cases from Quarter 3 to Quarter 4, 2018/19.

2.18 MRI had the highest number of open cases at the end of Quarter 4, 2018/19 with 65 open cases (52 of which were in the agreed timescale with the complainant). This compared to 79 open cases in Quarter 3, 2018/19, 98 open cases in Quarter 2, 2018/19 and 113 open cases in Quarter 1, demonstrating an ongoing improvement in the timely management of complaints. Of the cases open at the end of Quarter 4, 49 were within 0-25 days, 7 were within 26-40 days (4 of which were in the agreed timescale with the complainant) and 9 were over 41 days (9 of which were in planned and agreed timescale).

Resolved Complaints

2.19 The oldest complaint case closed during Quarter 4, 2018/19 was registered at MRI (Surgery) on 20th June 2018 and was 174 days old when closed on 12th March 2019. The complaint involved a High Level Investigation within MRI, which involved a meeting between the complainant, the Chief Executive of MRI and members of the Hospital team following completion of the investigation. The complainant was kept updated throughout the process.

2.20 **Table 2** provides a comparison of formal complaints resolved within each timeframe from Quarter 1, 2018/19 to Quarter 4, 2018/19.

Table 2: Comparison of formal complaints resolved by timeframe

	Quarter 1 2018/19	Quarter 2 2018/19	Quarter 3 2018/19	Quarter 4 2018/19
Formal complaints resolved	541	446	449	351
Resolved in 0-25 days	136 (25.1%)	160 (35.9%)	161 (35.9%)	159 (45.3%)
Resolved in 26-40 days	76 (14.0%)	94 (21.1%)	132 (29.4%)	85 (24.2%)
Resolved in 41+ days	329 (61.0%)	192 (43.0%)	156 (34.7%)	107 (30.5%)

2.21 The number of cases resolved within 0-25 working days in Quarter 4 was comparable to Quarter 3, 2018/19. Between Quarter 3, 2018/19 and Quarter 4, 2018/19 there was a decrease of 47 cases resolved between 26-40 days; there was a significant decrease (positive) in the number of cases resolved at 41+ days by 49 cases.

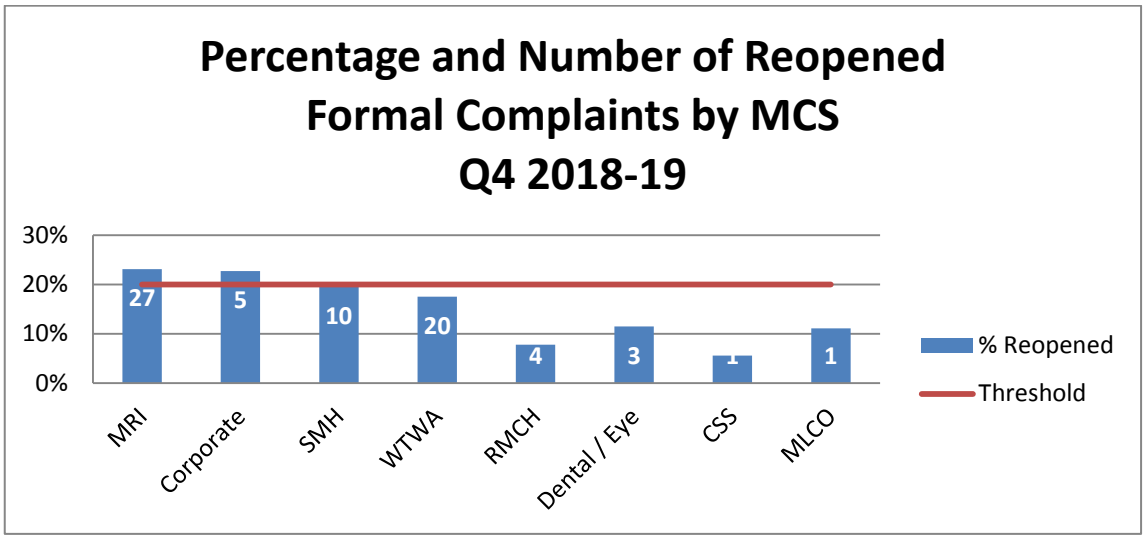
Re-opened Complaints

2.22 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 decrease in the number of re-opened complaints received in Quarter 4, 2018/19 (71 cases). This compares to 105 in Quarter 3, 2018/19. Overall re-opened cases accounted for 17.4% of all complaints received in Quarter 4, 2018/19 compared to 31.5% in Quarter 3, 2018/19.

2.23 The highest number of re-opened cases was received by MRI (27 cases) in Quarter 4, 2018/19 compared to 42 in Quarter 3, 2018/19. Of the 27 re-opened cases received by MRI the cases were predominantly re-opened due to unresolved issues or new concerns following the response.

2.24 **Graph 3** illustrates Hospital/MCS/MLCO performance against this threshold in Quarter 4, 2018/19; MRI 23.1% (27 re-opened cases), and Corporate Services 22.7% (5 re-opened cases), exceeded the 20% threshold during Quarter 4, 2018/19; with all the other Hospitals/MCS and the MLCO recording re-opened cases below the threshold. It should be noted, however, that small fluctuations in the total number of complaints received in a Hospital/MCS or the MLCO can result in large percentage changes for those areas with overall low number of complaints. Complaint management training is being offered to all Hospital/MCS/MLCO teams focused on the quality of complaint responses as part of the educational sessions as detailed in Section 9.2.2 of this report.

Graph 3: Percentage of re-opened Formal Complaints (Quarter 4, 2018/19).



3. Care Opinion and NHS Website feedback

3.1 Care Opinion and the NHS Website 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 Website comments by category; positive, negative and mixed positive and negative comments are detailed in **Table 3.**

3.3 The Care Opinion and NHS website feedback demonstrates almost half of the overall comments (49%) received in Quarter 4, 2018/19 were positive. This represents a minor reduction of 1% compared to Quarter 3, 2018/19 when the overall positive comments represented 50% of the total. Negative comments equate to 45% of the overall total received during Quarter 4, 2018/19, which compared to 41.1% during Quarter 3 reflects an increase of 3.9%.

3.4 The increase of negative comments received related to MRI and SMH, with MRI receiving a total of 9 negative comments in Quarter 4, 2018/19 compared to 7 in Quarter 3, 2018/19 and SMH receiving a total of 4 negative comments in Quarter 4, 2018/19 compared to 2 in Quarter 3, 2018/19. The Hospitals/MCS/MLCO's receive all the posted comments and provide responses and offer the person posting the comment to make contact with PALS should they require a level of support or investigation to ensure the service has opportunity to make improvements of the feedback.

3.5 All Care Opinion and NHS Website comments are received by the Patient Experience Team (PET) and shared with the relevant Hospital/MCS/MCLO, requesting a response for publication with 5 working days. Within each Hospital/MCS/MCLO designated staff support the provision of a response to the PET. The PET ensures responses are quality assured, either by the Hospital/MCS/MCLO or Corporate Team prior to posting on line.

Table 3: Number of Care Opinion/NHS website postings by Hospital/MCS/MLCO in Quarter 4, 2018/19.

Number of Postings received by Hospital/ MCS/ Division Q4, 2018/19			
Hospital/ Managed Clinical Service (MCS)/ Division	**Positive**	**Negative**	**Mixed**
Manchester Royal Infirmary	**6**	**9**	**1**
Wythenshawe, Trafford, Withington and Altrincham	**11**	**8**	**1**
Clinical Scientific Services	**4**	**0**	**1**
Corporate Services (Estates and Facilities)	**0**	**1**	**0**
Manchester Royal Eye Hospital / University Dental Hospital of Manchester	**1**	**0**	**0**
Royal Manchester Children's Hospital	**0**	**0**	**0**
St Marys Hospital	**2**	**4**	**0**
Overall MFT Total	**24**	**22**	**3**

3.6 **Table 4** provides two examples of the feedback received and the subsequent responses posted on Care Opinion and NHS Website during Quarter 4, 2018/19.

Table 4: Example Care Opinion/ NHS Website Postings and Reponses

Quarter 4 , 2018/2019
Nuclear Medicine Department, Manchester Royal Infirmary –PET Scan
Attended for a PET Scan and cannot thank the staff enough for the way they treated me. I have disabilities that affect my mobility and made the procedure quite challenging for me. The staff were wonderful, especially the nurse in charge of my procedure. She was patient and mindful of my condition and made sure I was updated at every opportunity and fully explained the process. She made the whole experience bearable and I was well looked after. So grateful. Thank you so much. Visited in February 2019.
Response
Thank you for your positive comments posted on the NHS website regarding your care in the Nuclear Medicine Department, 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 positive feedback which reflects their hard work and dedication. It was reassuring to read that you thought that the staff fully explained the process and kept you updated. I can assure you that we have passed on your thoughts to the Head of Nursing who will share your feedback and thanks with the team.
Opal House, Wythenshawe Hospital – Excellent care of my elderly grandfather
My grandfather was admitted into Opal House approx. 3 months ago. In the time he has been here the staff have provided an excellent standard of care, and have all treated him as if he were their family. They have gone above and beyond in every aspect and have made him feel at ease and comfortable, which is usually a difficult task for him as his dementia causes confusion and stress. I cannot express the gratitude I have for all the staff at Opal House. They have been amazing, and I'm sad to see him leave. Anyone who's wondering about their relatives being in here, you will not be disappointed. Everything was perfect.

Response
Thank you for your positive comments posted on the NHS website regarding your grandfather's care at Opal House, Wythenshawe Hospital. It was very kind of you to take the time to write and compliment the staff as it is good to receive positive feedback which reflects their hard work and dedication. It was reassuring to read that your grandfather received excellent care and that the staff went above and beyond, making him feel comfortable and at ease. I can assure you that we have passed on your feedback to the Head of Nursing who will share this with all the team at Opal House who have made you grandfather's experience perfect during his 3 month stay.

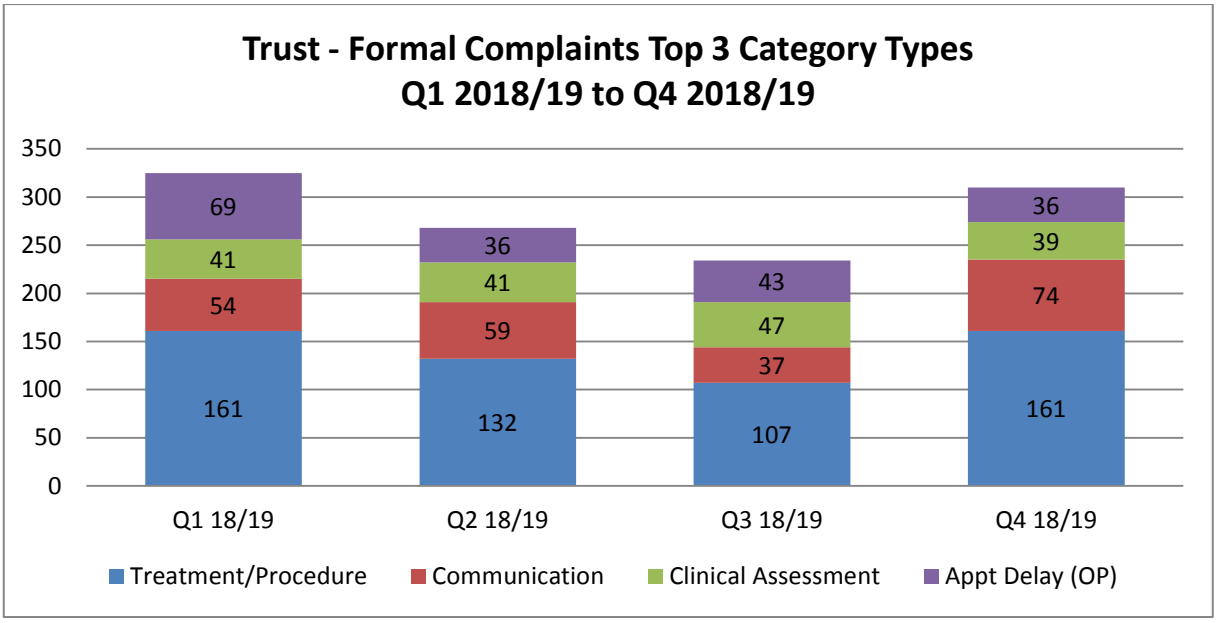
4. Themes from Complaints and PALS contacts

4.1 In Quarter 4, 2018/19 the medical staffing group were cited in 47.4% of all PALS contacts, compared to 45% in Quarter 3, 2018/19. This staff group were also cited in 47.4% of Formal Complaints in Quarter 4, compared to 53.2% in Quarter 3, 2018/19. Whilst recording limitations prevent further analysis of this data to determine whether these references relate to specific grades of medical staff it is recognised that medical staff as the lead practitioner for episodes of care it is not unusual for them to be cited by patients who wish to make a complaint. Actions in relation to this trend are undertaken on a case by case basis by the relevant Hospital/MCS/MLCO. In addition, the Head of Customer Services provides educational input with regard to customer service and complaints management on the New Appointed Consultants Programme (NACS).

4.2 The top three category types for formal complaints from Quarter 1, 2018/19 to Quarter 4, 2018/19 are shown in **Graph 4.**

4.3 'Treatment/Procedure' and 'Clinical Assessment' remain in the top three categories; however, in Quarter 4, 2018/19 'Communication' is the second category replacing 'Appointment Delay (OP)' which was in the top 3 categories in Quarter 3, 2018/19.

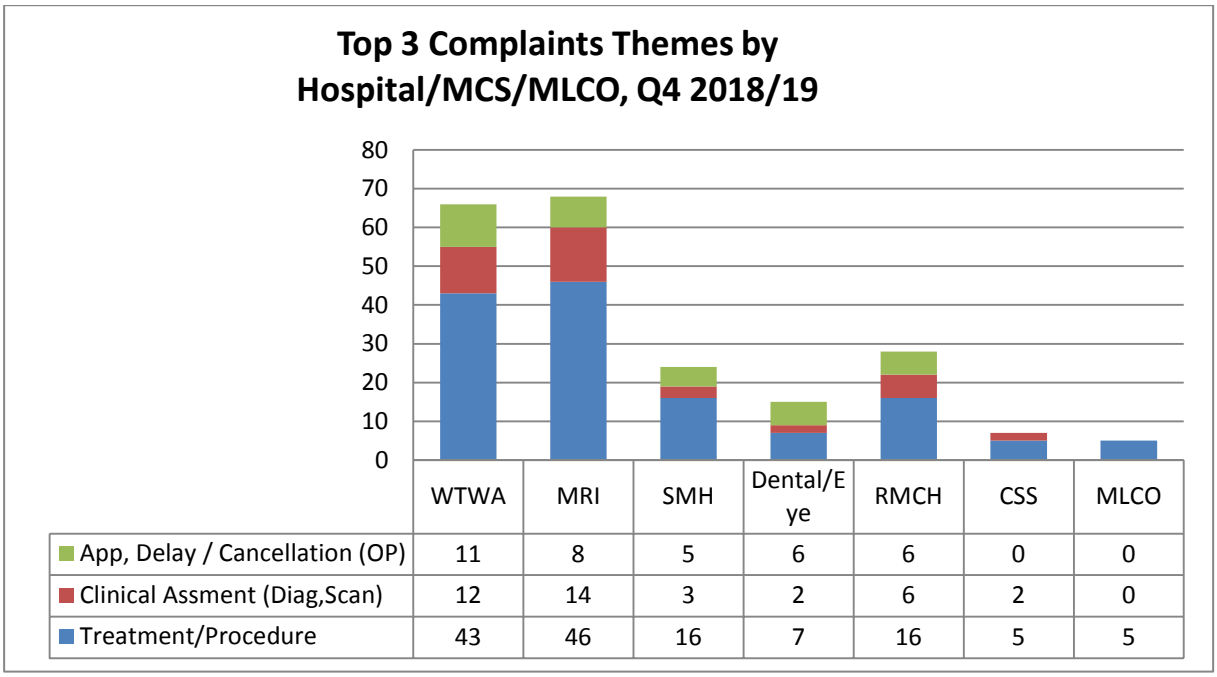
Graph 4: Formal Complaints – Top 3 Categories Quarter 1, 2018/19 to Quarter 4, 2018/19



4.4 **Graph 5** illustrates the total number of top 3 categories by Hospital/MCS/MLCO in Quarter 4 2018/19.

4.5 In Quarter 4, 2018/19 the top category, 'Treatment/Procedure' (161) was cited in 26.7% of WTWA's formal complaints and 28.5% of MRI formal complaints. In addition, 'Treatment/Procedure' accounted for 66.6% of SMH's and 65% of RMCH's formal complaints.

Graph 5: Total number of Top 3 Categories by Hospital/MCS/MLCO, Quarter 4 2018/19



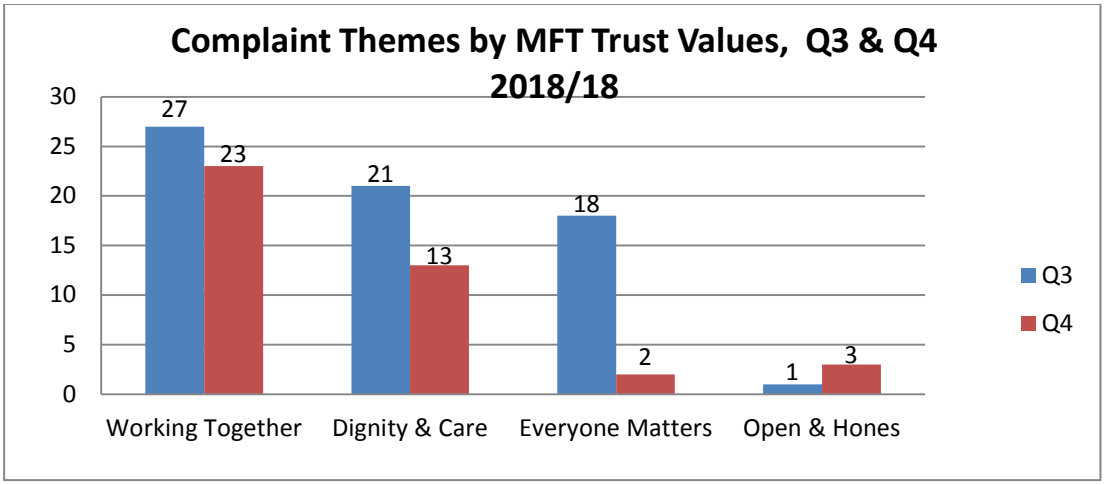
	WTWA	MRI	SMH	Dental/Eye	RMCH	CSS	MLCO
App, Delay / Cancellation (OP)	11	8	5	6	6	0	0
Clinical Assment (Diag,Scan)	12	14	3	2	6	2	0
Treatment/Procedure	43	46	16	7	16	5	5

4.6 **Theming Complaints**

Following implementation of the new Ulysses Complaints Module for MFT in Quarter 1, 2018/19, work is ongoing to theme the concerns raised in complaints to the new MFT Trust Values; ***Everyone Matters, Working Together, Dignity & Care & Open and Honest.***

The Trust-wide themes from the concerns identified in complaints compared to the MFT Trust Values from Quarter 4, 2018/19 are shown in **Graph 6**. This is the second quarter this information has been reported and as more data becomes available the accuracy of the data will improve; this will provide an opportunity to further understand the adoption and impact of Trust Values at both a group and Hospital/ MCS/ MLCO level, with the expectation that the number of concerns raised about the values not being adopted will reduce.

Graph 6: Formal Complaints – Theming of complaints to MFT Trust Values for Quarter 3 and Quarter 4, 2018/19



Due to the diversity of complaints received only 41 of the 409 new formal complaints received in Quarter 4, 2018/19, contained concerns which aligned with the MFT Trust Values. This compares to 67 out of 333 new formal complaints received in Quarter 3, 2018/19.

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 twice during Quarter 4, 2018/19. Clinical Scientific Services (CSS) and WTWA (Medicine) each presented a case at the January 2019 meeting. UDHM and MREH each presented a case at the March 2019 meeting.

5.2 The learning identified from the cases presented and the actions discussed and agreed at the meeting are outlined in **Table 5**. Transferable learning from complaints is identified and shared through this group.

Table 5: Actions identified at the Trust Complaints Scrutiny Group during Quarter 4, 2018/19.

Division/ Hospital	Learning	Actions
CSS	Patients with a disability may require help to change into a suitable gown and are not being offered assistance when attending for a scan.	All staff to be reminded of the importance of offering assistance when patients require help to change. Pictures of how gowns are worn to be placed on back of all changing room doors.
	Lack of experience & confidence from junior staff dealing with patients with a disability.	Fully trained/ Senior CT radiographer/s with a significant number of years' experience to be placed in the department to supervise junior staff.
	Lack of time to fully support patient throughout scan.	Certain scans to be performed on dedicated lists.

	Female radiographer unavailable to chaperone female patient in the CT Scanning Department.	Female radiographer to always be available in the CT Scanning Department.
WTWA (Medicine)	Patients in Phlebotomy clinic are not being treated with respect or in line with Trust Values & Behaviours.	Complaint shared with staff. Staff reflection taken place.
	No voicemail facilities detailing alternative contact telephone numbers for patients to contact.	Explore introduction of patient communication via email. Introduction of new Call Centre in November 2018. Introduction of new booking system at Trafford General Hospital. Introduction of new ticket option for waiting areas.
	Lack of accessible Phlebotomy Services across Trafford.	Explore other available options.
UDHM	Lack of clarity of NHS funded treatments for both General Dental Practitioner (GDP) & patients.	Engage with the Commissioners to discuss communication with GDPs. Review of information currently available on UDHM website & ensure criteria for implant funding is available to patients. Devise patient information leaflet detailing information on long term maintenance. Review the Newcastle Dental Hospital website. Explore the Referral Management Service (RMS) referral criteria.

MREH	Delays in clinic/length of wait to be seen in clinic.	Training in resolving concerns expressed by service users to be arranged for staff member. Staff to ensure patients concerns are escalated to nurse in charge in clinic. When delays experienced in clinic staff to ensure: ▪ Patients are kept informed of delay via the yellow boards ▪ Patients have been offered a pager ▪ Patients have been offered appropriate refreshments Ensure clinic notice boards indicate if Consultant present in clinic or not. Staff to be reminded of the importance of ensuring all clinic notice boards to be kept up to date at all time.
	Outpatient appointment cancelled & rebooked on several occasions.	Review waiting lists & sub-speciality information to determine where there is increased acuity. Review processes & determine if fit for purpose.

6. Parliamentary and Health Service Ombudsman (PHSO)

6.1 The PHSO makes the final decisions on complaints that have not been resolved by the NHS in England, United Kingdom Government Departments and other public organisations.

6.2 The Trust had 13 cases under the review of the Parliamentary and Health Service Ombudsman at the end of Quarter 4, 2018/19 compared to 15 under review at the end of Quarter 3, 2018/19. **Table 6** provides details of the progress of each PHSO case, specifically the number of reports that are awaited and shows the distribution of PHSO cases across the Hospitals/MCSs.

Table 6: Overview of PHSO Cases open as at 31st March 2019

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

SMH	1	Investigations on-going: Awaiting draft report (1 case)
Total	**13**	

6.3 The PHSO closed 5 cases in Quarter 4, 2018/19; of these cases 3 cases were not upheld, and 2 cases were partly upheld.

6.4 The Trust were asked to pay financial redress of £450 in Quarter 4, 2018/19 compared to £2,450 in Quarter 3, no financial redress in Quarter 2, 2018/19 and £100 in Quarter 1, 2018/19. The complaint to which the financial redress related to was in respect of the loss of a tooth due to delayed treatment and related stress.

Table 7: PHSO closed cases in Quarter 4, 2018/19 presented by outcome.

Division/ Hospital	Outcome	Date original complaint received	PHSO Rationale/ Decision	Recommendations
WTWA (Trafford)	Not upheld	14/08/18	No failings found	None
MRI (DMACS)	Partly upheld	01/02/18	Failings in record keeping	Written formal apology and action plan outlining lessons learnt
WTWA	Not upheld	25/09/18	No failings found	None
WTWA	Not upheld	20/08/18	No failings found	None
UDH	Partly upheld	02/10/18	Delay in treatment leading to loss of a tooth	Financial redress in the sum of £450

6.5 In February 2019, a joint publication by the PHSO and NHS Resolution for NHS Trusts in England[1] outlined guidance for the management of complaints and/or compensation claims raised against NHS Trusts. The guidance outlines the roles of the PHSO and NHS Resolution and how their services overlap and interact, as well as guidance to help staff decide when to involve us in complaints or compensation claims. The guidance supports the principle of financial remedy within the complaint handling process.

6.6 Following its earlier consultation in March 2019, the PHSO published its response to the review of the way it uses clinical advice in NHS-related casework. The review was led by Sir Alex Allan, a PHSO Non-Executive Director, with input from Sir Liam Donaldson, former Chief Medical Officer. Key changes in the way the PHSO will use clinical advice are:

- To ensure greater integration of clinical advisors into the casework process, with more interaction to ensure advice requests are framed correctly and that the advice obtained is used accurately in the final decision making process
- To increase transparency for complainants and the organisation being investigated, by providing clearer information about the use of clinical advice and the credentials of the clinical advisors.

[1] Available from: https://www.ombudsman.org.uk/publications/roles-parliamentary-and-health-service-ombudsman-and-nhs-resolution-information

The PHSO will be piloting the implementation of the recommendations during 2019/20 and 2020/21.

7. Learning from Feedback

Implementing Learning to Improve Services

7.1 All Hospital/ MCSs/MLCO regularly receive their complaint data and review the outcomes of complaint investigations at the Hospital/ MCS Meetings. **Table 8** demonstrates how learning from a selection of complaints has been applied in practice to contribute to continuous service improvement within the Hospitals/ MCSs.

Table 8: Examples of the application of learning from complaints to improve services, Quarter 4, 2018/19

Hospital/ MCS	Learning & Improvements
CSS	**Imaging Withington – Communication and Patient Experience (Trust Value: Dignity and Care)** A patient's son raised concerns regarding the care and treatment his mother received when she attended for an X-ray, where the member of staff did not offer any assistance and expected the son to help his mother prepare for her examination. The complaint referred to the behaviour of staff and the lack of compassion and not respecting the patient's privacy and dignity, which the son described as unprofessional. As a result of the complaint the line manager has reviewed the member of staff's development needs and is identifying training courses to improve the staff's communication skills and the care and treatment provided to patients especially regarding privacy and dignity. The member of staff has reflected on their current practice and will ensure that patients are offered appropriate assistance when they are preparing for an examination in future. **AHP Trafford – Poor Communication and Privacy and Dignity (Trust value: Working Together)** The son of an elderly patient complained that his father who had attended a Therapy teaching session was left alone waiting for his transport for three and a half hours. The patient was not given any update as to when his transport was expected. The investigation showed that there was a lack of communication between the AHP and the Manchester Orthopaedic Centre where the patient was located whilst awaiting transfer. As a result of the complaint, the Therapy Team will request that the Orthopaedic Waiting Lists Team book patients who require hospital transport and will inform the patient of the timeframe and ask the patient if they anticipate needing any support during their wait. Furthermore, a member of staff will be assigned to all patients who are awaiting transport home, and will offer refreshments and update patients as required. **The Bereavement Centre, Wythenshawe – Communication and Patient Experience (joint plan of action with Medicine) (Trust Value: Working Together)**

	The relative of a patient contacted a member of the Bereavement Team about acquiring a death certificate for their relative. The relative had been informed by the ward that the Bereavement Centre would be able to provide him with the actual death certificate. However, the Bereavement Team informed the relative that they did not provide a death certificate but a cause of death certificate which had not been prepared as the patient's death had been referred to the coroner. The relative became extremely upset that he had been given conflicting information. The member of staff spoke to him in a courteous and professional manner, but unfortunately, during this difficult time, communication broke down due to the added distress caused by the miscommunication of information. As a result of the complaint, the Bereavement Team will be providing training dates to the wards so that all ward nursing staff complete a Trust approved competency checklist regarding their responsibilities to patients and families after a death and the support that is available for relatives and carers.
UDHM	**Communication** The patient wrote to express his frustration and dissatisfaction regarding the administration services at the UDHM. Every time the patient telephoned to reschedule his appointment he stated he was put through to an answer machine in the wrong department, or the machine referred the patient back to the original telephone menu. The number and length of frustrating phone calls were such that in his view, he felt some patients would have given up and perhaps foregone treatment as a result of this type of experience. The patient also raised concerns around the generic email address patients can use to re-arrange their appointments at the hospital as he didn't received a response to the email he sent. **Findings** ▪ There are identified ongoing issues with the telephone system at UDHM. The UDHM team continue to review the service and monitor the number of faults reported to determine whether an upgrade to the system is required. Unfortunately, there is no answer machine facility and all unanswered calls should be re-directed to the main telephone menu. It appears that there was a fault within the system at the time the patient was experiencing problems. ▪ The emails patients send are managed and monitored regularly. The patient's email was received and forwarded to the relevant department; however, the email was not actioned. **Actions** ▪ The UDHM patient services team will continue to review the telephone service and monitor the number of faults that are reported in relation to the system. ▪ A Standard Operating Procedure will be implemented in the department for staff to adhere to when responding to patient emails. ▪ Any feedback received from patient complaints will be incorporated in training programmes for the team.
MREH	**Clinic Waiting Time** A patient, living with Dementia had a prolonged wait on the day of surgery, as their allocated theatre slot was towards the end of the theatre list. The theatre team were unaware the patient was living with dementia and were therefore not able to take this into consideration when prioritising the theatre list. Despite the patient being fasted for a long period prior to theatre, after theatre no appropriate refreshments were offered even though the patient was a diabetic and at risk of low blood sugar due to a prolonged period of time without food.

	Findings ▪ Ineffective communication was identified between the Day-case Unit and Theatre teams and the consultant carrying out the operation, regarding the patients dementia ▪ There was a lack of communication/documentation to identify whether the patient had been offered refreshments prior to going home **Actions** ▪ Develop a systematic process to ensure that patients living with Dementia and/or Diabetes are highlighted to the theatre staff to ensure patients are a priority on the theatre list ▪ A Matron Review procedure is currently in place to ensure that that all patients living with dementia being admitted to the Day-Case Unit or the Ophthalmology Ward will receive a review by a Matron to ensure the patient's care is planned and managed appropriately. ▪ A weekly nursing audit tool has been amended to ensure that the offer of refreshments post-surgery are recorded in the nursing care records and is included in the documentation audit. This will be monitored on a weekly basis to ensure patients are offered refreshments and this has been recorded in their notes.
WTWA (Heart and Lung)	**Cardiology** A Patient raised concerns regarding follow up care in the Cardiology Department. The Patient was transferred from Trafford General Hospital for an angiogram, following an 11 day admission for a Non ST segment elevation myocardial infarction (NSTEMI). The discharge letter stated the patient was for cardiac rehabilitation and follow up in the Cardiology Clinic which the patient was led to believe would be provided at Wythenshawe Hospital. The patient has previously undergone cardiac rehabilitation at their local hospital, Trafford General Hospital as arranged by the cardiac nurses. The patient had not received notification of a follow up appointment 6 weeks after surgery and contacted the Cardiology secretary to follow this up. The patient was informed a follow up appointment had not been arranged and the secretary agreed to discuss this with the consultant. The Patient did not receive any further communication from the hospital and made a number of telephone calls attempting to gain feedback. The patient eventually managed to speak to the secretary to be told that the Consultant had been undertaking procedures for 3 days, and that their case had unfortunately not been discussed. The patient received a call the same day to be told they did not require review at Wythenshawe Hospital and would be referred back to Trafford General Hospital for further follow up. **Findings** ▪ Ineffective communication between clinical teams and Hospital sites. ▪ Poor communication from secretarial staff to patient. ▪ Follow up care following discharge had not been adequately provided. ▪ Incorrect detail on patient discharge summary.

	Actions ▪ The complaint will be anonymised and the patient experience will be shared with the secretarial team with the aim of demonstrating the impact of poor communication and promote timely communication and feedback to patients. ▪ The lack of follow up arrangements for the patient post NSTEMI to be discussed at the Cardiology Directorate Governance Board in April 2019, which has clinical and management representation across all Cardiology teams. This will provide the opportunity to share learning on the appropriate follow up arrangements for patients following NSTEMI, including 'treat and return' patients. ▪ The Consultant Cardiologist and Trust Speciality Trainee Lead will review the case with all Cardiology junior doctors. Junior doctors are often responsible for completing the ward discharge summary, which includes reference to any follow up including the requirement for an outpatient appointment.
WTWA (Division of Medicine)	**Acute Medical Unit: End of Life Care** Family members raised formal concerns about the care provided to two patients approaching end of life on the Acute Medical Unit. Both patients sadly died very quickly following admission to the Acute Medical Unit which was very distressing for the families. **Findings:** It was established during the meetings held with family members that their concerns did not relate to the care or treatment provided to their loved one, but more specifically related to the difficulties experienced by family members when they tried to communicate with staff on the unit following the death of their loved one. The families felt they were not listened to in a timely manner to alleviate their distress and anxiety and were not consistently treated with dignity and respect. **Actions:** ▪ The Trust representatives who attended the family meetings sincerely apologised for the inadequate communication between clinical teams and family members following the death of their loved one, and offered their condolences. ▪ The anonymised complaint was shared at the ward meetings and staff safety huddles to discuss the concerns raised with the nursing teams and promote shared learning. ▪ The complaint was also shared at the Directorate meeting to brief the medical teams. ▪ A process has been established on the Acute Medical Unit where the Matron/Ward Manager and the Medical Registrar, who has a special interest in end of life care, contact the families/loved ones the next day or as soon as possible following a patient's death. This provides families with an opportunity to discuss concerns or raise any questions they have with the clinical team about the care provided to their loved one. It also provides families with a point of contact for any further communication with the unit in the future.
WTWA (Division of Surgery)	**Poor Experience – on the day cancellation of surgery** A complaint was received from a patient raising concerns that he did not receive adequate after care following the cancellation of his day surgery. The patient had been cancelled by the surgical team following discussion with the anaesthetist and cardiologists.

	There were concerns that the patient had an irregular heart beat which needed further investigation, therefore based upon the clinical findings it was established that it was not appropriate for him to have surgery on that day. The irregular heart beat had not been identified during pre-operative assessments. The referral for a cardiology review/ opinion was not made by the orthopaedic team for 14 weeks, causing the patient unnecessary anxiety and his surgery to be unduly delayed. **Actions:** As a direct result of the complaint the following actions have been identified: ▪ A clinician to complete a discharge summary for any patient who has had an 'on the day' surgery cancellation, clearly stating what the plan is/offering a rescheduled date, with the aim of ensuring that any follow up care requirements are noted and actioned. ▪ A copy of the discharge summary to be given to the patient and a copy sent to the patients GP.
MRI – Medicine	**Pain Management** Failure to assess and manage pain is one of the most frequent causes of complaints from patients attending the MRI Emergency Department, highlighting that failure to provide adequate analgesia is a significant cause of poor patient experience. Whilst this has always been a common theme within the complaints received for the ED, a recent spike in complaint numbers led to a review and implementation of a targeted work programme. The complaints ranged from pain relief not being provided at triage, to pain relief provided at triage not providing adequate respite and not being followed up in a timely manner. The ED is the first point of contact for patients who have injured themselves and therefore it is expected that a significant proportion of these patients will be in pain. Pain assessments and the management of pain are key steps in the patient journey and the first opportunity to intervene is at triage with pain assessments being included within the Manchester Triage system. The Improvement project, led by a Senior Sister in ED commenced with a 4 day internal audit where pain management at triage for patients streaming into the Minor Injuries Department were reviewed. A total of 173 patient care episodes were reviewed. Following the audit, the ED team have introduced a process whereby at triage, and having received pain relief, patients are provided with a postcard to advise them about what steps to take if the pain relief has not been sufficient whilst the wait to be seen by the relevant healthcare practitioner. This includes directions on how to alert the ED team so that the relevant steps can then be taken if they continue to experience pain whilst they are waiting. To date the initial patient feedback on this process has been positive and the team plan to work with the Patient Experience Team to undertake a formal evaluation of this change with patients attending ED

MRI – SMS	**Dignity of Care** A female patient reported they were not given the option to have a female sonographer or chaperone when they attended the hospital for a scan and this made them feel uncomfortable. The investigation into the concerns raised by the patient identified that there was no information or posters displayed within the Heart Centre to inform patients that a chaperone could be made available. On this occasion a chaperone was also not offered to the patient and instead the patient was offered two options, to wait for a female sonographer or return the following day if the patient was unable to wait. This resulted in a poor experience for the patient and her having an extended wait for her scan. As a result of this incident, and a lack of communication with patients, the Manchester Heart Centre have ensured that posters are displayed around the department to inform patients that they can request a chaperone during a procedure if they feel that they would like to have a chaperone present. Nursing staff also reconfirm the patient's wishes as they are called to their appointment in order that they can ensure a chaperone is arranged if this is required by the patient. This complaint has been shared with the MDT team to highlight the need for all members of the team to check with patients when examinations or scans are being undertaken whether they would like a chaperone. The clinic letters are also being updated to advise patients that if they would specifically prefer to be seen by a male of female member of staff that they can let the clinic team know in advance of their appointment in order for every effort to be made to arrange this for their appointment. This will help to clarify patient expectation and also provide their preferred care option when they arrive to clinic for their appointment. The Heart Centre Outpatients team plan to undertake a patient survey with the support of the Patient Experience Team to gain patient feedback in this area to ensure that the actions put in place have resulted in an improved service for the patients.
MRI Surgery	**Complex Care Needs and Lack of Communication** A patient's mother felt that after a number of years and admissions to various hospitals including the MRI a formal diagnosis had not been made for her daughter and her health was deteriorating. The patient's mother felt that there had been a lack of communication between departments and Hospitals over the years and as her daughter's medical notes were therefore so extensive, nobody had the time to identify new lines of investigation. As a result of her condition the patient attends the Emergency Department (ED) very frequently and she was concerned that each time her daughter attended the MRI ED they felt that they had to explain her care needs, and there was a delay in her daughter obtaining appropriate analgesia and care to meet her complex needs. On reviewing the care provided to the patient it was found that the teams managing the patient's care had not communicated with each other to reach a diagnosis and an MDT had not been arranged. The team at the MRI had not considered whether a specialist external to the hospital could investigate the patient's symptoms further until very recently.

	An MDT has been arranged which has resulted in a referral to an external specialist for review and advice about the patient's condition and possible care need. A note has been placed on the Trust electronic systems, specifically the ED Symphony system, advising that the patient has continuous pain due to her symptoms, and is still undergoing active investigations, therefore if it is clinically appropriate for her to receive a PCA at the doctors discretion should she attend the hospital as an emergency. The team will undertake a review of each attendance to ED in the future to ensure that the actions put in place have supported better communication in relation to this patients care needs.
St Mary's Hospital	**Communication and Patient Experience.** A lady attended the Emergency Gynaecology Unit (EGU) and had to wait 5 hours to be seen, and then had to wait 48 hours for an urgent scan. In recent months the activity seen by the EGU has escalated significantly and similar complaints / concerns have been raised as formal complaints, PALS concerns and Care Opinion postings. **Findings:** The lady was triaged correctly and in a timely manner, however the Unit was very busy that evening and there were patients who required more urgent care who were prioritised before her. The staff should have kept the lady and her partner informed of the waiting times and the reasons for the delay and kept them updated on any changes to these timescales. Scan appointments are usually provided within 24 hours, however again due to the business of the Unit, the earliest scan appointment available was 48 hours later. **Actions:** The pressures on the service have resulted in a number of similar complaints and the Division is currently undertaking a transformational work programme with the aim of reducing waiting times and improving the patient experience and includes the Radiology Department within Saint Mary's Hospital. The Ward Manager has shared this complaint letter with the EGU team during her communication sessions to ensure staff are fully aware and sensitive to the impact that extended waiting times have on the patients' experience. The need to inform patients and carers who are waiting about how long the waiting period realistically is and offering reassurance and practical comfort is very important. The Divisional Matron has met with the Radiology Manager, to highlight the need for more scan availability which has been escalated to the SMH Senior Leadership Team and is part of the EGU service review.

RMCH	**Blood test request not requested correctly** A complaint was received from a patient's mother raising concerns that she was still awaiting the results from her son's blood tests carried out in December 2018 (three months previously). The patient's mother had contacted various members of the Consultant's secretarial team who advised that the matter would be investigated and that a member of staff would call her back. Unfortunately, no contact was made; therefore the complainant felt that the only way to achieve some progress was to lodge a formal complaint. On investigating the matter with North West Regional Laboratory Operations, no record of a request/sample for testing could be found for the patient in December 2018. Further investigation concluded that although the patient's consultant had taken the blood test and documented on a paper record the required electronic request was not completed on the patient information system and therefore the laboratory team would not have been notified. On this occasion, the reason the patient's blood results were not available was due to human error, as they had not been requested correctly. As a result of the complaint and to avoid a similar incident happening in the future the following actions have been agreed: ▪ An investigation to be undertaken to determine why the blood request was not made on the electronic system and review the process to reduce future risk. ▪ Ensure robust cover is in place when secretaries are absent and an improved method of recording and relaying messages on their return. ▪ Arrangements made for the patient to return for a repeat blood test at the family's convenience.

8. Equality and Diversity Monitoring Information

8.1 **Table 9** provides Equality and Diversity information gathered from complainants for Quarter 4, 2018/19. As in Quarter 3, 2018/19 it is evident that the collection of this information is not consistent. The Corporate PALS team will continue to explore opportunities to improve the quantity and subsequently quality of this data.

Table 9: Quarter 4, 2018/19 Equality and Diversity monitoring information

Disability	**No.**
Yes	29
No	59
Not Disclosed	321
Total	**409**
Disability Type	
Learning Difficulty/Disability	0
Long-Standing Illness Or Health Condition	16
Mental Health Condition	3
No Disability	0
Other Disability	1
Physical Impairment	6
Sensory Impairment	1
Not Disclosed	382
Total	**409**
Gender	
Male	156

Female	243
Transgender	0
Not disclosed	10
Total	**409**
Sexual Orientation	
Heterosexual	80
Lesbian / Gay/Bi-sexual	1
Do not wish to answer	2
Not disclosed	326
Total	**409**
Religion/Belief	
Buddhist	2
Christianity (All Denominations)	50
Do Not Wish To Answer	0
Muslim	0
No Religion	28
Other	0
Sikh	0
Jewish	1
Hindu	1
Islam	7
Not disclosed	320
Total	**409**
Ethnic Group	
White – British	105
White – Irish	2
White – Other	1
Asian or Asian British – Bangladeshi	0
Asian or Asian British – Indian	1
Asian or Asian British – Pakistani	11
Asian or Asian British – Other Asian	1
Black or Black British – Caribbean	1
Black or Black British – African	1
Black or Black British – other Black	1
Mixed – White and Asian	2
Mixed - White and Black Caribbean	1
Mixed – Other Mixed	1
Any other ethnic group	2
Do not wish to answer	160
Not stated	119
Total	**409**

8.2 In Quarter 4, 2018/19 the number of complaints received from patients who report they have a learning difficulty/disability was equal with Quarter 3, 2018/19, highlighting complainants that identify having a disability are low in number and not representative of the overall patient population.

8.3 During Quarter 4, 2018/19 a meeting to discuss the Trust's Equality, Diversity and Inclusion Strategy was held with the Trust's Equality, Diversity and Inclusion Lead and Head of Customer Services.

8.4 Work commenced in Quarter 4, 2018/19 and will continue in Quarter 1, 2019/20 in exploring the alternative methods of improving the capture of equality and diversity data from complainants.

9. Quality Improvements

9.1 Improvements Quarter 4, 2018/19

9.1.1 New MFT Ulysses Complaint Module

Following the introduction of the new single Ulysses Complaint Module in Quarter 1 2018/19 and the work undertaken to tailor and configure the Module to meet the specific needs of the Hospitals/MCSs and MLCO full alignment of the Module was completed in Quarter 4, 2018/19.

9.2 Improvements, Quarter 4, 2018/19

9.2.1 'Tell us Today'

Whilst there has been no recorded activity during Quarter 4, 2018/19 the utilisation of the 'Tell us Today' process will continued to monitored. During Quarter 1, 2019/20 the PALS Manager will continue to explore opportunities to improve the quantity and subsequently quality of this data and engage with Hospital/ MCS team to understand how this process can be promoted.

9.2.2 Educational Sessions

Following the previous successful educational sessions for staff involved in responding to complaints, the Corporate PALS team facilitated four further educational sessions in Quarter 4, 2018/19 at Wythenshawe Hospital and the MLCO.

9.2.3 Complainant's Satisfaction Survey

The Complaints Satisfaction Survey is based upon ***'My Expectations'***[2] paper and has been developed by the Picker Institute. It is sent to complainants covering all MFT Hospitals/MCS/MLCO and during Quarter 4, 2018/19 18 responses to the survey were received, compared to 67 responses in Quarter 3, 2018/19.

Survey results for Quarter 4, 2018/19 indicate:

- 77.78% of complainants felt that they received acknowledgement of their complaint within an acceptable timeframe.
- 72.22% of complainants felt that they were taken seriously when they first raised a complaint.
- 66.67% of complainants felt that the Trust summarised the main points of their complaint correctly.
- 61.11% of complainants found it easy to make their complaint.
- 58.82% of complainants received the outcome of their complaint within the given timescale.
- 50% of complainants felt confident that future care would not be negatively affected by making a complaint.
- 41.18% of complainants felt that their complaint was handled professionally by the Trust.
- 37.50% of complainants were satisfied with the recommendations in response to their complaint.

Comments received during Quarter 4, 2018/19 include the following:

- I tried to make a complaint via the junior doctor and was dismissed. I really didn't want to complain but because she was so rude and dismissive I felt I had no choice to make things formal.

[2] Available from:
https://www.ombudsman.org.uk/sites/default/files/Report_My_expectations_for_raising_concerns_and_complaints.pdf

- We were advised that reply/summary would be early July. We received it 1 October. 8 points were raised - 1 recommendation made. Lack of holistic approach - not addressed.
- I am receiving better care from my treatment unit now.
- Summarising the main points in my letter helped. The recommendations made by the department were clear and this was the aim of my complaint - to improve future care and patient's experience.
- The correct procedures should have been followed. Felt the organisation tried to cover up what had happened rather than investigate properly.
- Things were dealt with easily and informative all questions answered in a timely manner.
- Very disappointed and still feel dissatisfied daughter not been helped in anyway by complaining just traumatised further.
- Excellent communication from the outset with process explained very clearly. I cannot fault the way in this was handled.

9.2.4 **Complaint Response Audit**

Following the development and piloting of the Complaint Quality Audit and Analysis Tool during Quarter 3, 2018/19 at WTWA, a detailed analysis of the findings was undertaken in Quarter 4, 2018/19.

The audit tool utilised focuses on the following aspects of the written response:

- **Plain English:** This section focuses on the use of appropriate grammar, punctuation, spelling, and sentence structure with the inclusion of explanations of medical terminology when required.
- **Tone:** This section focuses on the application of the Trust values, demonstrating care and compassion, transparency, understanding of the complainants concerns and appropriate personalisation.
- **Formatting:** This section focuses on professionalism, consistency, accuracy and absence of errors as well as inclusion of contact details for any further interaction
- **Content:** This section focuses on ensuring the response to the complaint is fulsome, with appropriate explanations, apologies (and or condolences) and details of improvements as a result of the feedback received.

A total of 23 WTWA complaint responses were audited relating to the period Quarter 2, 2018/19.

Table 10 demonstrates that by amalgamating the results of the four aspects of the tool (plain English, tone, formatting and content) the overall score of each complaint response shows that 43% of responses scored over 80%, 48% scored between 50-79%, whilst 4% scored under 50%.

WTWA Surgical Division demonstrated the best performance with 75% of their responses scoring over 80%.

Table 10: Percentage of audited complaint responses (Quarter 2, 2018/19)

Area	Over 80%	50-79%	Under 50%	Total
Surgery	6	2	0	8
Medicine	2	6	1	9
TWA	2	3	1	6
Total	10 (43%)	11 (48%)	2 (4%)	23

Results showed that the content of the response was the highest performing area, whilst the tone of response was identified as offering the greatest opportunity for improvement.

The analysis has been shared with the senior team at WTWA to inform ongoing improvements in the quality of responses.

Following the pilot of the audit tool, minor amendments to the audit tool have been made and both the audit and analysis tools are now available for use for all Hospital/ MCS and MLCO teams.

9.2.5 **Standard Operation Procedures**

Work continued during Quarter 4, 2018/19 and will continue throughout Quarter 1, 2019/20, reviewing the Formal Complaints and PALS Standard Operating Procedures (SOPs) to ensure Manchester University NHS Foundation Trust maintains compliance with the NHS Complaints Regulations (2009).

9.2.6 **Relocation of PALS office at Wythenshawe Hospital**

Work commenced on the new PALS office in March 2019 and completion of the new office is scheduled for June 2019.

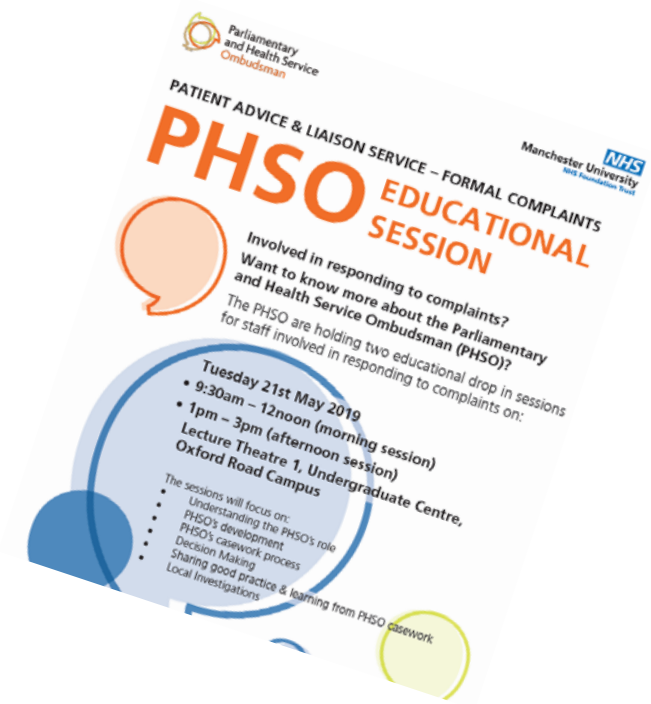
The new facility will provide a larger footprint for the service that is more accessible and includes a 4 person office, a welcoming reception for patients/ visitors and 2 interview/ quiet rooms.

An artist impression of the planed Reception area is provided below.

9.3 Future Planned Improvements 2019/20

9.3.1 Education and Training

Following the previous successful educational session facilitated by the Parliamentary and Health Service Ombudsman (PHSO) a further session has been arranged for Quarter 1, 2019/20 and a further PHSO session is currently being arranged for Quarter 2, 2019/20.



A number of bespoke training sessions have been facilitated based upon Hospital/ MCS and MLCO priorities and requests in Quarter 4 and as such the ***Safeguard Master Classes*** planned for Quarter 4 2018/19 have been postponed until Quarter 1 2019/20.

Work continued during Quarter 4, 2018/19 and will continue throughout Quarter 1, 2019/20 developing an in-house ***Complaints letter writing training course.*** The aim of the training course will be to provide delegates with the tools of how to improve content, structure and style of letters they produce by adopting best practice standards**.** Roll out of the training course is expected in Quarter 3, 2019/20.

9.3.2 Complaint Response Audit

The Complaint Quality Audit and Analysis Tools will be promoted to all Hospital/ MCS and the MCLO teams to enable them to review the quality of responses as during 2019/20.

9.3.3 Complaints Satisfaction Survey

In order to ensure the feedback is disseminated Trust wide and ensure continuous improvement during Quarter 4, 2018/19 the development of a Complaints Satisfaction Survey Dashboard is under development. The MFT Patient Experience Shared Learning Event on 24th April 2019 will be utilised as an opportunity to engage wit stakeholders to determine the content of the Dashboard.

10. Conclusion

The Group Board of Directors is asked to note the content of the Quarter 4, 2018/19 Complaints Report and the on-going work of the corporate teams and the Hospital/ MCS and 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. In conclusion, we will:

- Continue to monitor complaint response timescales against expected response timescales.
- Offer Corporate Nursing Support to Hospitals/ MCSs/ MLCO where performance is deteriorating.
- Continue to review and embed recommendations within MFT's policies from National Guidance, including the recently published ***'The roles of the Parliamentary and Health Service Ombudsman and NHS Resolution: Information for NHS trusts'***
- Continue to progress the improvements as outlined in this report.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Professor Cheryl Lenney, Group Chief Nurse and Director of Infection Prevention and Control (DIPC)
Paper prepared by:	Julie Cawthorne, Assistant Chief Nurse (ACN) and Clinical Director of Infection Prevention and Control (CDIPC)
Date of paper:	April 2019
Subject:	Annual Infection Prevention and Control Report 2018/19
Purpose of Report:	Indicate which by ✓ • Information to Note ✓ • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration of Risk against Key Priorities:	Patient Safety and Patient Experience
Recommendations:	The Board of Directors are asked to receive this report for April 2018 to March 2019 and approve for publication
Contact:	Name: Julie Cawthorne, CAN/CDIPC Tel: 0161 276 4042

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

Group Management Board – DATE

Infection Prevention and Control (IPC) Annual Report 2018/2019

1. Executive Summary

1.1 The Trust has a statutory responsibility to be compliant with the Health and Social Care Act 2008 (Department of Health, 2010). A requirement of this Act is for the Board of Directors to receive an annual report from the Director of Infection Prevention and Control. This report details Infection Prevention and Control activity from April 2018 to March 2019, outlining our key achievements and an assessment of performance against national targets for the year.

1.2 The prevention and control of infection is a high priority for the Trust. There is a strong commitment to preventing all Healthcare Acquired Infections (HCAI) and a zero tolerance to all avoidable infections. There has been an 80% reduction in the number of cases of *Clostridium difficile* infection (CDI) reported (from 540 Trust-attributable cases in 2007/2008, to 110 cases reported in 2018/2019). The Trust also observed a 67% reduction in the number of Trust attributable[1] Meticillin resistant *Staphylococcus aureus* (MRSA) blood cultures (from 33 to 11 cases during the same period).

1.3 There is a national ambition to reduce healthcare associated Gram-negative blood stream infections (GNBSIs) by 50% by March 2021 by providers and commissioners working together across the whole healthcare economy. Members of the Infection Prevention and control (IPC) team represented the Trust in a collaborative group including partners from across the whole healthcare economy to focus on reducing the incidence of Urinary Tract Infection (UTI), catheter associated UTI and appropriate antibiotic stewardship, which are the main risk factors for GNBSI, (Public Health England (PHE), 2018)

2. Key Achievements and Challenges

2.1 Professor Cheryl Lenney, Chief Nurse, was designated to the post of Director of Infection Prevention and Control (DIPC) for MFT and Chaired the Group Infection Control Committee (GICC). The Infection Prevention and Control/Tissue Viability (TV) Nursing Team became integrated as one team across all sites following the management of change process undertaken in accordance with the Trust policy. Microbiology Services will integrate in summer 2019.

2.2 Infection Control Committees were established within each Hospital/MCS. The portfolio for IPC was delegated to the Directors of Nursing by the Chief Nurse/DIPC. Each Hospital/MCS appointed a Clinical Lead to support IPC policy and practice across professional groups.

2.3 The MFT objective for the 2018/2019 reporting year was zero incidents of avoidable MRSA bacteraemia. There were 11 Trust-attributable MRSA bacteraemias, reported: six at Oxford Road Campus (ORC) three attributable to MRI and three attributable to Royal Manchester Children's Hospital, and five at Wythenshawe Hospital. All incidents of MRSA bacteraemia were investigated, reviewed locally and actioned as appropriate supported by the IPC Team.

[1] Following individual root cause analysis the bacteraemia is attributed to a Trust/service/CCG based on PHE guidance

2.4 Following four incidents of attributable MRSA bacteraemia at Wythenshawe in the first quarter of the year a meeting was held in June 2018 with Clinicians, Nurses and Pharmacists from the areas where the MRSA bacteraemias had occurred. The meeting was also attended by the Estates and Facilities Team. The meeting was led by the DIPC and was a 'call to action'. A local action plan was developed and implemented through the Heads of Nursing and Clinical Leads.

2.5 This year ORC/Trafford Hospital reported 69 attributable cases of CDI and Wythenshawe hospital reported a total of 41 attributable cases. Each case was investigated and reviewed locally supported by the IPC Team. Working closely with the Clinical Commissioning Group (CCG) and colleagues from local Trusts, all cases of CDI were presented at monthly peer-review meetings to determine whether they were associated with a lapse in care: 35 of the 110 Trust-attributable cases demonstrated a lapse in the care provided.

2.6 During Quarter 1 Wythenshawe Hospital reported a total of 19 attributable cases against a trajectory of 10 ORC/Trafford Hospital reported a total of 19 attributable cases against a trajectory of 13 (15 attributable to MRI and 4 to Trafford Hospital). This represented a 5.6% increase from last year's position for ORC/Trafford and a 46.2% increase for Wythenshawe Hospital for the same period.

2.7 A look back exercise was undertaken into each case of CDI by the Infection Prevention and Control (IPC) Team. The results indicated that the cases were spread across several wards, across three sites with no obvious connection. A report was prepared for the Quality and Performance Scrutiny Committee July 2018 to provide an overview of the investigation, findings and recommendations for action to all the senior management teams in each Hospital/MCS.

2.8 The Trust is required to submit a minimum of one quarter of data per year to comply with mandatory reporting for orthopaedic implant surgery. Hip and knee replacement data was submitted for each quarter of 2018 for ORC/Trafford Hospital. Data for hip replacements conducted at Wythenshawe Hospital was submitted for the first 3 quarters of 2018.

2.9 Of the 491 knee replacement procedures only one patient (0.2 %) developed a surgical site infection (SSI). The most recent national SSI rate for knee replacement surgery is 1.3 % (based on 350,026 national procedures over the previous 5 years). The most recent national SSI rate for hip replacement surgery is 0.9% (based on 322,160 national procedures over the previous five years). The last four periods for which data was submitted shows that across all sites, MFT reported an SSI rate of 0.0% for 494 hip replacement procedures performed.

2.10 In preparation for the 2018/2019 flu season the GICC approved a number of actions. These included widespread communication of updated guidance and a rapid testing service with extended laboratory hours/ additional support from the IPC Team during the weeks of peak activity. These were developed in response to lessons learned from the 2017/2018 flu season which demonstrated higher levels of activity than seen over the previous two seasons.

2.11 The Healthcare Workers Flu Vaccination Programme was launched on the 1st October 2018 and had Executive leadership provided by both the Group Chief Nurse/DIPC and Group Executive Director of Workforce. Across MFT a total of 13,890 staff (64.12%) received the vaccine, of which 11,339 staff (76%) were Frontline Healthcare Workers. This exceeded the Department of Health target of 75%. The success of this year's programme received National recognition as the Trust was shortlisted for the NHS Employers Flu Fighter Award in the 'Most Improved' Category

2.12 There was a 29% reduction in the number of new Carbapenemase producing enterobcteriaceae (CPE) acquisitions during 2018/2019 which decreased from 525 in 2017/2018, to 372. This reduction demonstrates the sustained Trust-wide efforts in tackling the spread of multidrug resistant organisms within MFT.

2.13 Currently there are two methods in use for CPE testing; a CE marked commercial Polymerase Chain Reaction test (PCR) test used at the Oxford Road Campus (ORC) microbiology laboratory and conventional bacterial culture at Wythenshawe microbiology laboratory. A business case to align both sites to PCR testing was supported by the GICC in November 2018. This is now being progressed with the expectation that funding will be made available when the PHE microbiology laboratory is moved to the ORC later this year.

2.14 The Trust is at the forefront of developing national as well as local policy for the management and control of patients with CPE and continued to work with PHE at a local and national level throughout the year to share the learning from local experience. Dr Andrew Dodgson, (Infection Control Doctor, ORC), Mrs Julie Cawthorne (Assistant Chief Nurse IPC/TV/Clinical DIPC) and Dr Ryan George (HCAI Surveillance Officer) were invited to speak on *Past and Present CPE Screening Strategies Employed in Central Manchester*' at the Clinical Services and Public Health Delivery Group Professional Meeting on Carbapenem resistant organisms in a healthcare setting (September, 2018).

2.15 As previously reported the TRACE (Transmission of Carbapenemase producing Enterobacteriaceae), study investigated the role of the environment in the transmission of CPE. The findings from the study were published in two separate publications in December 2018.

- 'A Large, Refractory Nosocomial Outbreak of Klebsiella pneumoniae Carbapenemase-Producing Escherichia coli Demonstrates Carbapenemase Gene Outbreaks Involving Sink Sites Require Novel Approaches to Infection Control'
  Antimicrobial Agents and Chemotherapy, December 2018 (TRACE Investigators Group)

- 'Carbapenem-resistant Enterobacteriaceae dispersal from sinks is linked to drain position and drainage rates in a laboratory model system'
  Journal of Hospital Infection, December 2018 (TRACE Investigators Group)

2.16 *Escherichia coli (E.coli)* is the main cause of GNBSI with increasing numbers observed internationally .There were 595 incidents of *E. coli* bacteraemia reported to PHE during the current reporting year for MFT. Of these, 152 (25.5%) cases were determined to be Trust-attributable and 364 were attributed to the community. Only 14% of Wythenshawe Hospital isolates were attributable (32 of 228 cases), compared to 32.7% of cases reported by Oxford Road/Trafford Campus (120 of 367 cases). This represents an increase in the total number of cases reported last year (119 attributable cases), which reflects the national profile.

2.17 A review of incidents of *E.coli* bacteraemia at Wythenshawe Hospital from January – October 2018 was presented to the Group Infection Control Committee (GICC) in January 2019. The primary cause of GNBSI was identified as urosepsis (61%) of which 24% were attributed to catheter associated urinary tract Infection (CAUTI). Many of the patients with urosepsis had a urine sample sent to the laboratory for culture and sensitivity testing from their GPs in the month prior to admission. The review identified that the sample sent from the GP grew the same bacteria as caused the subsequent bacteraemia.

2.18 All incidents of CAUTI that occurred in patients across MFT were monitored, investigated and reviewed at Hospital/MCS Harmfree care meetings. Lessons learned and actions were incorporated into local Infection Control work plans. In addition training and education regarding urinary catheterisation was delivered each month across all sites by the Urology specialist nurses at ORC and the practice educator at WTWA.

2.19 Highlights from the joint initiatives to reduce incidents of GNBSI included a Nutrition Hydration Week 11th – 17th March across MFT to raise awareness of the importance of hydration to prevent UTI. Within the wider Health Economy there are plans to engage with United Utilities to facilitate Hydration messages to the Public.

2.20 The Trust Antimicrobial Stewardship Committee included representatives from PHE, Clinical Commissioning Group (CCG) and Primary Care. This group liaised with Primary Care and the Community care teams to advise on the appropriate management of patients with recurrent UTI. The Trust Sepsis group also included representation from the CCG and a local General Practitioner. They are currently in the process of developing a diagnostic bundle that will facilitate early diagnosis and identification of microbial resistance in patients with sepsis, including GNBSI.

2.21 The Care Quality Commission (CQC) conducted a comprehensive inspection twelve months following the creation of MFT from the 2nd October to 8th November 2018. Following this inspection the trust received an overall rating of **'Good'**, with some areas of 'Outstanding' practice. The inspection identified many areas of good and outstanding practice with comments such as *"The service controlled infection well and there were low infection rates" (MREH)*. There were some areas that were identified as *requires improvement*; immediate action was taken following the inspection and actions are followed up through the Group and hospital/MCS ICC including action plans as part of the response to the CQC report (see section 11).

2.22 The IPC nursing Team delivered face-to-face training on the key principles of infection prevention and control to all new starters at corporate induction until September of 2018. From October 2018 and in line with other mandatory training fields, an 'e' learning package was introduced. The team also delivered training on the key principals of infection prevention and control to new Medical staff and Medical Students on placement in the Trust.

2.23 Over the last 12 months the IPC team supported the participation in a national initiative focusing on infection prevention and control including: the World Health Organisation (WHO) Save Lives: It's in your hands – prevent sepsis in healthcare where the emphasis was on using the WHO 5 moments to clean hands to avoid sepsis in healthcare and raising awareness in our patients to challenge staff regarding hand hygiene. The Campaign received positive feedback from both staff and members of the general public

2.24 The programme of works to upgrade the Trust's Endoscope Decontamination Suites continued; the Children's Hospital theatres, MRI Out Patients Department, Elective Treatment Centre and Main Endoscopy, and Withington Hospital Suites have all been completed. At the time of writing the Trafford Hospital Endoscope Decontamination Suite is being re-commissioned following an upgrade programme.

2.25 The Trafford Suite was commissioned with three endoscope re-processing machines. To achieve the recommended future capacity a fourth machine is required and waits funding. This leaves the Wythenshawe suite which is in urgent need of upgrade as it's equipment is now time served. The manufacturer of the equipment has advised that they can no longer supply electrical components for maintenance beyond the end of the next fiscal year. This matter was raised at the GICC in April and the level of risk reassigned on the Trust Risk register.

2.26 The annual Patient Led Assessments of the Care Environment (PLACE Assessments) were carried out across the MFT Sites during April and May 2018. The assessors visited wards, outpatient departments and emergency departments, carried out food assessments and undertook a review of the external and internal public areas on all sites. PLACE Assessment teams comprised Patient Assessors (who are required to make up 50% of each Assessment team), together with representatives from Nursing, IPC team and Estates and Facilities. The final scores were: Wythenshawe Hospital 87.18%; Trafford Hospital 90.54%; ORC 89.2%. These figures demonstrated an increase for both Trafford Hospital and ORC from the previous reporting year: Trafford Hospital 87.01%, ORC 87.65% and Wythenshawe 90.78%.

2.27 The Antimicrobial Stewardship Group was harmonised for the Group in the first quarter of 2018/19. The first priority was to synchronize antibiotic prescribing guidelines and stewardship activities. Best practice prescribing principles to promote antimicrobial stewardship are described in national guidance including PHE Start Smart then Focus (March 2015), the national CQUIN and the Trust Medicines policy. These include documenting the rationale for starting antimicrobial therapy and regular review. A monthly audit was undertaken to provide a regular snapshot of compliance with these standards with timely feedback to clinical areas so that actions could be rapidly implemented to achieve improvement if necessary.

2.28 In November 2018 The Antimicrobial Stewardship Group, supported by the IPC team and Microbiologists undertook a campaign to raise antibiotic prescribing awareness in line with World Antibiotic Awareness Week. A variety of promotional activities were implemented across both the ORC and Wythenshawe Hospital sites over a two week period. The events invited participation and were much appreciated.

2.29 The Director of Infection Prevention and Control acknowledges the breadth and depth of work undertaken by the wider IPC Team, members of the Infection Control Committees as well as the day to day contribution of all our staff and clinical leaders working together to reduce the incidence of HCAIs.

Recommendation

The Board of Directors are asked to receive the Infection Prevention and Control Annual Report for 2018/19 and approve for publication.

SECTION 3: INFECTION PREVENTION and CONTROL ARRANGEMENTS

3.1 The Director of Infection Prevention and Control (DIPC)

Professor Cheryl Lenney,
Chief Nurse, was designated as DIPC from September 2017.

3.2 Members of the IPC Team

The senior members of the IPC team can be found below:

***Dr Andrew Dodgson**,*
Infection Prevention & Control Doctor (IPCD), Oxford Road(ORC)/Trafford Campus

***Mrs Julie Cawthorne**,*
Assistant Chief Nurse/Clinical DIPC, MFT

***Dr Moira Taylor**,*
Infection Prevention & Control Doctor (IPCD) Wythenshawe and Withington Hospitals

3.3 The Infection Prevention and Control (IPC) Team

The Infection Prevention and Control/Tissue Viability (IPC/TV) Nursing Team became integrated as one team across two sites from April 2019 following the management of change process undertaken in accordance with the Trust policy. Microbiology Services will integrate in summer 2019.

A diagram demonstrating the updated structure of the combined IPC/TV Nursing Team can be found in Appendix 1.

3.4 Antibiotic Pharmacists

There were 1.6 Whole Time Equivalent (WTE) Antibiotic Pharmacists at the Oxford Road/Trafford Campus and one 0.4WTE Antibiotic Pharmacist at Wythenshawe Hospital.

3.5 Provision of IPC Team Services

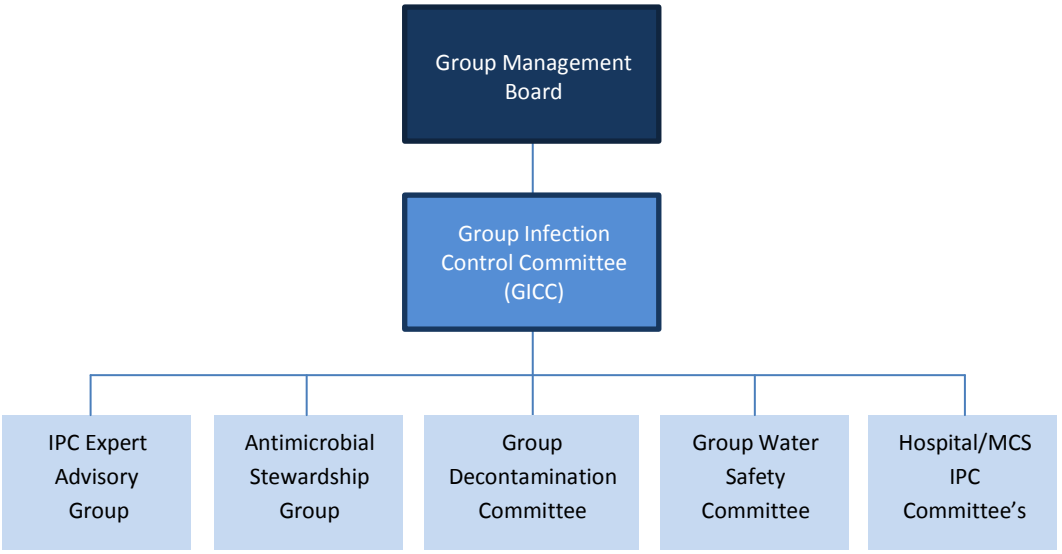
The IPC teams provided 24-hour advice and support on IPC issues to the staff and patients of the Trust across all sites. At the Oxford Road/Trafford Campus this included an out of hour's telephone on-call service by the IPC nursing team and microbiology. At Wythenshawe Hospital out of hours IPC advice was provided by the Microbiologist on call.

3.6 The Group Infection Control Committee (GICC)

The Group Infection Control Committee had corporate responsibility for overseeing the implementation of infection prevention and control activities. The GICC met six times during the year and was chaired by the DIPC. The Group Infection Control Committee reported to the Group Management Board. The GICC Terms of Reference can be found in Appendix 2.

3.7 Framework for IPC

The IPC governance framework can be seen below;



3.8 Infection Prevention and Control Structure within the Hospitals/Managed Clinical Services (MCS)

An Infection Control Committee was established within each Hospital/MCS. The portfolio for IPC was delegated to the Directors of Nursing by the Chief Nurse/DIPC. Each Hospital/MCS appointed a Clinical Lead to support IPC policy and practice across professional groups and represent their Hospitals/MCS at the GICC.

The minutes from the Hospital/MCS IPC Committees were presented at the GICC.

3.9 Framework for Infection Prevention and Control (IPC)

The new Trust Strategy/ Policy for Prevention and Control of Healthcare Associated Infections for Manchester University NHS Foundation Trust was ratified at the GICC in July 2018.

3.10 Funding for Infection Prevention and Control Services

The IPC/Tissue Viability nursing teams provided a service to the organisations. Funding for the IPC/TV nursing services was provided within the Clinical and Scientific Managed Clinical Services.

3.11 Microbiology Laboratory Services

Funding for Microbiology services was covered by the service level agreement between the Trust and Public Health England (PHE). Financial support for outbreaks of infection (excluding laboratory costs) were sourced locally by the Hospitals/MCS.

3.12 Electronic Surveillance System

Recurrent funding for ICNet (electronic Infection Prevention & Control surveillance database) was from the Clinical and Scientific Managed Clinical Services.

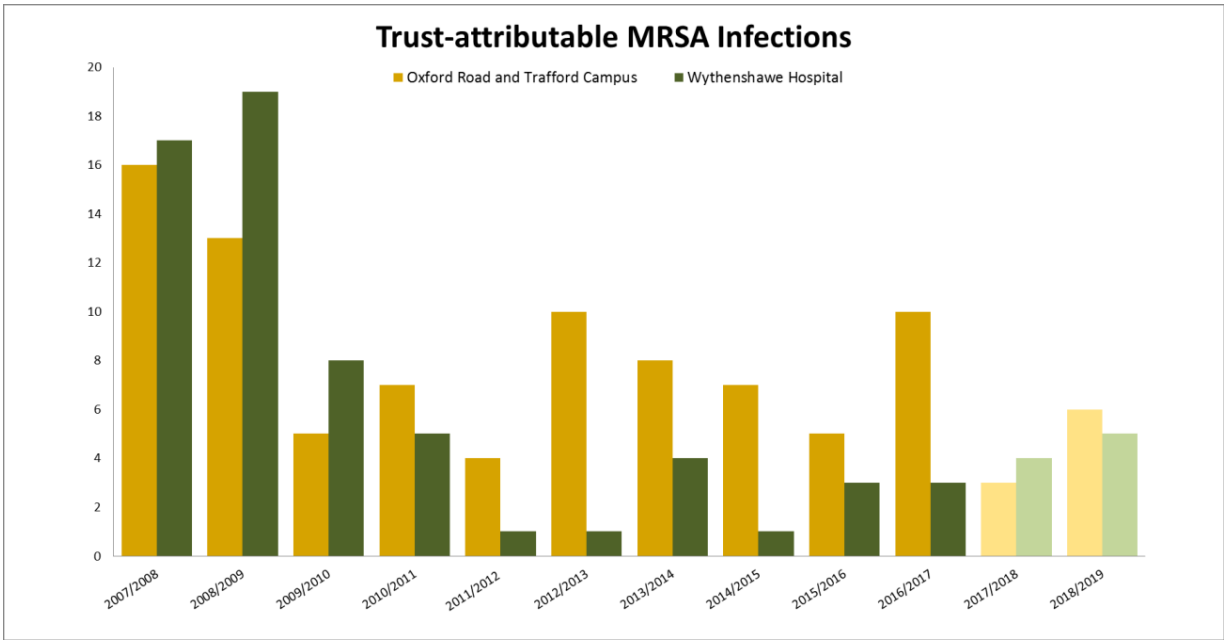
SECTION 4: HEALTHCARE ASSOCIATED INFECTION (HCAI)

4.1 HCAI Performance Targets

The prevention and control of infection remained a high priority for the Trust and there is a strong commitment to preventing all Healthcare Acquired Infections. There has been an 80% reduction in the number of cases of CDI reported (from 540 Trust-attributable cases in 2007/2008 to 110 cases reported in 2018/2019). The Trust also observed a 67% reduction in the number of Trust attributable-MRSA blood cultures reported (from 33 to 11 cases) between 2007/2008 and 2018/2019.

The significant reductions achieved since 2007 are clearly demonstrated below in Figures 1 and 2. Lighter shaded colours indicate years reporting as MFT. The reporting year 2018/2019 shows an increase in MRSA bacteraemia on the Wythenshawe Hospital site. These were addressed by developing an action plan in response. See section 4.3 below for full details.

Fig. 1 Trust-Attributable Meticillin resistant Staphylococcus aureus (MRSA) bacteraemia (2007/8 -2018/19)



4.2 Meticillin Resistant *Staphylococcus aureus* (MRSA) Bacteraemia

The MFT objective for the 2018/2019 reporting year was zero incidents of avoidable MRSA bacteraemia. There were 11 Trust-attributable MRSA bacteraemias, reported: six at ORC (three attributable to MRI and three attributable to Royal Manchester Children's Hospital), and five at Wythenshawe Hospital. All incidents of MRSA bacteraemia were investigated reviewed and actioned as appropriate with support from the IPC Team.

4.3 Increased incidents of MRSA bacteraemia at Wythenshawe Hospital Quarter 1 2018/19

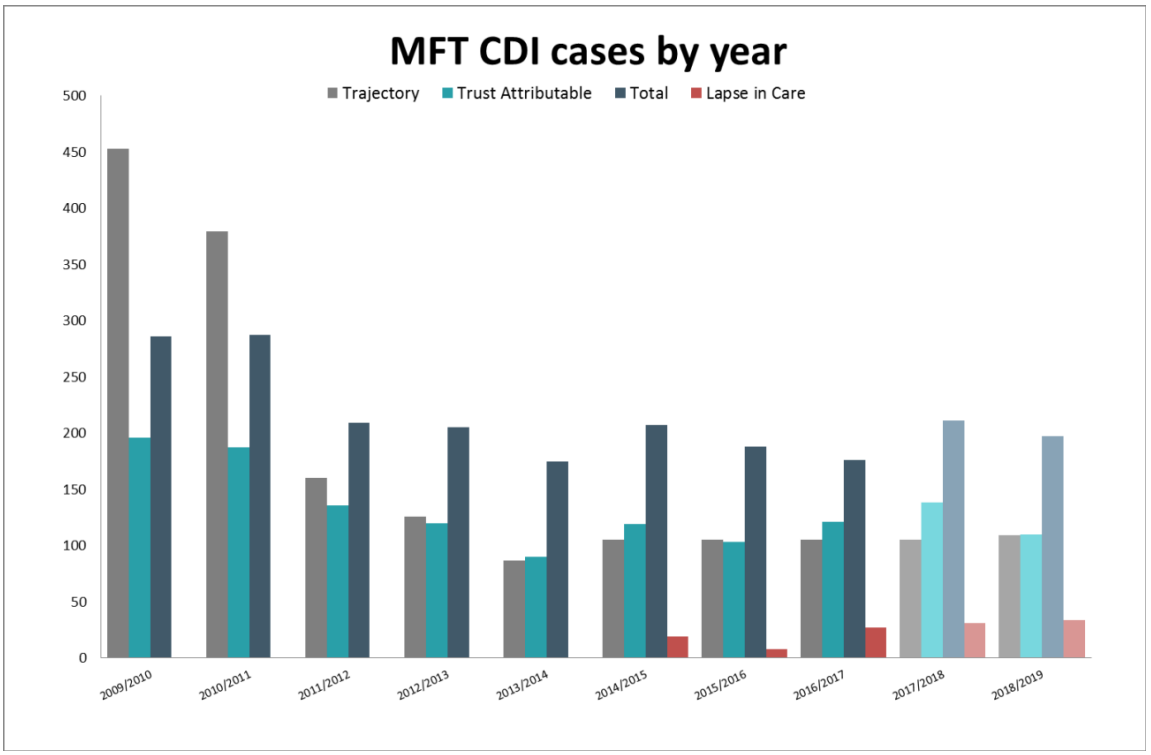
Following four incidents of attributable MRSA bacteraemia at Wythenshawe in the first quarter of the year a meeting was held in June 2018 with Clinicians, Nurses and Pharmacists from the areas where the MRSA bacteraemia had occurred also in attendance were the Estates and Facilities Team. The meeting was led by the DIPC and was a 'call to action'. A local action plan was developed and implemented through the Heads of Nursing and Clinicians.

4.4 Clostridium difficile Infection (CDI)

This year ORC/Trafford Hospital reported 69 attributable cases of CDI and Wythenshawe Hospital reported a total of 41 attributable cases. Each case was investigated and reviewed locally supported by the IPC Team. Working closely with the Clinical Commissioning Group and colleagues from local Trusts, all cases of CDI were presented at monthly peer-review meetings to determine whether they were associated with a lapse in care: 35 of the 110 Trust-attributable cases demonstrated a lapse in the care provided.

The total number of Trust-attributable CDI and lapse in care figures for previous reporting years can be found in Figure 2 below.

Fig. 2 Cumulative CDI cases (2009/10-2018/19)



4.5 Investigation into an increase in the incidents of CDI during Quarter 1 2018/19

During quarter 1 the Trust reported 38 attributable cases against a trajectory of 23. Wythenshawe Hospital reported a total of 19 attributable cases against a trajectory of 10, ORC/Trafford reported a total of 19 attributable cases against a trajectory of 13, (15 attributable to MRI and 4 to Trafford Hospital). This represented a 5.6% increase from last year's position for ORC/Trafford and a 46.2% increase for Wythenshawe Hospital for the same period.

A review of the investigation undertaken into each case of CDI was undertaken by the Infection Prevention and Control (IPC) Team. The results indicated that the cases were spread across several wards, across three sites with no obvious connection. Common themes identified included; failure to send specimens in a timely manner and inconsistencies in the recording indication and duration of antibiotic therapy (poor antimicrobial stewardship). All isolates of CDI were sent for typing, results indicated that there was no single focus of infection in one area.

A report was prepared for the Quality and Performance Scrutiny Committee July 2018 to provide an overview of the investigation, findings and recommendations for action to all the senior management teams in each Hospital/MCS.

4.6 Meticillin Sensitive *Staphylococcus aureus* (MSSA)

Mandatory reporting of all MSSA bacteraemia commenced in January 2011. A total of 243 MSSA bacteraemia cases were reported during 2018/2019 for MFT. Of these, 80 (32%) were-Trust apportioned (i.e. occurred 48 hours or more after admission): 35.8% of the cases reported by Wythenshawe Hospital were Trust-apportioned and 29.2% of cases reported by ORC/Trafford Hospital were Trust-apportioned. There is currently no target associated with MSSA bacteraemia incidence.

4.7 Vancomycin Resistant Enterococci (VRE)

The national VRE bacteraemia reporting cycle runs from 1st October to 30th September each year. To date, there have been a total of 10 VRE bacteraemias reported for the current reporting year (three cases at Wythenshawe Hospital and seven cases for ORC/Trafford Hospital).

4.8 Orthopaedic Surgical Site Infection (SSI) Rates

The Trust is required to submit a minimum of one quarter of data per year to comply with mandatory reporting for orthopaedic implant surgery. Hip and knee replacement data was submitted for each quarter of 2018 for ORC/Trafford Hospital. Data for hip replacements conducted at Wythenshawe Hospital was submitted for the first 3 quarters of 2018.

The results from knee replacement procedures can be found in Fig. 3 below. Of the 491 knee replacement procedures conducted during the previous four quarters only one patient (0.2 %) developed a SSI which is significantly below the national average. The most recent national SSI rate for knee replacement surgery is 1.3 % (based on 350,026 national procedures over the previous 5 years).

Fig. 3 ORC/Trafford Trends in SSI Rates for Knee Replacement Surgery for 2018

Year and Period	No. Operations	All SSI*
2018 Q1	136	0.0%
2018 Q3	120	0.8%
2018 Q3	112	0.0%
2018 Q1	123	0.0%

**All SSI = Inpatient & readmission, post-discharge confirmed and patient reported*

The results from hip replacement procedures performed can be found in Fig. 4A & B below. The previous periods for which data are available are included for comparison. The most recent national SSI rate for hip replacement surgery is 0.9% (based on 322,160 national procedures over the previous five years). The last four periods for which data was submitted

shows that across all sites, MFT reported an SSI rate of 0.0% for 494 hip replacement procedures.

Fig. 4A ORC/Trafford Hospital Trends in SSI Rates for Hip Replacement Surgery for 2018

Year and Period	No. Operations	All SSI*
2018 Q1	92	0%
2018 Q2	103	0%
2018 Q3	86	0%
2018 Q4	102	0%

** All SSI = Inpatient & readmission, post-discharge confirmed and patient reported*

Fig. 4B Wythenshawe Hospital Trends in SSI Rates for Hip Replacement Surgery 2017 – 2018

Year and Period	No. Operations	All SSI*
2017 Q4	40	0.0%
2018 Q1	43	0.0%
2018 Q2	23	0.0%
2018 Q3	52	0.0%

4.9 Coronary Artery Bypass Graft (CABG) SSI Rates – ORC/Trafford

The Trust has participated in voluntary CABG SSI in Manchester Heart Centre (MHC) since 2011. The last period reported was Q1 of 2018 (results published following last year's Annual Report). The results from the last four quarters reported can be found in Fig. 5. The latest report from PHE identifies a **national SSI rate of 6%** for CABG for the last 5 years, based on 31,171 procedures. The latest SSI rate for CABG conducted at ORC was 5.3%: which confirmed 5 SSI out of 95 procedures performed. Only 2 of these were inpatient/readmissions. All confirmed SSI were investigated locally.

Fig. 5 ORC/Trafford Hospital SSI Rates for CABG 2017-2018

Year and Period	No. Operations	All SSI*
2017 Q1	100	5.0%
2017 Q2	105	5.6%
2017 Q3	119	5.0%
2018 Q1	95	5.3%

** All SSI = Inpatient & readmission, post-discharge confirmed and patient reported*

4.10 Outbreaks of Diarrhoea and Vomiting

In total, there were 2379 lost bed days for 2018/2019.

A total of 15 wards were closed or partially closed over 19 occasions due to outbreaks of diarrhoea and vomiting during 2018/2019 across ORC/Trafford Hospital and Wythenshawe Hospital (Fig. 6 and 7).

Fig. 6 Ward Closures due to Diarrhoea and Vomiting ORC/Trafford Hospital (April 2018 - March 2019)

Area	Ward	Date of closure	No. of Days Closed	No. of Patients Affected	No. of Staff Affected	Bed Days Lost
RMCH	Ward 85	16/05/2018	6	14	6	168
Surgery	Manchester Vascular Centre	18/05/2018	5	7	0	42
Specialist Medicine	Ward 3	11/10/2018	2	7	0	14
RMCH	Ward 85	18/11/2018	8	19	5	224
Intermediate Care – Gorton Parks	Delemere Unit	08/03/2019	13	15	11	260

Fig. 7 Ward Closures due to Diarrhoea and Vomiting Wythenshawe (April 2018 - March 2019)

Area	Ward	Date of closure	No. of Days Closed	No. of Patients Affected	No. of Staff Affected	Bed days lost
Cardio thoracic	Ward F6	02/04/2018	2	8	0	8
Complex Health & Social care	Ward F4 North	09/04/2018	11	6	1	176
Complex Health & Social Care	Ward F4 South	23/04/2018	8	9	0	128
Complex Health	Opal house – Dunham /Lymm	18/05/2018	4	11	4	80
Complex care	Ward F4 South	24/05/2018	8	7	0	128
Respiratory	Wilson ward	18/06/2018	4	8	0	56
Complex Health	Ward F15	02/07/2018	4	7	0	16
Complex Health	Ward 14	18/12/2018	6	6	5	40
Complex Health	Ward 4 South	15/01/2019	13	8	1	208
Complex Health	Opal House	18/01/2019	20	29	16	401
Medical Specialities	Ward F12	21/01/2019	8	22	2	224
Urology	Ward F3	29/01/2019	2	2	1	8
Complex Health	Opal house – Dunham/Lymm	19/03/2019	9	9	1	180
Respiratory	Doyle	22/03/19	3	8	1	18

SECTION 5: MANAGING THE RISK of INFLUENZA

5.1 Management of Patients with Influenza 2018/2019

Activity at MFT in the 2017/18 flu season reflected the national picture with high levels of Influenza related admissions across all sites in comparison to the previous two seasons.

The increased activity provided challenges for service delivery with the implementation of additional actions from January 2018. This was directed by regular cross site meetings led by the DIPC, to facilitate safe and effective patient management. Lessons learned from last year were incorporated into the plan for the 2018/19 and approved by the Group Infection Control Committee. The actions include:

- A review and update of the patient clinical management and infection control pathways to reflect national guidance and reflect the availability of rapid testing.

- A rapid testing service for flu was put in place in November 2018. This was supported by a seven day laboratory service with extended laboratory working hours and a dedicated rapid testing phone line.

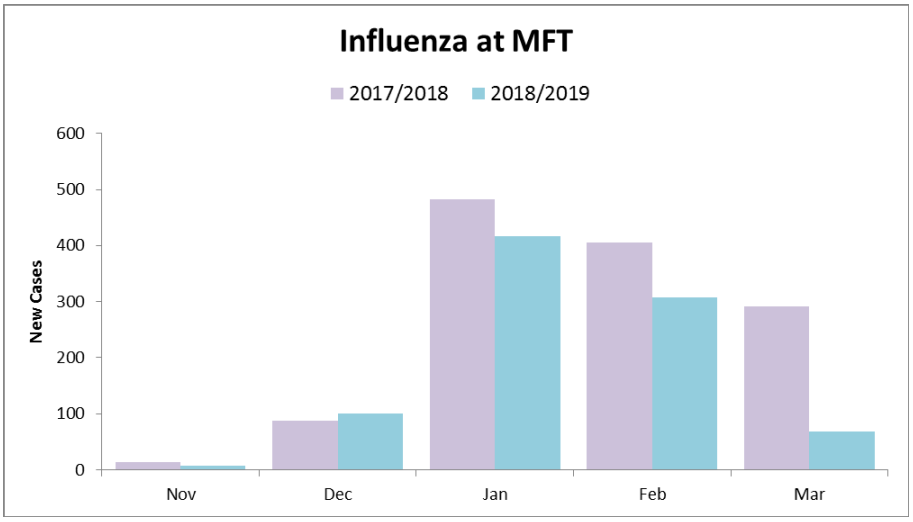
- Laboratory data and Trust inpatient data were used to provide real time updates on inpatient flu positive cases via the Trust Reporting and Information Service in order to assist the IPC team and bed management teams to facilitate patient flow.

- Flu guidance, including control measures, clinical management and testing pathways were available on the Trust intranet. Clinical teams were made aware of the guidance via email and the intranet homepage.

Plans to provide additional support to the Trust in the form of further extended laboratory testing times and provision of additional IPC team support were activated from 11th January 2019 in response to increased activity and a request from the Hospital/MCS Management Teams. This was stood down in March 2019.

The number of new cases of flu for the 2018/19 season to date can be seen in Figure 8 below. There were 915 new cases reported for the 2018/2019 flu season compared to 1281 cases reported for the same period last year. This year clinical staff were more aware of the need to test patients for flu earlier in the season, isolate patients promptly and provide treatment when appropriate.

Fig.8 New Flu Cases at MFT 2017/18 and 2018/19



5.2 Staff Flu Vaccination Campaign 2018/19

The Healthcare Workers Flu vaccination Programme was launched on the 1st October 2018. The programme plan was led and managed by the Group Employee Health and Wellbeing (EHW) Service working in partnership with Hospitals/Managed Clinical Services, Infection Control and Communication teams.

This year Trusts were asked to provide data relating to the reasons why staff declined to have the vaccine (to try and target messages and to aim development of future programmes). At MFT the flu enrolment form was adapted to capture the required data in readiness for submission and to provide further organisational insight re staff perceptions.

Considerable improvements were made to the data collection process to ensure accurate and timely weekly reporting. The reports supported Hospital/Managed Clinical services to target their flu champion programmes.

The programme included targeting messages to engage and encourage uptake of the vaccination in staff including weekly flu messages on iNews, social media campaigns, screen savers and bespoke hospital communication. Over 170 flu champions were recruited to vaccinate and ensure availability to all staff across MFT and this was supported by the EHW team. In addition clinics were used at key events for example the Nursing, Midwifery and Allied Health Professionals Conference and staff induction. The EHW Service also offered 'pop up clinics' across MFT and open access drop-in clinics in EHW (between 8am – 4pm) every weekday.

The vaccination campaign had Executive leadership provided by both the Group Chief Nurse/DIPC and Group Executive Director of Workforce. Across MFT a total of 13,890 staff (64.12%) received the vaccine, of which 11,339 staff (76%) were Frontline Healthcare Workers. This exceeded the Department of Health target of 75%. The success of this year's programme received National recognition as the Trust has been shortlisted for the NHS Employers Flu Fighter Award in the 'Most Improved' Category.

SECTION 6: CARBAPENEMASE PRODUCING ENTEROBACTERIAECEAE (CPE)

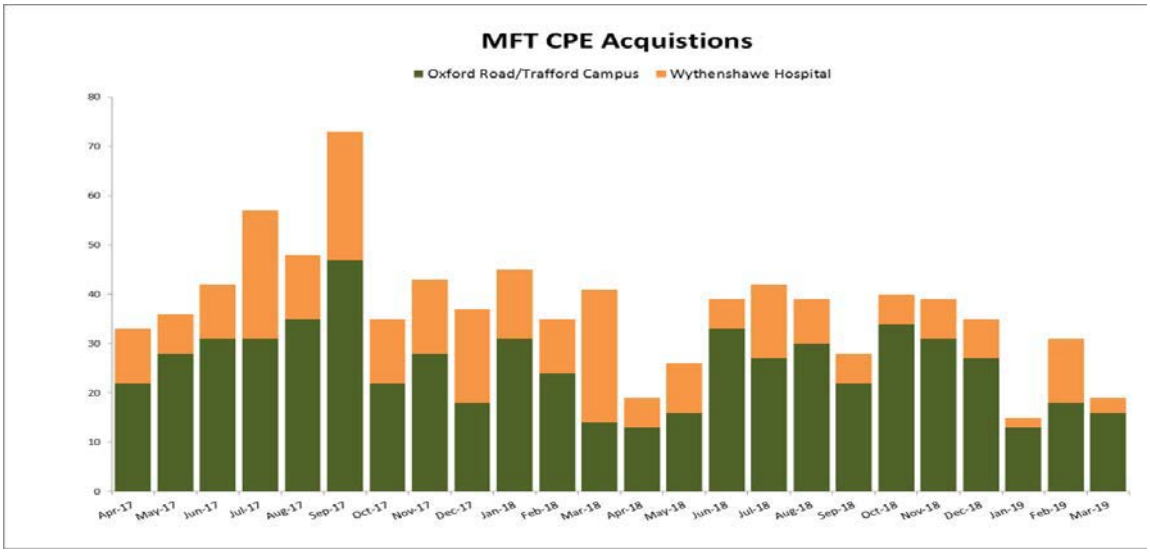
6.1 Incidents of CPE

The number of incidents of CPE acquisition across both sites for the past 12 months can be seen in Figure 9 below. There was a 29% reduction in the number of new CPE acquistions during 2018/2019 which decreased from 525 in 2017/2018, to 372. This reduction demonstrates the sustained Trust-wide efforts in tackling the spread of multidrug resistant organisms within MFT.

The main focus of activity this year has been to align the CPE screening policy across both sites (ORC and WTWA). Currently there are two methods in use for CPE testing; a CE marked commercial Polymerase Chain Reaction (PCR) test used at ORC and conventional bacterial culture at Wythenshawe microbiology laboratory. Bacterial culture takes up to three days to produce a positive result compared with PCR which can be used to give a 2-4 hour turnaround from receipt in the laboratory.

A business case to align both sites to PCR testing was supported by the GICC in November 2018. This is currently being progressed with the expectation that funding will be available when the PHE microbiology laboratory is moved to the ORC late this year.

FIG 9 incidents of CPE acquisition across MFT



The Trust is at the forefront of developing national as well as local policy for the management and control of patients with CPE and continued to liaise with PHE at a local and national level throughout the year to share the learning from local experience.

6.2 The TRACE project

The investigation was undertaken by the IPC Team in collaboration with PHE and the National Institute for Health Research (NIHR), Public Health Research Unit (PHRU) and the national Lead for Infection Control Professor Derrick Crook, based at the University of Oxford.

This study investigated the role of the environment in the transmission of CPE and involved taking patient screens and environmental samples for CPE across six wards in the Manchester Royal Infirmary. The field work was completed in January 2017. The results from this study were published in the following papers;

- *'A Large, Refractory Nosocomial Outbreak of Klebsiella pneumoniae Carbapenemase-Producing Escherichia coli Demonstrates Carbapenemase Gene Outbreaks Involving Sink Sites Require Novel Approaches to Infection Control'*

Antimicrobial Agents and Chemotherapy, December 2018 (TRACE Investigators Group)

- *'Carbapenem-resistant Enterobacteriaceae dispersal from sinks is linked to drain position and drainage rates in a laboratory model system'*

Journal of Hospital Infection, December 2018 (TRACE Investigators Group)

- In addition Dr Andrew Dodgson (infection control Doctor, ORC), Julie Cawthorne (Assistant Chief Nurse IPC/TV) and Dr Ryan George (HCAI Surveillance Officer) were invited to speak on '*Past and Present CPE Screening Strategies Employed in Central Manchester*' at the Clinical Services and Public Health Delivery Group Professional Meeting on Carbapenem resistant organisms in a healthcare setting (September, 2018).

SECTION 7: GRAM-NEGATIVE BLOODSTREAM INFECTIONS (GNBSI)

There is a national ambition to reduce healthcare associated Gram-negative blood stream infections by 50% by March 2021 by providers and commissioners working together across the whole healthcare economy. *E.coli* is the main cause with increasing numbers observed internationally. There is also a direct link to social deprivation with higher numbers in the North West and North East of England. Key risk factors include Urinary Tract Infection (UTI) catheter associated UTI and antibiotic therapy.

This section of the report provides an overview of the work undertaken locally and in partnership with other providers over the last 12 months towards achieving this ambition.

7.1 *Escherichia coli* (*E. coli*) Bacteraemias

There were 595 incidents of *E. coli* bacteraemia reported to PHE during the current reporting year for MFT. Of these, 152 (25.5%) cases were determined to be Trust-attributable and 443 were attributed to the community. Only 14% of Wythenshawe Hospital isolates were attributable (32 of 228 cases), compared to 32.7% of cases reported by ORC/Trafford Campus (120 of 367 cases). This represents an increase in the total number of cases reported last year (119 attributable cases), which was also observed nationally.

7.2 Review of incidents of *E.coli* Bacteraemia at Wythenshawe Hospital January – October 2018

A review of the above presented to the Group ICC in January 2019 indicated:

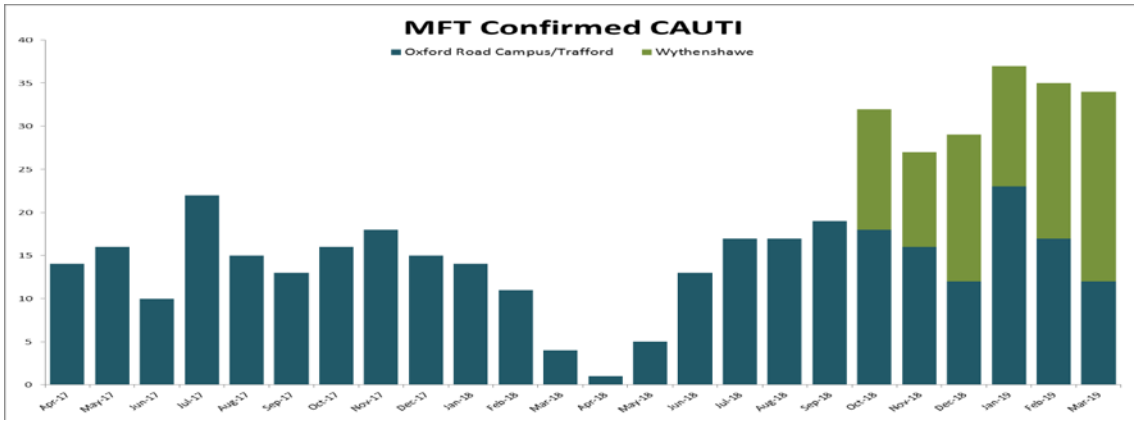
- There was an exponential rise in rate with increasing age
- 87% presented < 48hrs after admission but of these 24% were an inpatient in the previous 30 days
- 83% were admitted from their own home; 11% admitted from nursing or residential care home
- Source – 61% urosepsis (of these 24% Catheter associated urinary tract infection (CAUTI); 15% biliary; 9% intraabdominal sepsis
- Many of the patients had life threatening malignancy or frailty

The primary cause of GNBSI was identified as urosepsis (61%) of which 24% were attributed to CAUTI. Many of the patients with urosepsis had a urine sample sent to the laboratory for culture and sensitivity testing from their GPs in the month prior to admission. The review identified that the sample sent from the GP grew the same bacteria as caused the subsequent bacteraemia.

7.3 Surveillance of CAUTI across MFT

All positive catheter specimens of urine were investigated on a daily basis by the IPC/TV team and Continence Specialist Nurse. Fig. 10 details the number of confirmed CAUTI identified during 2017/2018. Surveillance of all incidents of CAUTI at the ORC/Trafford site commenced in 2014 and at Wythenshawe Hospital from October 2018.

Fig10 confirmed CAUTI Identified during 2017/18



7.4 Actions to reduce the incidence of CAUTI across MFT

- All incidents of CAUTI that occur in patients across MFT were monitored, investigated and reviewed at Hospital/MCS Harm Free Care meetings. Lessons learned and actions were incorporated into local Infection Control work plans.

- Training and education regarding urinary catheterisation was delivered each month across all sites by the Urology specialist nurses at ORC and the practice educator at WTWA.

- The Bladder and Bowel Service (formerly Continence Specialist Nurse Team) also provided support and advice to develop a Trust-wide action plan to manage patients with a urinary catheter.

7.5 Working in partnership across the whole healthcare economy

There is an established Group of healthcare providers from across the whole healthcare economy which includes representatives from the Trust IPC Team to oversee the joint approach to achieving the objective to reduce the number of incidents of Gram-negative bacteraemia (GNBSI) by 50% by 2020. The focus points for action over the last year can be found below.

- **Investigation of incidents of GNBSI -** at MFT we reviewed all incidents of GNBSI to inform local action plans within each hospital/MCS. At the wider group the Surveillance Team from MFT have helped to develop a pilot of surveillance data from a cohort of patients who have developed a GNBSI in Primary and Community care.

- **Focus on reducing Urinary Tract Infection (UTI) and Catheter Associated UTI (CAUTI) –** There was a focus on prevention by raising awareness about hydration in the form of a Nutrition Hydration Week 11th – 17th March across MFT. Within the wider Health Economy there are plans to engage with United Utilities to facilitate Hydration messages to the Public. There are also plans to develop patient/public awareness sessions in Spring/Summer.

- **Antimicrobial Resistance** -The Trust Antimicrobial Stewardship Committee included representatives from Public Health England, CCG and Primary Care. This group liaised with Primary Care and the Community care teams to advise on the appropriate management of patients with recurrent urinary tract infection (UTI). The Trust Sepsis group also included representation from the CCG and a local General Practitioner. They are currently in the process of developing a diagnostic bundle that will facilitate early diagnosis and identification of microbial resistance in patients with sepsis, including GNBSI.

SECTION 8: TRAINING and EDUCATION

The IPC nursing Team delivered face-to-face training on the key principles of infection prevention and control to all new starters at corporate induction until September of 2018. From October 2018 and in line with other mandatory training fields, an 'e' learning package was introduced.

8.1 Aseptic Non-Touch Technique (ANTT) theory sessions

The IPC Team supported the delivery of the ANTT theory component and key principals of infection prevention and control to a wide range of new starters to the Trust. Sessions were delivered to all Medical staff and delivered sessions for Medical Students on placement in the Trust on the key principles of infection prevention and control as well as ANTT theory.

Following the theoretical training session all members of staff whose practice included ANTT were competency assessed in the clinical environment. Thereafter staff must complete an annual re-assessment of competency to practice.

8.2 Bespoke learning activities

The IPC nursing teams maintained learning activities bespoke to the individual sites of WTWA and ORC.

At Wythenshawe Hospital quarterly study days were provided for the Infection Prevention Link Workers, who acted as Champions in their wards and departments raising awareness on current infection prevention and control practices and supporting the implementation of policies, guidelines and best practice. The study days included practical sessions and lectures delivered by microbiologists, guest speakers and members of the IPC Team.

During the last year the IPC Team at Oxford Road/Trafford Campus welcomed nursing students on spoke placements to spend dedicated time with the IPC Team. The IPC Team at Wythenshawe Hospital provided 8-12 week placements for 1st and 2nd year nursing students. The feedback was positive and enabled the students to gain a valuable insight into the principles of infection prevention and control nursing.

The IPC Team at Oxford Road/ Trafford Campus continued to support the Universities of Bolton and Salford delivering the ANTT theory component to both Nursing students and the Trainee Nurse Associates. In addition, the IPC Team delivered a range of training /education sessions to the following staff groups:

- International Nurses recruited to Oxford Road/Trafford campus
- Hospital Volunteers
- Work experience Students
- Toolbox training for the Supervisors of the Sodexo Contractors working in the Trust
- Annual Young Peoples Open Day

- Staff working in areas when there was an increase/outbreak of infection
- Bespoke training on Ward/Departments

8.3 Hand Hygiene – Focus on practice

It is universally agreed that performing hand hygiene correctly and at the right time is the most effective measure in reducing Healthcare Associated Infections (HCAI). The Trust expects all staff to comply with good hand hygiene practice at all times.

Over the last 12 months the Infection Prevention and Control team supported the participation in two national initiatives focusing on infection prevention and control. These included the World Health Organisation (WHO) Save Lives: It's in your hands – prevent sepsis in healthcare where the emphasis was on using the WHO 5 moments to clean hands to avoid sepsis in healthcare and raising awareness in our patients to challenge staff regarding hand hygiene.

The second initiative was International Infection Control week in October 2018. During this week the Infection Prevention and Control/Tissue Viability team used a timeline developed by the team to highlight the changes in infection prevention and control over the last 100 years. The timeline was used in travelling roadshows across the Trust.

Both campaigns received positive feedback from both staff and members of the general public who participated.

The IPC Team also supported the hospitals/MCS across the Trust to refresh their local hand hygiene initiatives providing advice, training and a range of resources that involved staff in fun, interactive hand hygiene training sessions.

Section 9: MAINTANING a CLEAN ENVIRONMENT

9.1 Governance Arrangements

Decontamination, Ventilation and Water services were governed by policies along with local operational plans. Each topic had group level committees and local safety groups that met quarterly and reported into the Group Infection Control Committee. All appropriate professional appointments, including Authorising Engineers, were in place and monitored through the Estates and Facilities Group Management Board. The services were assured by a programme of independent annual audits.

9.2 Decontamination Services

Sterilisation of re-useable surgical devices were undertaken centrally on site at the Oxford Road Campus in the Decontamination Services Department. The Department was accredited to ISO 13485:2016 and was also assessed and certified as meeting the requirements of Directive 93/42/EEC on medical devices, Annex V.

Wythenshawe, Trafford and Withington Hospitals continued in partnership with Christies and North Cheshire to receive sterile services from Steris. This was monitored by the WTWA Estates & Facilities Decontamination Group through Positional Reports provided by the Contract Manager.

Decontamination of flexible endoscopes was undertaken on the Oxford Road Campus in satellite units within associated clinical areas and at Trafford, Wythenshawe and Withington in centralised units. The Endoscopy Departments at Trafford and Wythenshawe Hospitals were accredited by the Joint Advisory Group (JAG). The Manchester Royal Infirmary (MRI) Endoscopy Unit had its JAG Accreditation confirmed in year after the complete refurbishment and upgrade of this unit.

Achievements:

- The programme of works to upgrade the Trust's Endoscope Decontamination Suites continued; the Children's Hospital theatres, MRI Out Patients Department, Elective Treatment Centre and Main Endoscopy, and Withington Hospital Suites have all been completed. At the time of writing the Trafford Hospital Endoscope Decontamination Suite was being recommissioned after an upgrade programme.

Risks Identified:

- The Trafford Suite was commissioned with three machines. To achieve the recommended future capacity a fourth machine is required and awaits funding. This leaves the Wythenshawe suite which is in urgent need of upgrade as it's equipment is now time served. The manufacturer of the equipment has advised that they can no longer supply electrical components for maintenance beyond the end of the next fiscal year this is now on the Trust risk register awaiting funding.

- Nasendoscopes used in the Ear Nose and Throat (ENT) Department at Trafford and Altrincham are currently decontaminated by a manual wash followed by use of the Tristel Wipe System (this meets the Essential Quality Requirements (EQR) in HTM01-06). Spot audits were carried out on the process to maintain a minimum standard. Now the Trafford Decontamination Suite has been upgraded it is intended to move the Trafford ENT scopes into the upgraded unit but the lack of a fourth automated endoscope reprocessor has generated concerns for capacity and throughput.

- There is an ongoing work relating to Scopes, Blades and Probes which require either Decontamination or Sterilisation but cannot be reprocessed through the equipment the Trust currently has available. This is being reviewed with Procurement and the IPC & TV team for a resolution and will be added to the trust risk register.

9.3 Water Safety: Management of Risk for *Legionella*

Water sampling for *Legionella* was undertaken in accordance with L8 and Health Technical Memoranda (HTM-04). Remedial action was successfully undertaken on outlets that did not meet the required standard. All building and engineering projects were required to provide additional testing if they included modification or connection to the existing water system including the need to undertake Water Risk Assessments in line with the HTM.

9.4 Management of *Pseudomonas aeruginosa* from Water Outlets in High Risk Clinical Areas

Pseudomonas risk assessments for all augmented care areas were in place. Sampling for *Pseudomonas* continued in accordance with the addendum to HTM 04 with appropriate follow up on positive results.

Achievements:

- Comprehensive maintenance programme and water testing regime for WTWA which now includes an in-house pseudomonas water testing facility (IDEXX Pseudalert) which identifies positive results within 24 hours rather than 3 days.
- A Healthy Water Project that monitored water temperature and flow was undertaken at ORC. This identified areas of concern and timely resolution for low or no use outlets utilising new technology.

9.5 Ventilation

The management of Ventilation Systems was based upon monitoring the legal and mandatory requirements of ventilation systems in healthcare premises. This includes the design, maintenance and the operation of ventilation systems:

Annual performance and verification checks were undertaken on all critical ventilation systems including Ultra Clean Theatres for assurance purposes. A 2019 Theatre PPM planner was issued for all theatres and critical ventilation plant.

Critical Ventilations systems are currently under review across MFT to establish where investment is required to improve existing facilities in Theatre areas.

9.6 Cleaning Services

Contracting Arrangements: The Trust cleaning services were provided by both internal and external contractors/teams.

- Sodexo Healthcare was the main contractor for the provision of cleaning services across the Oxford Road Campus, including the Dental Hospital and Old Saint Mary's building and Wythenshawe Hospital.
- Withington, Trafford and Altrincham Hospitals and the Intermediate Care Units all had services provided by in-house teams.

9.7 Monitoring Arrangements

As part of the contracts Sodexo were required to self-monitor the performance of cleaning services against key performance indicators. These were reported to the Trust on a monthly basis for analysis and challenged where appropriate by the Estates and Facilities Team.

The services at Withington, Trafford and Altrincham Hospitals and the Intermediate Care Units were managed and monitored through internal in-house arrangements with the service managers and local users.
In addition, the standards of cleanliness were monitored and reported for all sites through the monthly Quality of Care Rounds, (see section 11), the Ward Accreditation Process and the Patient Experience Tracker (Oxford Road Campus/Trafford Hospital). These results informed areas of best practice and areas where additional focus was required.

9.8 The Role of the Infection Prevention and Control Team

The Infection Prevention and Control Team worked in conjunction with the Trust Estates and Facilities Teams, Clinical Divisions, Sodexo and internal providers to ensure cleaning standards were met across the Trust.

9.9 Cleaning Schedules

Cleaning schedules were publicly displayed in all clinical areas and processes were in place to report and escalate cleaning problems. These included an agreed process which provided users with information on what services should be delivered and how to escalate non-compliance and a cleaning matters/log book process which required clinical and cleaning staff to record the completion of tasks and log additional or amended requirements.

9.10 Infection Prevention and Control Training for Domestic Staff

All new employees attended a generic induction which included the principles of Infection Prevention and Control.

9.11 Patient Led Assessment of the Care Environment (PLACE)

The annual Patient Led Assessments of the Care Environment (PLACE Assessments) were carried out across the MFT Sites during April and May 2018. The assessors visited wards, outpatient departments and emergency departments, carried out food assessments, and undertook a review of the external and internal public areas on all sites. PLACE Assessment teams comprised Patient Assessors (who are required to make up 50% of each Assessment team), together with representatives from Nursing, Infection Prevention and Control Team and Estates and Facilities.

The scores for each of the eight assessment categories are shown in Fig 11:

Fig. 11 PLACE Assessments 2018

Category	Wythenshawe %	Trafford %	ORC %
	2018	2018	2018
Clean	99.05	99.43	99.29
Food	88.00	86.33	93.14
Organisational Food	83.81	87.62	86.83
Ward Food	89.09	85.15	94.41
Privacy, Dignity & Wellbeing	86.73	88.89	85.75
Condition, Appearance & Maintenance	94.48	98.20	97.49
Dementia	81.96	87.00	79.98
Disability	87.18	90.54	89.92

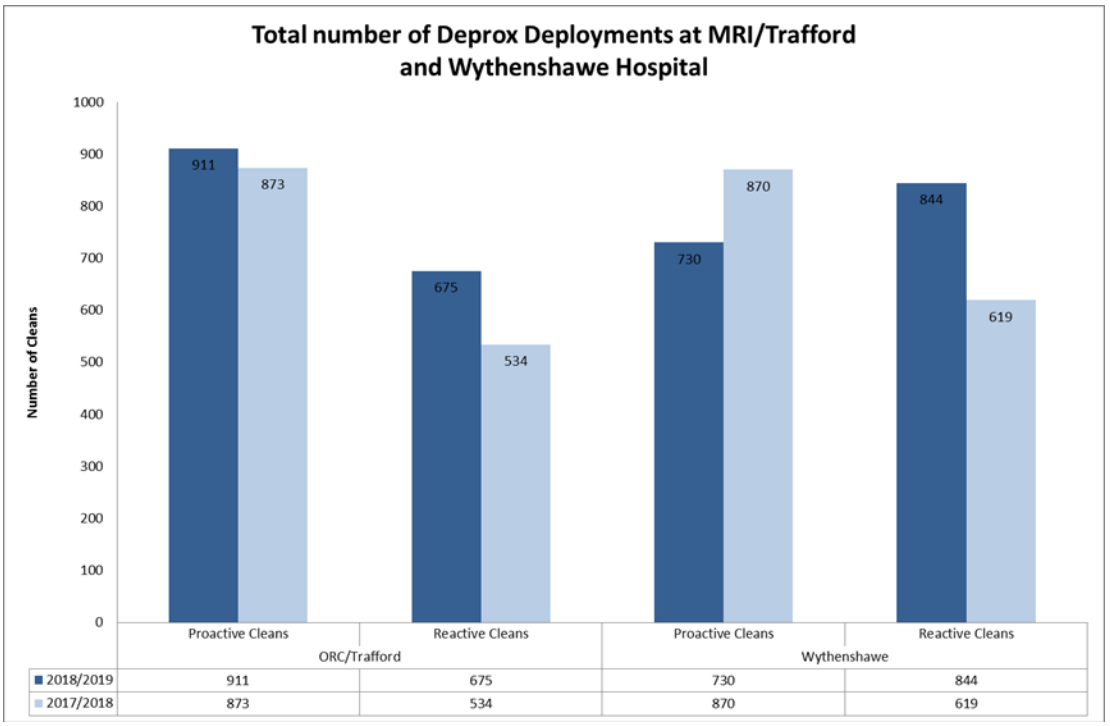
9.12 Contract for the use of Hydrogen Peroxide Vapour (HPV) with Hygiene Solutions (Deprox)

Hygiene Solutions provided a contract for a managed service for the Oxford Road/Trafford Campus and Wythenshawe Hospitals. Fig. 12 demonstrates HPV usage for this year compared to the previous year), by site;

- Reactively (red clean) to decontaminate an area following discharge of a patient with infection.
- Proactively (proactive clean) to decontaminate 'high risk' zones in clinical areas such as bathrooms/toilets where there were in-patients with infection.

The IPC team also worked with Hygiene Solutions to develop the use of Ultra – Violet technology (UV-C), as an adjunct to cleaning in areas where it is difficult to use HPV.

Fig. 12 Total Number of Deprox Cycles Deployed at Oxford Road/Trafford Campus and Wythenshawe Hospitals



SECTION 10: ANTIMICROBIAL STEWARDSHIP

10.1 Antimicrobial Stewardship Group

The Antimicrobial Stewardship Group was harmonised across all sites in the first quarter of 2018/19. The first priority was to synchronize antibiotic prescribing guidelines and stewardship activities.

Best practice prescribing principles to promote antimicrobial stewardship are described in national guidance including PHE Start Smart then Focus (March 2015), the national CQUIN and the Trust Medicines policy. These include documenting the rationale for starting antimicrobial therapy and regular review.

10.2 Antibiotic Audit

A monthly audit was undertaken to provide a regular snapshot of compliance with these standards with timely feedback to clinical areas so that actions could be rapidly implemented to achieve improvement if necessary.

The objectives of the audit were to perform a monthly audit collecting data for five patients selected at random, on all inpatient areas receiving a clinical pharmacy service within the Trust.

Actions following the Audit:

- Presented the data monthly at Hospital / MCS level as a Red (Compliance < 75%), Amber (Compliance 75-89%), Green (Compliance >90%) dashboard.
- Presented data quarterly to the Trust Antimicrobial Stewardship Committee
- The Trust Antimicrobial Stewardship Committee had an overview of the audit results and where necessary held Hospitals/MCSs to account for improvement plans.

Table 1: Trust wide data monthly performance

Antimicrobial Prescribing Standards:		April	May	June	July	August	September	October	November	December	January	February	March
	Sample Size:	106	46	341	293	324	345	325	309	278	321	283	236
a	Is the total antimicrobial duration or review date documented?	65%	63%	80%	76%	77%	78%	83%	79%	71%	79%	78%	75%
b	Have all antimicrobials prescribed for 72 hours or longer been reviewed by the prescriber?	93%	86%	89%	92%	93%	93%	95%	88%	92%	96%	97%	93%
c	Is the indication for treatment documented on the medication chart?	87%	87%	90%	85%	88%	87%	92%	91%	88%	91%	89%	86%
d	Is or was the patient receiving IV antimicrobials?	83%	78%	73%	72%	71%	71%	71%	76%	69%	73%	71%	75%
e	If on IV, was a blood culture taken?	58%	71%	78%	75%	73%	75%	84%	71%	76%	79%	84%	77%
	Average % compliance :	76%	77%	84%	82%	83%	83%	89%	82%	82%	86%	87%	83%

Table 2: Results for 2018/19 for each Hospital/MCS

Antimicrobial Prescribing Standards:		Trust-wide	MRI - Medicine	MRI - SMS	MRI - Surgery	CSS	RMCH	SMH	MREH	Trafford	Wythenshawe
	Sample Size:	3216	589	189	372	113	227	70	30	186	1440
a	Is the total antimicrobial duration or review date documented?	77%	74%	69%	62%	100%	64%	74%	73%	82%	83%
b	Have all antimicrobials prescribed for 72 hours or longer been reviewed by the prescriber?	93%	91%	91%	87%	100%	95%	94%	77%	90%	95%
c	Is the indication for treatment documented on the medication chart?	89%	92%	88%	87%	100%	74%	54%	80%	81%	92%
d	Is or was the patient receiving IV antimicrobials?	73%	73%	83%	87%	99%	81%	73%	30%	51%	68%
e	If on IV, was a blood culture taken?	58%	77%	83%	62%	95%	94%	72%	n/a	61%	72%
	Average % compliance :	79%	84%	83%	75%	99%	82%	74%	77%	78%	86%

Table 3: Staff completing antimicrobial review at 72 hours

Who was the review preformed by?	Trust-wide	MRI - Medicine	MRI - SMS	MRI - Surgery	CSS	RMCH	SMH	MREH	Trafford	Wythenshawe
Sample Size:	2008	370	135	249	97	140	45	10	91	871
Microbiology/ID	22%	21%	24%	22%	19%	29%	7%	30%	19%	23%
ST3 Doctor or above	58%	55%	61%	48%	30%	62%	87%	60%	57%	62%
Antibiotic Pharmacist	0%	1%	0%	0%	2%	1%	0%	0%	1%	0%
Other	12%	11%	9%	9%	49%	6%	4%	10%	16%	11%
Not Documented	6%	9%	3%	19%	0%	1%	2%	0%	3%	4%

Table 4: Outcome of the 72 hour review

What was the outcome of the review?	Trust-wide	MRI - Medicine	MRI - SMS	MRI - Surgery	CSS	RMCH	SMH	MREH	Trafford	Wythenshawe
Sample Size:	2008	370	135	249	97	140	45	10	91	871
Continue NO review date	12%	12%	16%	23%	1%	9%	16%	50%	12%	8%
Continue with review date	54%	44%	59%	43%	49%	59%	40%	10%	46%	61%
IV to oral	16%	21%	10%	18%	15%	9%	24%	20%	8%	15%
OPAT	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%
Switch based on cultures	5%	7%	1%	3%	11%	6%	2%	10%	9%	3%
Treatment escalation	3%	5%	1%	4%	4%	2%	0%	0%	7%	2%
Treatment step-down	3%	1%	4%	2%	13%	4%	0%	10%	7%	1%
Stopped	7%	8%	6%	4%	5%	11%	16%	0%	9%	7%
Outcome not documented	0%	0%	0%	1%	0%	0%	2%	0%	0%	0%

10.3 World Antibiotic Awareness Week

In November 2018 The Antimicrobial Stewardship Group, supported by the IPC team and Microbiologists undertook a campaign to raise antibiotic prescribing awareness in line with World Antibiotic Awareness Week. A variety of promotional activities were

implemented across both the ORC and Wythenshawe Hospital sites over a two week period. The events were participative and there was good staff engagement.

Fig. 13 Timetable for World Antibiotic Awareness Week

World Antibiotic Awareness Week @ MFT

12 – 22nd November 2018

	Monday	Tuesday	Wednesday	Thursday	Friday
Week 1	**Superbug Exhibition** **Venue** - Atrium of Royal Manchester Eye Hospital, ORC **Time** - 10:00 – 16:00 Meet the expert sessions and daily activities will take place between 12noon and 2pm, to include Microbiologists, Specialist in Infection, Antimicrobial Pharmacists and the Microbiology lab team				
	"The great infection bake off " **Venue** - Atrium of Royal Manchester Eye Hospital, ORC **Time** - 12:00	**'Never listen to your sister: the story of Action on Antibiotic Resistance: One Student, One Campus, One World.'** Guest speaker Roger Harrison (from the University of Manchester) **Venue** - Pharmacy Seminar room, 4th Floor inpatient pharmacy, ORC **Time** - 13:00	**Action on Antibiotics Information Stalls** **Venue –** Stopford & Jean MacFarlane Buildings @UoM and various locations at MMU	**`Sepsis and AMR: Unrecognised Global Health Challenges` and `The Movement of Antibiotics and Resistance for Local to Global to Local`** **Venue –**Lecture Theatre A, University Place, UoM **Time –** 17:30	
Week 2	**Follow us on twitter @antibioticangel**	**Superbug Exhibition** **Venue -** Education and Research Centre, Wythenshawe **Tuesday – Thursday 11:00 – 14:00** Meet the expert sessions and daily activities will take place between 12noon and 2pm, to include Microbiologists, Specialist in Infection, Antimicrobial Pharmacists and the Microbiology lab team			BECOME AN ANTIBIOTIC GUARDIAN
		`Meet the angels` **Venue -** Education and Research Centre, Wythenshawe **Time –** 11:00	**`The Super Bug Fight` Infection Control Dr.** **Venue -** Education and Research Centre, Wythenshawe **Time –** 12:00	**Antibiotic Hero competition winners announced** **Venue -** Education and Research Centre, Wythenshawe **Time –** 13:00	**Make a pledge today and become an antibiotic guardian here**

SECTION 11: MONITORING CLINICAL PRACTICE STANDARDS

11.1 Care Quality Commission (CQC) Inspection

The Care Quality Commission (CQC) conducted a comprehensive inspection twelve months following the creation of MFT from the 2nd October to 8th November 2018. Following this inspection the trust received an overall rating of **'Good'**, with some areas of 'Outstanding' practice. The inspection identified many areas of good and outstanding practice:

"The trust had a comprehensive infection prevention and control action plan in place to reduce the risk of infection spread and maintenance of high standards. We saw that the action plan was regularly updated and actions were assigned to senior staff"

"The service controlled infections well and there were low infection rates" (MREH).

"We received positive comments from one feedback card left by a visitor on the level of cleanliness on the unit, stating 'cleaners doing a fine job always clean and hygienic' (Saint Mary's)

"Infection rates were monitored and reported to the infection control team and the Manchester critical care network. We saw that infection rates were low. The Intensive Care National Audit and Research Centre from 1 April 2018 to 31 June 2018 demonstrated that the cardiac and general critical care units had no unit acquired infections and were performing better than the comparators." (Critical care)

"We observed all staff followed 'bare below the elbow' and infection, prevention and control protocols. We observed staff using personal protective equipment and washing their hands before delivering patient care. The parents and carers we spoke with were happy with the cleanliness of the ward. "(RMCH)

Infection control audits took place monthly across the wards and theatre areas…..The high impact interventions are an evidence-based approach that relate to key clinical procedures or care processes (such as the insertion of catheter and cannulas). Wythenshawe Hospital

We observed good hand washing and infection control practices throughout.(Trafford)

Out of 14 compliance areas we reviewed in the health visiting audit in September 2018, only one hand hygiene area was not 100% compliant. (MLCO)

There were some areas that were identified as *requires improvement*; immediate action was taken following the inspection and actions are followed up through the Group and hospital/MCS ICC including action plans as part of the response to the CQC report:

"Hand hygiene audits were undertaken on a weekly basis. Records indicated that compliance during this period had varied between 92% and 100%. Areas of non-compliance had included staff not washing their hands or using hand gel after patient contact as well as before entering or exiting the department. However, we noted that the management team had implemented actions to make improvements to staff compliance with infection control." (MRI)

Whilst the CQC noted overall that infection rates were low they recommended a number of improvements relating to training staff, compliance with guidelines and cleanliness of the environment and some equipment.

Immediate actions and improvements have been put in place and include enhanced environmental monitoring, new processes devised for monitoring compliance to IPC policies and the development of a programme of surgical site infection surveillance to reduce HCAI.

All plans will be monitored and overseen through the Hospital/MCS ICC and the group ICC in addition to the monitoring of key infections and patient experience through the group Assurance reports, the Assurance Oversight framework and the Quality Care Round.

11.2 Audit of Hand Hygiene Practice

All clinical areas undertook a monthly audit of hand hygiene practice using a standard proforma. The frequency was increased to weekly during periods of increased risk of infection. Results were discussed at local ICC's and action taken as indicated.

11.3 Annual ANTT Competency Assessment

All clinical staff who practiced ANTT underwent an annual competency assessment. Records were maintained by the Ward Manager for nursing staff and the post-graduate centre for medical staff at ORC. Assessments of the seven stages of hand hygiene were included in the assessment process. Compliance figures were reported to the local ICC.

11.4 Quality Care Round (QCR) Data

The QCR and Ward Accreditation Process led by an Accreditation Team was undertaken by the Ward Manager/Matron to monitor compliance against standards of practice. This included standards related to infection prevention and control practice and the patient environment. Adverse results were addressed at the time of the audit. The results for infection prevention and control (averaged over 12 months) can be found in figures 14 and 15 below:

Fig. 14 Quality Care Round Indicators for Infection Control

Infection Control	Clinical & Scientific Services	Manchester Local Care Organisation	Manchester Royal Eye Hospital	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Trafford General Hospital	Wythenshawe	MFT
Staff demonstrate the correct ANTT procedure?	99	100	100	98	99	100	98	99	99
Do staff adhere to the Dress Code Policy?	96	97	100	98	99	98	93	98	98
Is alcohol hand gel available at the point of care?	100	100	100	97	99	99	100	98	98
Staff demonstrate the correct procedure of cleaning their hands before direct patient contact?	97	99	98	97	96	99	94	95	96
Today have you seen ward staff washing their hands or using alcohol gel before treating you?	99	99	93	95	93	97	95	96	96
Staff demonstrate an awareness of the Trust policy for admitting and care management a patient with MRSA?	100	100	100	97	99	99	99	100	99
Staff demonstrate an awareness of the Trust policy for admitting and care management for a patient with known Carbapenamase Producing Enteropbacteriaceae (CPE)?	100	100	93	98	99	98	100	99	99
Staff demonstrate an awareness of the Trust policy for admitting and care management for a patient with suspected/confirmed Clostridium difficile?	100	100	97	97	97	98	98	99	98
How would you manage infectious patients within the department, e.g. suspected infectious diarrhoea, known CPE, infectious TB, chicken pox, etc?	100	100	97	98	100	99	97	99	99
Observe staff members leaving an isolation facility. Were effective barrier practices observed?	100	100	96	96	95	100	97	98	97
Can staff explain the process for the procedure for decontamination of clinical equipment for both non infection and infection?	100	97	97	97	99	99	96	98	98
Are all commodes clean and labelled as clean?	97	94	97	95	97	98	81	93	93
Overall	99	99	97	97	97	99	95	97	97

Fig. 14 Quality Care Round Indicators for Ward Cleanliness

Cleanliness	Clinical & Scientific Services	Manchester Local Care Organisation	Manchester Royal Eye Hospital	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Trafford General Hospital	Wythenshawe	MFT
Is environment tidy and clutter free?	98	93	100	96	98	98	94	96	96
Inspect bathrooms/shower rooms/toilets.	97	97	100	90	94	94	87	95	93
Is all patient shared equipment clean and labelled?	83	97	80	95	96	94	89	90	92
Inspect bed/trolleys spaces to ensure clean, tidy and equipment in full working order.	99	97	90	96	96	99	91	96	96
Inspect static mattress on patients bed as per policy.	56	86	88	87	82	89	87	85	85
Inspect curtains and tracking, blinds.	95	92	100	96	95	92	98	93	94
Inspect linen trolley/cupboard.	99	100	100	97	98	97	96	97	97
Inspect ceilings and vents.	86	97	80	85	88	93	94	87	88
Are all store rooms clean, tidy and all items well organised and easily accessible?	98	96	93	92	92	95	96	95	94
Overall	92	95	93	91	91	94	91	92	92

SECTION 12: CONCLUSION

The content of this report establishes the broad spectrum of activity associated with infection prevention and control across the Group. The outcomes of the practice and process described are evidence of the hard work and commitment of staff working across the organisation.

The formation of MFT has seen the consolidation of IPC practice across the Group and the merger and harmonisation of structures and committees which has required a great deal of focus by the IPC and management teams. The merger of the medical IPC teams remains outstanding and will be a priority for 19/20.

The Group has maintained its reputation for strong and effective prevention and management of Infection prevention and control and continues to be at the forefront of developing national as well as local policy for the management and control of patients with CPE. The IPC have showcased some of the hard work and lessons learned with other organisations and continue to be a source of expert advice and information to support IPC services across the region.

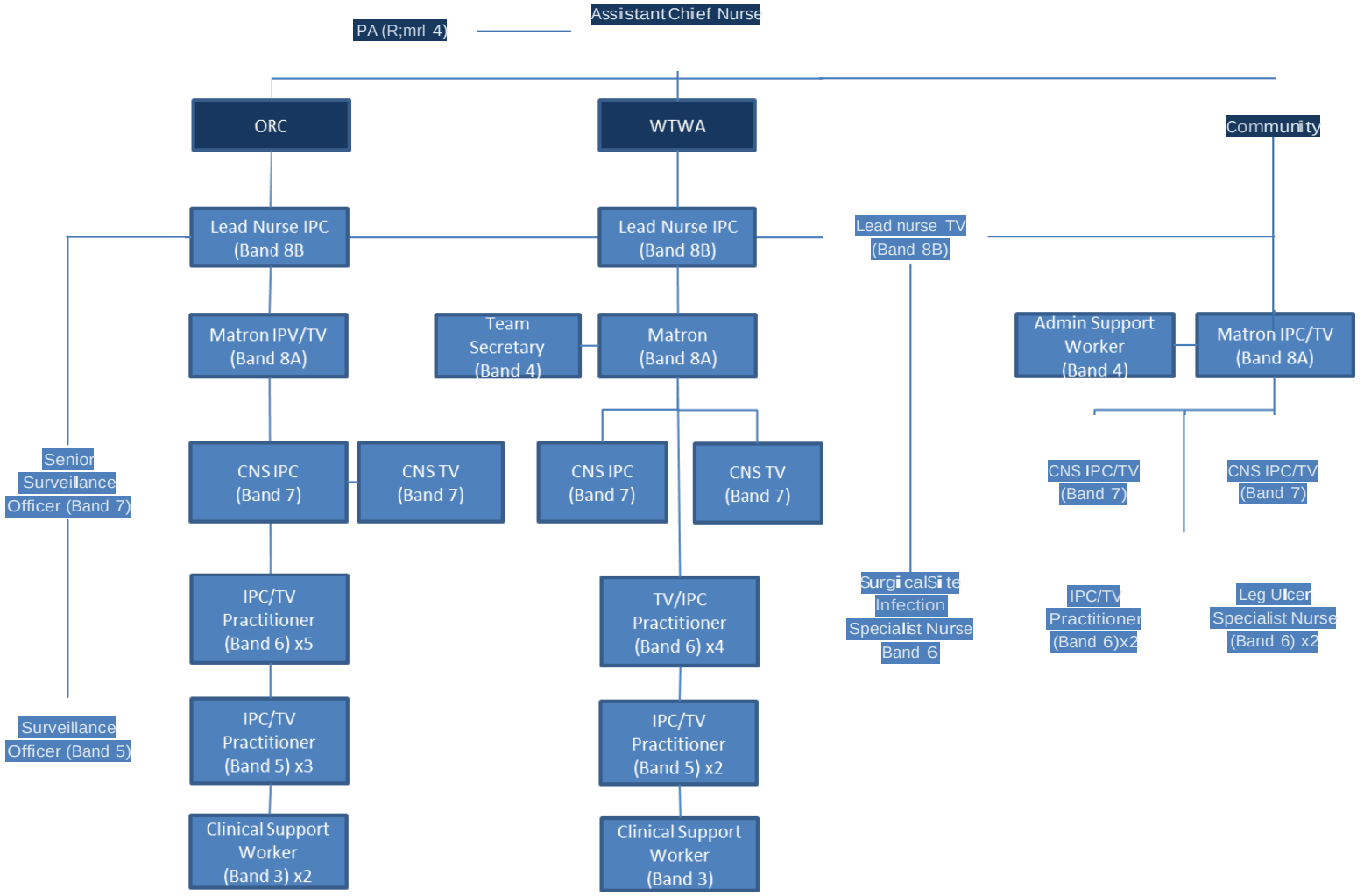
The content of this report reflects the breadth of activity and the enthusiasm to constantly improve and to develop new and innovative means of improving patient care. Moreover, this report demonstrates a culture of openness and transparency in regards to the internal and external review processes for key infections.

The Board of Directors are asked to receive this report for April 2018 to March 2019 and approve for publication.

Julie Cawthorne
Assistant Chief Nurse/Clinical Director of Infection Prevention and Control
April 2019

Appendix 1

MFT IPC/TV Nursing Team Structure 2018/19



Appendix 2

GROUP INFECTION CONTROL COMMITTEE
TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Group Management Board has established a Committee to be known as the Infection Prevention and Control Committee. The committee is an executive committee and holds the powers delegated to it in these terms of reference. The Infection Control Committee is chaired by the Chief Nurse/ Director of Infection Prevention and Control.

2. MEMBERSHIP

2.1 Membership shall consist of:

Chief Nurse/DIPC (CHAIR)
Consultant Microbiologist/Infection Control Doctors (Vice-Chair)
Deputy Infection Control Doctor
Directors of Nursing
Assistant Chief Nurse Clinical DIPC
Lead Nurses Infection Prevention and Control
Hospital/MCS Clinical Leads for Infection Control
Consultant in Communicable Disease (Public Health England)
MHCC Infection Control Lead
Antimicrobial Pharmacist
Director of Estates and Facilities
Clinical Audit representative
Director of Clinical Governance
LCO representative

All group executives have an open invitation to and may attend committee meetings

2.2 No business should be transacted at the meeting unless a minimum of ten members are present, which must include the Chair or Deputy Chair, four Hospital Clinical Leads, and either the Director of Nursing (Corporate) or the Assistant Chief Nurse/Clinical DIPC

3. ATTENDANCE AT MEETINGS

3.1 The Infection Control Committee may require the attendance of any Trust employee (or agent of the Trust)

4. FREQUENCY OF MEETING

4.1 The Committee will meet every three months (four times a year), but may be convened at other times as deemed necessary.

5. OVERVIEW

5.1 The Committee will set the strategic direction for infection prevention and control and seek assurance on an exception or as required basis

5.2 The Committee is responsible for developing the group organisational strategy and clinical standards for infection prevention and control in line with national/international evidence based practice and standards.

6. SCOPE AND DUTIES

6.1 Provide strategic leadership for infection prevention and control, including identifying priorities and setting performance targets.

6.2 Develop the strategy and agree the clinical standards for infection prevention and control across all the Trust sites.

6.3 Approve the programme of work of the Trust Clinical Infection Control committee.

6.4 Receive Hospital/MCS ICC performance and exception reports

6.5 Receive, review and ratify group policies, clinical pathways and reports, including the Annual Infection Control Report

6.6 Approve the annual audit calendar to provide assurance that standards are met and any required changes to practice, systems and processes are delivered.

6.7 To report to the Group Management Board on performance against infection control indicators and audits, including actions taken to address any areas for improvement.

6.8 To determine and commission programmes of work required to deliver the work programme of the Infection Control Committee

6.9 Oversee the Trust's involvement in and response to, internal and external assessments and inspections.

6.10 Agree the education and training framework for infection prevention and control for the Trust, ensuring compliance with infection prevention and control standards.

6.11 Approve the Trust's Annual Infection Control Report.

6.12 To describe, review and monitor the principle and significant risks related to infection control on behalf of the Trust and present these with the plan of controls to the Group Management Board and Risk Management Committee.

6.13 The Infection Control Committee will receive exception reports from the Hospital/MCS Infection Control leads where performance is out with the standards set out in the IPC strategy

6.14. The Infection Control Committee will receive at each meeting a report from the Trust Infection Control Group to include:

1. Policy and pathway development
2. Infection Control Group activity
3. Changes to national or local strategy
4. Trust wide themes identified from adverse events

7. AUTHORITY

7.1 The Infection Control Committee is empowered to examine and investigate any activity within the Trust pursuant to the above scope and duties.

8. REPORTING

8.1 The Committee will report to the Group Management Board.

8.2 The Committee will work closely with relevant Group Committees and the Clinical Advisory Committee and will provide assurance to the Board of Directors in relation to infection prevention and control

8.3 The minutes and exception report (as required) will be considered at the next Risk Management Committee and Quality and Performance Scrutiny Committee

9. REVIEW

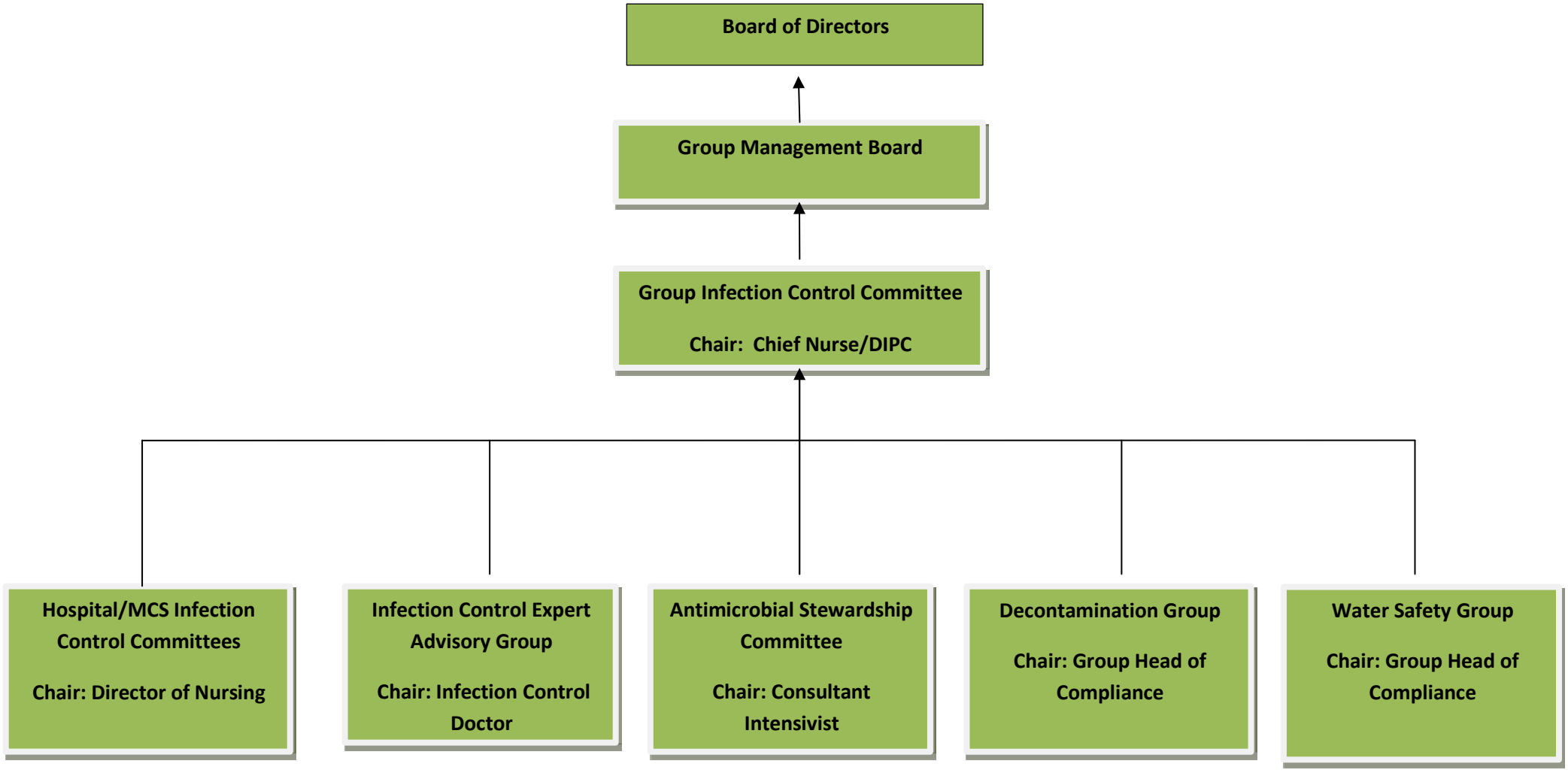
9.1 These terms of reference will be reviewed annually.

10. KEY PERFORMANCE INDICATORS

10.1 These Terms of Reference will be measured against the following key performance indicators:

1. 75% attendance of all listed members or nominated deputy
2. Presentation of the Annual Infection Control Report.

Reporting Framework for Infection Prevention and Control Group Structure 2018/19



MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Professor Cheryl Lenney, Group Chief Nurse
Paper prepared by:	Karen Meadowcroft, Corporate Director of Nursing Andrea Boland, Acting Assistant Chief Nurse (Education) Anne Woodward, Head of Nursing Professional Education and Development Elizabeth Charnock, Matron Post Registration Education
Date of paper:	April 2019
Subject:	Nursing and Midwifery Revalidation Annual Report 2018/19
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration of Risk against Key Priorities:	Staff and Patient Experience
Recommendations:	To note the actions taken and on-going plans in place to support nurses, midwives and nursing associates across the Trust to meet the Nursing & Midwifery Council Statutory Revalidation requirement.
Contact:	Name: Andrea Boland, Acting Assistant Chief Nurse (Education) Tel: 0161 276 4103

BOARD OF DIRECTORS

1. Introduction

1.1 This is the second annual report for Manchester University NHS Foundation Trust (MFT) to provide assurance on Nursing and Midwifery Revalidation to the Board of Directors. Within the report, the data is reported from 1st April 2018 to 31st March 2019 for MFT.

2. Background

2.1 Since April 2016, Nurses and Midwives have been required to undergo a three yearly process of revalidation to demonstrate that their practice is in line with the Code (Nursing and Midwifery Council (NMC) (2015). Revalidation replaced the previous post-registration education and practice (PREP) standards.

2.2 The NMC opened the Nursing Associate part of the professional register on 28th January 2019. Nursing Associates registered with the NMC are now in employment throughout MFT and will be subject to the same regulation and revalidation criteria as all other registered nurses and midwives. The first Nursing Associates who qualified and registered in January 2019 will be subject to revalidation in January 2022. Revalidation reports from January 2022 will therefore also need to provide assurance of Nursing Associate revalidation to the Board of Directors.

2.3 The requirements for revalidation are as follows:

- 450 practice hours, or 900 if renewing as both a nurse and midwife
- 35 hours of Continuing Professional Development including 20 hours of participatory learning
- Five pieces of practice-related feedback
- Five written reflective accounts
- A reflective discussion with an appropriate “Confirmer”
- Health and character declaration
- Professional indemnity arrangement
- Confirmation that the requirements have been met

2.4 Registrants are required to maintain a portfolio of evidence, which demonstrates they have met the requirements for revalidation.

2.5 It is the individual Nurse, Midwife and Nursing Associate’s professional responsibility to ensure that they meet the revalidation standards. However, as a supportive employer, the Trust has a responsibility to support Registrants in meeting the requirements in order to demonstrate that practice is safe and effective.

3. National Process

3.1 All registrants will receive direct communication from the NMC to provide a reminder of their pending revalidation and the time to prepare their evidence for completion of the process.

3.2 Registrants can be granted an extension; this does require an application to be made to the NMC which looks at any exceptional circumstances causing delay in the process.

3.3 For quality assurance purposes, each year, the NMC will select a sample of Nurses, Midwives and Nursing Associates to provide further information about their revalidation application. This process is known as verification.

4. Implementation of Revalidation

4.1 The Chief Nurse remains the responsible officer for all nursing, midwifery and nursing associate revalidation, supported by the Deputy Chief Nurse and the Hospital/MCS/MLCO Directors of Nursing/Midwives.

4.2 The Directors of Nursing have oversight of the process and compliance position for individual registrants in their hospital/MCS/MLCO. They link closely with the Professional Education & Development Team to maintain scrutiny and oversee the process for their areas.

4.3 The process for revalidation is supported through the Trust's annual appraisal process; in preparation for revalidation, nurses, midwives and nursing associates are asked about their revalidation date, and are required to produce two pieces of reflective evidence and two pieces of practice related feedback to discuss at their appraisal each year. This evidence will then allow the registrant to submit the five required reflective accounts and feedback at the three year renewal point.

4.4 From an organisational perspective, ongoing support is provided through resources online and local revalidation champions.

4.5 The MFT Nursing and Midwifery Revalidation Policy and the Verification of Professional Registration Policy have been updated to include the monitoring and recording of Nursing Associate revalidation, and is currently awaiting ratification.

5. Revalidation figures 1st April 2018 - 31st March 2019

5.1 From 1st April 2018 to 31st March 2019, 1,967 nursing and midwifery staff were due to revalidate 1,965 revalidated. Two nurses did not revalidate, one does not require NMC registration for their employed role in the Assault Centre and the other nurse allowed their NMC registration to lapse due to family circumstances this was following communication with the Director of Nursing/Midwifery and the NMC; the NMC register shows that this nurse has now completed the revalidation process following a period when she was not on the NMC register.

6. 2019/20 Revalidation work programme

6.1 A significant factor in the successful implementation of Nursing and Midwifery Revalidation has been the integration of the requirement within everyday practice. To ensure continued success within MFT the following actions are in progress:

- The MFT Nursing and Midwifery Revalidation Policy and the Verification of Professional Registration Policy are currently awaiting ratification.
- Update resources, support and advice available to staff through the revalidation microsite on the Intranet and the Learning Hub.

7. Conclusion and Recommendation

7.1 Revalidation for Nurses and Midwives has been a mandatory requirement since April 2016. The initial wave of registrants revalidating will be repeating this process in 2019.

7.2 The Trust has developed and delivered a range of mechanisms to prepare its Nurses, Midwives, Nursing Associates and their managers for the requirements of revalidation. Nursing and Midwifery Revalidation is now embedded across MFT. The continued support of registrants to ensure that they successfully revalidate remains a core patient safety objective for the Trust.

7.3 The Board of Directors is asked to receive the report for assurance regarding the NMC revalidation process.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Professor Cheryl Lenney, Group Chief Nurse
Paper prepared by:	Karen Meadowcroft, Corporate Director of Nursing Debra Armstrong, Assistant Chief Nurse (Quality and Professional Practice) Anne-Marie Varney, Assistant Chief Nurse (Workforce)
Date of paper:	April 2019
Subject:	Annual Accreditation Report
Purpose of Report:	Indicate which by ✓ • Information to Note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration of Risk against Key Priorities:	Patient & Staff Experience
Recommendations:	To note the content of the report and the progress of the Trust Accreditation Programme
Contact:	**Name:** Debra Armstrong – Assistant Chief Nurse (Quality and Professional Practice) **Tel:** 0161 276 5061

Manchester University NHS Foundation Trust (MFT) Accreditation Report 01st April 2018 – 31st March 2019

1. Executive Summary

1.1 The Accreditation process is part of the Trust's assurance mechanisms for ensuring the provision of high quality care and the best patient experience.

1.2 Following the establishment of the Trust on 01st October 2017 the MFT Accreditation Programme was developed and commenced on April 1st 2018. Accreditation assessment models and criteria were developed for wards, day case areas, emergency departments, theatres, treatment centres, outpatient departments and community services. The process for each of the accreditations was designed to provide consistency of assessment whilst allowing adequate flexibility to adjust the process based on the differences between the clinical areas.

1.3 In total 153 areas were accredited in 2018/19 utilising the newly designed MFT Accreditation assessment, establishing a baseline position for MFT.

1.4 The Accreditation involves assessment against agreed criteria for each standard and is scored as gold, silver or bronze. The collated result across all categories provides an overall result for the area. Areas that cannot demonstrate they are achieving minimum accreditation standards are described as 'White', indicating the requirement for an intensive support package.

1.5 In 2018/19, 35% of areas attained Gold, 46% attained Silver and 19% attained Bronze status. No area was classified as White in 2018/19.

1.6 Areas attaining Gold were presented with their certificates by the Hospital/ Managed Clinical Service Director of Nursing and/ or the Chief Executive and representatives were invited to the MFT Excellence Awards in recognition of and to celebrate, their achievement.

Illustration 1: Gold Certificate presentation, Royal Manchester Children's Hospital

1.7 This report analyses the specific leadership assessment within the Accreditation process compared to the overall Accreditation result; demonstrating the correlation between effective leadership and high performing teams.

1.8 The correlation between human resource metrics and the overall Accreditation result is explored. The overall Accreditation results including human resource indicators demonstrates no direct correlation between turnover, sickness or vacancy rate and the Accreditation outcome.

1.10 The Group Board of Directors are asked to note the content of the report and the plans for the MFT Accreditation Programme 2019/20.

2. Background

2.1 The Accreditation Programme is a process that assesses the quality of care and aims to raise the overall standard of care provided to patients.
The Accreditation process is part of the Trust's assurance mechanisms for ensuring the provision of high quality care and the best patient experience. The process is underpinned by the Improving Quality Programme and supported by, the Trust Values, 'What Matters to Me' patient experience programme and the Nursing, Midwifery and AHP Strategy.

2.2 Areas that undergo Accreditation include inpatient wards, day-case and treatment areas, critical care areas, theatres, emergency departments, dialysis units, community services and outpatient departments. The Accreditation assessment process includes reviewing a series of defined standards and metrics within wards and departments across hospitals and Managed Clinical Services. Each area is required to display details of their performance and their improvement programme on their local Improving Quality Programme.

Illustration 2: Improving Quality Board

2.3 Following the establishment of the Trust on 01st October 2017 the MFT Accreditation Programme was developed and implemented from 1st April 2018; as such 2018/19 is

the first year of the MFT Accreditation Programme. Accreditation assessment models and criteria have been established for wards, day case area, emergency departments, theatres, treatment centres, outpatient departments and community services. The process for each of the Accreditations has been designed to provide consistency of assessment whilst allowing adequate flexibility to adjust the process based on the differences between the clinical areas.

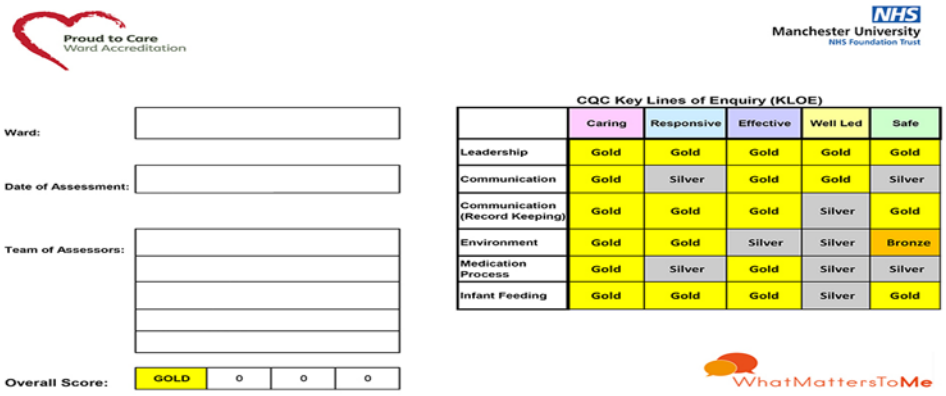
2.4 The Accreditation involves assessment against agreed criteria for each standard and scored as gold, silver or bronze. The collated result across all categories provides an overall result for the area. All areas accredited under the new MFT process in 2018/19 have been awarded an overall result of Bronze, Silver or Gold in order to establish a baseline position for MFT. The criteria for each of the scores are as follows:

- **Gold:** Excellent, achieving highest standards with evidence in the data that success sustained for at least six months
- **Silver:** Very good, achieving minimum standards or above with evidence of improvement in relevant data
- **Bronze:** Good, achieving minimum standards or below but with evidence of active improvement work
- **White:** Not achieving minimum standards and no evidence of active improvement.

A summary of each standard is mapped against the appropriate CQC Key Line of Enquiries (KLOE), to support teams to identify if areas are:

- **Safe**
- **Effective**
- **Caring**
- **Responsive to people's needs**
- **Well-Led**

Illustration 3: KLOE Calculator



2.5 The Accreditation process is described in detail in an Accreditation Standard Operating Procedure (SOP). The SOP is reviewed annually to ensure the criteria for assessment and processes remain current and relevant.

3. Accreditation 2018/19

Culture of Care Survey

3.1 As part of the MFT Accreditation programme for 2018/19 the Culture of Care Survey was introduced as part of the process.

3.2 The Culture of Care Barometer is a national reflective tool that can help teams and organisations assess and understand better, each workplace's culture of care. If used as part of a planned process, it can help to inform conversations about the culture of care, identify areas of strength and weakness and inform planning to make improvements (NHS England and Kings College London 2017)[1]

3.3 The MFT Culture of Care survey provides staff members the opportunity to provide anonymous feedback on how they feel working in that particular clinical area and for senior managers to reflect on the ward and department responses by the teams, celebrate achievements and identify any areas for improvement. Reports detailing the results are circulated bi-annually and the information is utilised as an integral part of the Accreditation assessment used to get staff feedback in the leadership and culture of continuous improvement domains

The Improving Quality Programme (IQP)

3.4 IQP is the Trust's methodology for continuous improvement which supports staff to review their data, identify areas of concern, research best practice based on current evidence, implement changes, follow a structured approach that involves Model for Improvement and Plan-Do-Study-Act (PDSA) cycles, to ensure that changes are evidence based, measurable, embedded and sustained in practice. IQP also enables teams to improve their ward environment and processes, which is intended to 'release time' that can be reinvested in improving quality, safety and the patient experience.

3.5 As a part of the MFT Accreditation process, teams are assessed on their continuous improvement journey to ensure the best patient experience.

3.6 The roll-out of IQP to the teams at Wythenshawe Hospital commenced in 2018/19. The roll-out required an intensive training and support programme, which involved the Corporate Matron for Quality and Patient Experience working on site at Wythenshawe Hospital to develop and deliver a supportive structured implementation plan.

3.7 The clinical teams at Wythenshawe have been allocated into 7 IQP cohorts. The roll-out involves the delivery of 4 modules: 'IQP data and Masterclass', 'Well Organised Area (WOA)', 'Shift Hanover/ Core Huddle Standard', 'Mealtimes Standards. Cohort 1 is currently undergoing their final assessment with the plan for Cohort 7 to complete programme March 2020.

Champion Handbooks

3.8 A series of Improving Quality Programme Champion Handbooks are in the process of development to support teams to implement the Improving Quality Programme and deliver continuous improvements. The first Handbook the Well Organised Area was produced in 2018/19.

[1] NHS England and Kings College London (2017), Culture of Care Barometer. Available from: https://www.england.nhs.uk/leadingchange/staff-leadership/ccb/

Illustration 4: Improving Quality Programme – Champion Handbook

4. Accreditation Results 2018/19

Illustration 5: Gold Certificate presentation, WTWA

4.1 In 2018/19 153 Accreditations were undertaken utilising the newly designed MFT accreditation process between May 2018 and February 2019; the results are detailed below in Table 1. Results by area can be found at Appendix 1.

Table 1: MFT Accreditation Results (2018/189

MFT– Accreditation Results 2018/19		
	No	**%**
Gold	54	35
Silver	70	46
Bronze	29	19
White	0	0
Total	153	100

4.2 All areas attaining Gold were presented with their certificates by the Hospital/ Managed Clinical Service Director of Nursing and/or the Chief Executive and representatives were invited to the MFT Excellence Awards in recognition of and to celebrate the result.

4.3 As the new MFT process was introduced in 2018/19 and there is no data for comparison from previous years. From 2019/20 comparative data will be presented and analysed to identify progress from the previous year.

5. Leadership

5.1 Frontline clinical Leadership particularly compassionate inclusive leadership is considered key to enabling cultural change so that NHS organisations can deliver high quality care[2]. The MFT Culture and Leadership Strategy recognises that this means every interaction by every member of staff, every day, influences the extent to which the Trust develops a culture of high quality, continually improving and compassionate care[3].

5.2 Inclusion of an assessment of leadership, in the context of the journey of continuous improvement, is a key standard that is assessed as part of the Accreditation.

5.3 Analysis has been undertaken of the results of the assessment of the specific leadership domain within the MFT Accreditation Programme compared to the overall Accreditation result for an area to determine whether there was a correlation.

5.4 The results of the MFT Accreditation analysis are shown in Table 2 below.

Table 2: MFT Accreditation: Overall Result compared to Leadership Domain Result

MFT 2018/2019		
	Overall Result (Number of areas)	**Leadership Domain Result (Number of areas)**
Gold	53	Gold – 45 Silver – 8 Bronze – 0
Silver	70	Gold – 33 Silver – 32 Bronze –5
Bronze	29	Gold – 1 Silver – 11 Bronze – 16
White	0	N/A
Total		100

5.4 The results demonstrate a correlation between the performances in the Leadership domain of the Accreditation assessment with the overall Accreditation award, with 85% of areas awarded Gold overall also achieved Gold in the Leadership Domain and 55% of areas who were awarded Bronze overall also achieved Bronze in the Leadership Domain.

[2] NHSI and The Kings Find (2017) Culture and Leadership Toolkit; Phase2.
Available from:https://nhsicorporatesite.blob.core.windows.net/green/uploads/documents/01-NHS104 Phase_2_Toolkit_060717_FINAL.pdf

[3] MFT Culture and Leadership Strategy (2017)

5.5 The correlation of leadership with the achievement of professional standards, demonstrated by analysis of the Accreditation findings, emphasises the importance of the development of clinical leaders not only in clinical areas but at every level of the organisation in order to ensure a high quality experience for patients.

6. Impact of Workforce Factors on Accreditation Results

6.1 Concern that the quality of patient care can be compromised if there are not enough nurses and midwives available, is well-publicised[4].

6.2 The human resource indicators of turnover, sickness and qualified nurse vacancies have been analysed and compared to Accreditation outcomes for 2018/19 to determine if there is a correlation between human resource indicators and Accreditation outcome.

6.2 **Turnover:** Those areas that were accredited as Gold overall had turnover rates ranging from 0.0% to 35.29%, with 19 of the 54 (35%) awarded Gold exceeding the Trust target Turnover rate of 12.6%. Areas that were accredited as Bronze overall equally had turnover rates ranging from 0.0% to 31.7% with 12 of the 29 (41%) Bronze areas exceeding the Trust target Turnover rate of 12.6%.

6.2 **Sickness Absence:** Those areas that were accredited as Gold had sickness rates ranging from 1.09% to 17.4%. Similarly, areas that were accredited as Bronze had sickness rates ranging from 1.46% to 15.33%.

6.3 **Vacancies:** Those areas that were accredited Gold had a 6 month rolling average of Registered Nurse/Midwife vacancy rate ranging from 0.0% to 48.13% and those areas accredited as Bronze had a 6 month rolling average Registered Nurse/Midwife vacancy rate ranging from 0% to 56.02%. The variance in the percentage vacancy rates need to be considered with the size of the teams therefore fewer vacancies have a greater percentage impact on staffing dashboards.

6.4 In summary the overall Accreditation results have been triangulated with human resource indicators and do not demonstrate a direct correlation between turnover, sickness or vacancy rate and Accreditation outcome. The data presented above does however highlight the value of clinical leadership in maintaining the delivery of a high quality service to patients; sometimes despite the clinical pressures as a result of vacancies and sickness absence. The Trust will continue to focus on the leadership development for Ward/ Department Managers and Matrons.

7. Accreditation 2019/20

7.1 Accreditations will recommence in April 2019, with 154 areas currently scheduled to undergo Accreditation in 2019/20; this number may, increase further during the year as appropriate sub-divisions of Outpatient Departments, Community Services and Treatment Centres are agreed.

7.2 In 2019/20, if an area achieves Gold for a second year, the Ward/Team Manager will have the opportunity to apply for a higher award of Diamond[5]. Such applications will be assessed by a panel chaired by the Chief Nurse or Deputy Chief Nurse on her behalf and will include a Non-Executive Director and/or a governor. Eligibility criteria will include achieving Gold-level criteria for a minimum of four domains of the

[4] Francis, R. (2013) The Mid Staffordshire NHS Foundation Trust: Public Enquiry. Available from: http://webarchive.nationalarchives.gov.uk/20150407084231/http://www.midstaffspublicinquiry.com/report

[5] further discussion to agree the name of the award is underway

Accreditation assessment, one of which must be 'Medications'. In addition, a Gold-level result must have been achieved for the key standards 'clear leadership by Ward/Team Manager' and 'Culture of evidence-based practice'. These criteria reflect the Trust's vision to excel in quality, safety, patient experience, research, innovation and teaching. The criteria for application and assessment and the process are scheduled for ratification at the Nursing, Midwifery and Health Care Professionals Board in May 2019.

7.3 In 2018/19 outpatient areas were provided with 48 hours' notice of their Accreditation. The Outpatient Accreditations will be unannounced in 2019/20 in line with other clinical areas, with the exception of Manchester Local Care Organisation (MLCO), as detailed below.

7.4 In 2018/19 areas in the Manchester Local Care Organisation (MLCO) were provided with 48 hours' notice of their Accreditation to support the identification of shadowing opportunities with staff undertaking home visits. The MLCO Accreditations will continue to the provided with 48 hours' notice in 2019/20.

8. Recommendation

8.1 The Group Board of Directors is asked to note the content of the Annual Accreditation Report 2018/19 and the plans for the MFT Accreditation Programme for 2019/20, which commenced April 2019.

Illustration 4: MFT Excellence Award presentation

Appendix 1: Validated Results 2018/19

Manchester Royal Infirmary (MRI):

Division of Surgery	
Name	**2018/19 Validated Results**
Ward 1 & 2 (Previously ESTU)	22.01.19
Central Manchester Urology Unit (ETC)	04.09.18
ETC Day case + Surgical Admissions Lounge (SAL)	09.10.18
Head and Neck Surgical Unit	19.06.18
Main OPD including Fracture Clinic	05.02.19
Manchester Vascular Ward (MVC)	05.06.18
MRI Theatres	09.10.18
Peter Mount OPD	03.07.18
Ward 8	26.06.18
Ward 9 & 10	22.01.19
Ward 11 & 12	17.07.18
Division of Specialist Medicine	
Name	**2018/19 Validated Result**
Acute Cardiac Centre (ACC - Ward 35)	31.07.18
Acute Kidney Unit (Ward 37a)	28.08.18
Altrincham Renal Dialysis Unit	17.07.18
AM3	17.07.18
AM4	19.06.18
Diabetes OPD	29.01.19
Haematology Daycase	07.08.18

Manchester Heart Centre OPD	03.07.18
MRI Renal Dialysis Unit	30.10.18
NMGH Renal Dialysis Unit	05.02.19
Rheumatology OPD	31.07.18
Tameside Renal Dialysis Unit	18.01.19
Ward 3	26.06.18
Ward 4	21.08.18
Ward 36	23.10.18
Ward 37	15.01.19
Ward 44	23.10.18
Division of Acute Medicine	
Name	**2018/19 Validated Result**
AM1	03.07.18
AM2	18.12.18
Ambulatory Care Unit (ACU previously OMU)	08.01.19
AMU	30.10.18
Ward 6	08.01.19
Ward 30 (previously Ward 15)	04.12.18
Ward 31	07.08.18
Ward 32	30.10.18
Ward 45	09.10.18
Ward 46	09.10.18
Manchester Ward	11.12.18
MRI Emergency Department	28.08.18

Clinical and Scientific Services (CSS):

Clinical & Scientific Services Managed Clinical Service	
Name	**2018/19 Validated Result**
Acute Intensive Care Unit (AICU) (based Wythenshawe Hospital)	**08.01.19**
Cardiac Intensive Care Unit (CICU previously CSITU)(based MRI)	**23.10.18**
Cardiothoracic Critical Care Unit (CTCCU)(based Wythenshawe Hospital)	**13.11.18**
Intensive Care Unit (ICU)(based MRI)	**19.06.18**
High Dependency Unit (HDU)(based MRI)	**03.07.18**
High Care Unit (HCU TGH)(based Trafford Hospital)	**11.12.18**
Radiology Intervention Unit (RADU)	**11.12.18**

Research and Innovation (R&I):

Research & Innovation	
Name	**2018/19 Validated Result**
Adults Clinical Research	**27.11.2018**
Children's Clinical Research	**18.09.2018**

Manchester Royal Eye Hospital (MREH) and University Dental Hospital of Manchester (UDHM):

Manchester Royal Eye Hospital	
Name	**2018/19 Validated Result**
Ward 55	**05.06.18**
Day Case Unit (Eye J)	**12.06.18**
MREH Theatres and Dental Sedation Unit	**03.07.18**
Emergency Eye Department	**10.07.18**

MREH OPD	27.11.18
Macular Treatment Centre (MTC Central)	05.02.19
University Dental Hospital of Manchester	
Name	2018/19 Validated Result
Dental OPD	01.03.19

St Mary's Hospital (SMH):

Saint Mary's Hospital	
Name	2018/19 Validated Result
Ward 47a (MLU)	12.06.18
Ward 47b (MLU)	07.08.18
Ward 62	04.12.18
Ward 63 EGU	07.08.18
Ward 64 (CDU and Triage)	20.11.18
Ward 65	14.08.18
Ward 66	01.02.19
Ward 68 - Neonatal Intensive Care Unit (NICU) (Based at St Marys Hospital)	14.08.18
Antenatal OPD	06.11.18
Enhanced Recovery Programme (ERP)	04.12.18
SMH Gynaecology OPD	14.08.18
Reproductive Treatment Centre (Ward 90)	12.02.19
SMH Theatres	26.02.19
Birth Centre (Based at Wythenshawe Hospital)	20.11.18
Ward C2	06.11.18

Ward C3	18.09.18
Delivery Suite (Based at Wythenshawe)	18.01.19
Ward F16	20.11.18
Neonates (NNU) (Based at Wythenshawe Hospital)	06.11.18

Royal Manchester Children's Hospital:

Royal Manchester Children's Hospital	
Name	**2018/19 Validated Result**
Starlight Inpatients (based at Wythenshawe Hospital)	19.2.2019
BMTU and Stem Cell Unit (Ward 84a & 84c)	18.12.18
Children's Resource Centre (based at TGH)	01.02.19
Galaxy House	11.12.18
Haematology Daycase (Ward 84b)	05.02.19
RMCH ED	18.12.18
RMCH OPD	31.07.18
RMCH Theatres	14.08.18
Ward 75	12.02.19
Ward 76 (Short Stay/Day Case)	27.11.18
Ward 77	12.02.19
Ward 78	17.07.18
Ward 80 (Paediatric Intensive Care Unit)	08.01.19
Ward 81 (Burns Unit)	15.01.19
Ward 82 (Paediatric High Dependency Unit)	05.06.18
Ward 83 (TCU)	05.02.19

Ward 84 (Inpatients)	**09.10.18**
Ward 85	**07.08.18**

Wythenshawe, Trafford, Withington and Altrincham Hospitals (WTWA):

WTWA	
Wythenshawe Hospital	
Medicine	
Name	**2018/19 Validated Result**
Acute Medical Unit (AMU)	**23.10.18**
Clinical Decision Unit (CDU)	**12.02.19**
F4 North	**29.01.19**
F4 South	**17.12.18**
F7 North	**18.12.18**
F7 South	**11.09.18**
Ward A9	**21.08.18**
Ward F12	**18.01.19**
Ward F14	**14.09.18**
Ward F15	**22.01.19**
OPAL House	**06.11.18**
Wythenshawe ED	**23.10.18**
Heart and Lung	
Name	**2018/19 Validated Result**
Acute Coronary Care unit (ACCU)	**17.12.18**
Doyle Ward	**21.08.18**

Jim Quick Ward	**04.01.19**
North West Ventilation Unit (NWVU)	**05.09.18**
Pearce Ward	**26.02.19**
Ward A7	**07.08.18**
Ward F11: Planned Investigation and Treatment Unit (PITU)	**14.08.18**
Ward F2 Lung Surgery	**17.12.18**
Pulmonary Oncology Unit (POU)	**20.11.18**
Ward F5 + F2 Day Case	**11.12.18**
Ward F6	**04.09.18**
Wilson Ward	**31.07.18**
Surgery	
Name	**2018/19 Validated Result**
Acute Theatres (A Block)	**13.11.18**
Burns Unit	**29.01.19**
Theatres (F Block)	**11.02.19**
Treatment and Diagnostic Centre (TDC)	**15.01.19**
Ward A1 - Vascular	**13.11.18**
Ward A2	**08.01.19**
Ward A3 - Orthopaedics	**06.11.18**
Ward A4	**25.09.18**
Ward A5	**31.07.18**
Ward A6	**30.10.18**
Ward F1	**19.02.19**
Ward F3 - Urology	**30.10.18**

Ward F9	**11.09.18**
Trafford General Hospital	
Name	**2018/19 Validated Result**
Ward 2	**03.07.18**
Ward 3 INRU	**17.7.18**
Ward 4	**30.10.18**
Ward 6	**06.06.18**
Ward 11 (Previously Ward 1 Stroke)	**31.07.18**
Ward 12 MOC and DC	**23.10.18**
Altrincham Minor Injuries Unit	**29.01.19**
Altrincham OPD & MREH OPD	**11.12.18**
Acute Medical Unit (AMU TGH)	**10.07.18**
Medical Day Unit TGH	**01.02.19**
Trafford OPD	**18.09.18**
Trafford Theatres	**21.08.18**
Trafford Urgent Care	**27.11.18**

Manchester Local Care Organisation (MLCO):

Manchester Local Care Organisation	
Name	**2018/19 Validated Result**
District Nursing Service - Patch 1	**07.02.19**
District Nursing Service - Patch 2	**22.01.19**
District Nursing Service - Patch 3	**15.01.19**
District Nursing Service - Patch 4	**22.01.19**
Gorton & Levenshulme District Nursing Team	**17.12.18**

Stancliffe Road & Forum Health Visiting Team	**29.01.19**
Chorlton, Fallowfield and Whalley Range Community Services	**22.01.19**
School Nursing Team North	**29.01.19**
Dermot Murphy House	**04.01.19**
Buccleugh Lodge	**25.09.18**

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Peter Blythin, Group Executive Director of Workforce & Corporate Business
Paper prepared by:	Alwyn Hughes, Director of Corporate Services / Trust Secretary
Date of paper:	May 2019
Subject:	NHSI FT Self-Certification Requirements (2019)
Purpose of Report:	Indicate which by ✓ • Information to Note ✓ • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration of Risk against Key Priorities:	Failure to meet the range of conditions of the NHS Provider Licence for a licensed provider can lead to NHSI (Monitor) imposing compliance and restoration requirements or monetary penalties. Ultimately, it could lead to revocation of a provider's licence. The greatest damage is most likely to be to reputation, and the impact that has on patient choice and stakeholders' confidence in MFT as a provider of NHS services.
Recommendations:	The Board of Directors is asked to approve NHSI (Monitor) FT Self-Certifications for Condition G6(3), G6(4) & CoS7(3) and note progress with Self-Certificate FT4(8)
Contact:	Name: Alwyn Hughes, Director of Corporate Services / Trust Secretary Tel: 0161 276 6262

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

1. Background

On 1st April 2013, Monitor's healthcare licensing regime was implemented for all NHS Foundation Trusts (The Health and Social Care Act 2012). It replaced the Terms of Authorisation for Foundation Trusts and is the main tool NHSI (Monitor) uses for regulating providers of NHS services.

All NHS Foundation Trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence, have the required resources available if providing commissioner requested services, and, have complied with governance requirements.

The Manchester University NHS Foundation Trust has an NHS Provider Licence (**No. 130164**) and in the past, the previous Legacy FTs (UHSM & CMFT) were required to submit six self-certifications, on an annual basis, to meet NHSI's (Monitor) Provider License conditions for NHS services, along with a declaration of risks against healthcare targets and indicators. However, this year (2019), similar to last two years, the guidance issued by NHSI on March 2019 (Updated) requires NHS Providers to self-certify only the following three Licence Conditions after the financial year-end:

- The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution - **Condition G6(3)** & **Condition G6(4)**
- The provider has complied with required governance arrangements - **Condition FT4(8)**
- If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service - **Condition CoS7(3)**

2. NHSI Foundation Trusts Self-Certification

2.1 Self-Certification - Condition G6(3) & Condition G6(4)

Not later than two months from the end of the Financial Year (by 31st May 2019), the MFT Board of Directors ('the Licensee') is required to self-certificate to the effect that it "Confirms" or "Does not confirm" that it had well established and effective processes and systems to identify risks and guard against their occurrence in 2018/19, and, that these are still in place and their implementation and effectiveness is regularly reviewed going forward.

Recommendation: Based on the evidence highlighted in Appendix A, it is recommended to the Board that the 'Condition G6(3)' Self-Certification is formally signed-off as **"Confirmed".**

Recommendation: In keeping with the requirements of Condition G6(4), the Trust will publish its self-certification - **Condition G6(3)** - by 30th June 2019

2.2 Self-Certification - Condition FT4(8)

The Board of Directors is required to self-certificate "Confirmed" or "Not confirmed" (by 30th June 2019) to a number of governance-related statements (see Appendix B for summary of statement requirements) and set-out any risks and mitigating actions planned for each one within the NHSI self-declaration template. The Board has already received an electronic copy of the *draft* summary set of evidence to support this 'Condition FT4' Self-Certification with the aim of identifying any risks with compliance and any action taken, or, being taken to maintain future compliance.

Recommendation: The Board is recommended to review and comment (via the Board Secretary) on the draft governance statements during May and early June 2019.

Recommendation: The Board is recommended to delegate authority for 'sign-off' of the Self-Certification for 'Condition FT4(8)' to the Group Chairman & Group Chief Executive in order to meet the self-certification deadline of 30th June 2019; which is prior to the next Board of Directors meeting on 8th July 2019.

2.3 Self-Certification - Condition CoS7(3)

Not later than two months from the end of the Financial Year (by 31st May 2019), the MFT Board of Directors ('the Licensee') is required to self-certificate to the effect that it "Confirms" one of the following three declarations about the resources required to provide 'Commissioner Requested Services' (CRS):

A. After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account of distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate;

B. After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below (Appendix C)**, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors** (as described in Appendix C) **which may cast doubt on the ability of the Licensee to provide Commissioner requested Services;**

C. In the opinion of the Directors of the Licensee, the Licensee will not have the required Resources available to it for the period of 12 months referred to in this certificate.

(Footnote: Providers do not need to state the other two are not confirmed)

Recommendation: Based on the statement of main factors taken into account in Appendix C, it is recommended to the Board that **Declaration B** within the Condition CoS7(3) Self-Certification is formally signed-off as **"Confirmed".**

APPENDIX A

Self-Certification Condition G6(3) – MFT Supporting Evidence of Compliance

- The Board and supporting Committees (Audit Committee, Quality & Performance Scrutiny Committee, Human Resources Scrutiny Committee, Finance Scrutiny Committee, MLCO Scrutiny Committee and the Group Risk Management Committee) receive regular reports and supporting data analysis covering patient safety, clinical quality, patient experience, workforce, performance and finance.

  Examples include: Board Assurance Reports; Internal & External Audit Reports; Clinical Audit Reports; Patient Surveys; Staff Surveys; CQC Inspection Reports; Board Assurance Framework (BAF); Royal College Accreditation; H&S Executive Inspection Reports; Internal Quality Review Reports (and FU); Senior Leaderships Walk-rounds; Ward / Department Accreditation; Clinical Pathology Accreditation; E&D Reports; General Medical Council Reports, and, Governor Hospital/MCS Visits Programme Feedback

- A programme of Board Seminars and Group Management Board Development Sessions provide an opportunity for 'deep dives' into specific topics/themes and these are identified through the governance structure, the BAF, the Group Risk Register and the Accountability Oversight Framework (AOF).

- The Group Risk Management Committee (GRMC) is informed by the Governance structure as a whole and ensures that high level risks are overseen by the Board of Directors. The Committee is Chaired by the Group CEO, attended by the Group Executive Director Team, Hospital/MCS CEO's and open to all Group Non-Executive Directors. The Committee reviews the management of risk as detailed below:

  - New risks at level ≥15 – single report detailing management and oversight arrangements
  - Group wide risks
  - Risks escalated for review/support by Hospitals/MCS where further mitigation is outside of the control of the Hospital/MCS (for example a national tariff issue)
  - Level ≥15 risks in Hospital/MCS with an AOF score of 6
  - The GRMC may also identify risks that require more detailed scrutiny arising from the Group Board Assurance Report, Group Board Assurance Framework, regulatory issues, national reports, patient/service user feedback and public interest issues

  The risk registers from the legacy organisations have been reviewed and brought together.

- The Trust's Single Operating Model is underpinned by the AOF which contributes to the overarching Board Governance Framework enabling the Group Board of Directors to fulfil its obligations and effectively run the organisation. The AOF is one of the key enabling processes to support the delivery of the MFT vision, strategic objectives, and operational plan, and incorporates the key elements below:

  - Fosters a culture of devolved decision making and accountability.
  - Sets out how the Group Board of Directors and Hospitals/MCS/LCO will interact.
  - The framework supports the principle of earned autonomy in high performing Hospitals/MCS/LCO and the support provided to challenged sites.
  - An annual performance agreement process will formally capture the contribution of each Hospital/MCS to Group corporate objectives and targets for the year.
  - The framework operates a process of performance review, led by the Group Executive Team, which assesses the performance and risk of each Hospital/ MCS in delivering its plans and objectives and meeting agreed KPIs.
  - Enables the corporate functions to identify potential support needs, by theme, as they emerge, allowing tailored support packages to the specific needs of each Hospital/ MCS, and drawing on expertise from across the corporate functions.

APPENDIX A (continued)

Self-Certification Condition G6(3) – MFT Supporting Evidence of Compliance

- The Trust AOF process incorporates 6 domains: Safety, Patient Experience, Operational Excellence, Finance, Workforce & Leadership, and, Strategy. The process provides a holistic and transparent process for the monitoring of Hospital/MCS performance, all domains are equally weighted with the exception of 'Safety' which is the override for monthly Hospital/MCS AOF scores

- To support the AOF, monthly cycle a performance dashboard for each Hospital/MCS has been developed which captures in one place the overarching Hospital/MCS AOF score, individual domain scores and performance against the KPIs which form each domain. All domains are equally weighted with the exception of safety which is the override for monthly Hospital/MCS AOF scores.

- The Trust has an agreed document 'Responding to Recommendations and, Requirements of External Agency Visits, Inspections and Accreditation Policy' (October 2017). The policy sets out the processes to ensure that all recommendations made by external agency visits, inspections and accreditations are implemented within a specific time scale, that they are monitored following their implementation, and that there is a formal reporting and review process and that the Group Board of Directors are assured of the outcome.

- The Trust has an established Quality Review process in place since 2013/14 in response to the recommendations set out by the Francis, Keogh and Berwick reports earlier the same year (2013). Internal reviews are informed by extensive data packs which pull together key indicators reflecting the quality of care across each Hospital/MCS.

- The Trust has a well-established Improving Quality Programme (IQP) and Accreditation process in place which examines performance across four domains; leadership and culture of continuous improvement, environment of care, communication about and with patients and nursing processes: including medication management and the meals service. Findings are mapped against agreed criteria for each standard and clinical areas are scored as white, bronze, silver or gold. The Trust is in the process of defining a further level of award for areas that consistently achieve a Gold rating. Patient experience survey data and quality of care data is used along with Accreditation outcomes to drive continuous improvement. The Board of Directors receives regular reports on accreditation outcomes and receive an Annual Accreditation Report.

- The Trust has in place a staffing escalation process to ensure the appropriate deployment of nursing and midwifery staff to support the needs of patient groups. An electronic e-rostering system is used to ensure that the planning and management of nursing and midwifery staffing across the Trust is effective and safe.

- Governors hold Group Non-Executive Directors (individually and collectively) to account for the performance of our Board of Directors by ensuring that they act so that MFT does not breach the terms of authorisation. Governors receive details of meetings, agendas and approved minutes of each Board of Directors' Meeting. A private session between the MFT Governors and the full Board of Directors is held immediately following each bi-monthly Public Meeting of the Board of Directors (bi-monthly). The aim of this regular session is to enable Governors to discuss with the full Board issues raised during the Public Meeting and/or any other issue(s) which may require further feedback, clarification, consideration and dialogue. In early 2018, regular Governor/NED Networking Sessions have been introduced on the same day as the Council of Governors meetings. Also, monthly Chairman Surgeries are held with Governors (with NEDs in attendance). Governors monitor the performance of MFT via the main Council of Governors meetings, quarterly Performance Review Meetings to ensure high standards are maintained along with three (x3) Governor Groups which are due to commence in Q1 (2018/19) focused on Patient Experience, Staff Experience, and, Membership & Engagement.

APPENDIX B

Self-Certification Condition FT4(8) - Corporate Governance Statement Requirements

1. The Board is satisfied that Manchester University NHS Foundation Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

2. The Board has regard to such guidance on good corporate governance as may be issued by NHSI (Monitor) from time to time

3. The Board is satisfied that Manchester University NHS Foundation Trust implements:

a) Effective board and committee structures;
b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
c) Clear reporting lines and accountabilities throughout its organisation.

4. The Board is satisfied that Manchester University NHS Foundation Trust effectively implements systems and/or processes:

a) to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively;
b) for timely and effective scrutiny and oversight by the Board of the Licence holder's operations;
c) to ensure compliance with health care standards binding on the Licence holder including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions.
d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licence holder's ability to continue as a going concern);
e) to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
f) to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
h) to ensure compliance with all applicable legal requirements.

5. The Board is satisfied that the systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:

a) that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
b) that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations
c) the collection of accurate, comprehensive, timely and up to date information on quality of care;
d) that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
e) that Manchester University NHS Foundation Trust including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
f) that there is clear accountability for quality of care throughout Manchester University NHS Foundation Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to Board where appropriate.

6. The Board of Manchester University NHS Foundation Trust is satisfied that there are systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

Training of Governors

The Board is satisfied that during the financial year most recently ended, the Trust has provided, and continues to develop the necessary training to its new Governors as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

APPENDIX C

Self-Certification Condition CoS7(3) - Commissioner Requested Services (CRS) Requirements

CRS Definition: *Services that will be subject to regulation by NHSI (Monitor) in the course of a licensee's operations; and, Location Specific Services, which is a subset of CRS that, in the event of a provider failure, must be identified and kept in operation at that specific locality*.

- The current designation of MFT services as CRS continues to be a 'default' position (i.e. automatic full designation, across all services). Commissioners have again postponed a full and recurrent review of MFT services to make a proper and considered CRS designation.

- In effect, the current CRS designation remains inherited from the position in April 2013, when CRS principles were first established. At that point in time, the FT licence saw all NHS-funded services "grandfathered" into CRS status (pending service-line review) until 31st March 2016.

- In March 2016, the Manchester CCGs decided to extend that position through until at least October 2017. Since then (again in October 2017 through to March 2019, and now in April 2019 with effect for 2019/20) Manchester CCG has formally written to further extend this in light of the MFT merger, ongong SHS and LCO developments. Given this it would not be meaningful for MFT in isolation to undertake self-certification work across all services

- It remains the CCG's ultimate intention to work with MFT and the wider Manchester Health and Care Commissioning (MHCC) partnership to identify a revised list of CRS designated services. In the meantime, the CCG's view is that the current default designation provides stability and protection for services even though Commissioners remain able to re-procure or transfer services as has been the case for time to time during the period since April 2013 (e.g. outpatient Dermatology by CCGs, ACHD by NHS England).

- Given this position, MFT is unable to fully self-certify, across all services provided, that Option **A** or Option **C** are definitive.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Peter Blythin, Group Executive Director of Workforce and Corporate Business
Paper prepared by:	Alwyn Hughes, Trust Board Secretary
Date of paper:	April 2019
Subject:	MFT Board of Directors' Register of Interests (April 2019)
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration of Risk against Key Priorities	The MFT *'Constitution'* and *'Standing Orders for the Practice & Procedure of the Board of Directors'* requires the Board of Directors to provide a Register of Interests.
Recommendations	The Board is asked to note the MFT Board of Directors' Register of Interests (April 2019)
Contact	Name: Alwyn Hughes (Trust Board Secretary) Tel: 0161 276 4841

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS

Board of Directors' Register of Interests

APRIL 2019

1. Introduction

The Board of Directors, in line with the MFT constitution and standing orders, is required to make a declaration of its register of interests.

The register has to include details of all directorships and other relevant and material interests which have been declared by both Executive and Non-Executive members.

The Register is available to the public.

2. Recommendation

The Board is asked to note the MFT Board of Directors' Register of Interests (April 2019).

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS

REGISTER OF DIRECTORS' INTERESTS

(April 2019)

BOARD OF DIRECTORS

REGISTER OF INTERESTS – April 2019

NAME	POSITION	INTERESTS DECLARED
Kathy Cowell OBE DL	Group Chairman	• Vice Chair Cheshire Young Carers • Deputy Lieutenant for Cheshire • Chairman of Totally Local Company (formally known as Solution SK Stockport) (3 year term) • Member Manchester Academic Health Science Centre • Chairman of the Hammond School (Chester) • Chairman of 'Some Women Coach' (Sub Committee Pankhurt Trust) • Ambassador for Active Cheshire • Member of the QVA's mentoring panel (Cheshire) • Member of Aspirant Chairs Programme (NHSI) • Chairman Wythenshawe Health Academy • Chair of the Manchester Health Academy Trust Board
Barry Clare	Group Deputy Chairman	• Partner (Clarat Partners LLP) • Partner (Clarat Healthcare LLP) • Chairman (Vantage Diagnostics Ltd) • Non-Executive Director (Ingenion Medical Ltd) • Chairman (Crescent OPS Ltd) • Non-Executive Director (Walmark) • Non-Executive Director (Trimb Healthcare AB) • Chairman (FLOBACK Ltd) • Non-Executive Director Helperby Therapeutics LTD • Chairman Evgen Pharma PLC • Non-Executive chairman of Parton Biopharme Ltd

NAME	POSITION	INTERESTS DECLARED
Dr Ivan Benett	Group Non-Executive Director	• Standing member of a NICE Quality Standards Committee and Topic Specific Guideline Update Committee • Member of the Primary Care Cardiology Society • Salaried GP with Heart Network (Manchester)
John Amaechi OBE	Group Non-Executive Director	• Managing Director, Amaechi Performance Systems (APS Ltd, London • Non-Executive Director, KPMG UK LLP Inclusive Leadership Board (ILB) • Senior Fellow, Applied Centre for Emotional Literacy, Learning and Research (ACELLR), USA • Professional Member, European Mentoring & Coaching Council • Member, BPS Division of Occupational Psychology • Member, BPS Psychological Testing Centre (PTS) • Research Fellow, University of East London • Trustee, Duke of Edinburgh Award • Fellow, Royal Society for Public Health
Professor Dame Susan Bailey OBE DBE	Group Non-Executive Director	• Senior Clinical Advisor for Mental Health to Health Education England • External Advisor to Minister for Health and Social Care, Review of CAMHS in Wales – Together for Children • NED – Department of Health & Social Care – PSED NED Champion • Chair of the Children and Young People's Mental Health Coalition • Chair of Choosing Wisely Campaign – Academy of Medical Royal Colleges • Incoming Chair of Centre for Mental Health [from November 2018] • Member of the Bevan Commission • Council Member of Salford University

NAME	POSITION	INTERESTS DECLARED
Professor Luke Georghiou	Group Non-Executive Director	• Deputy President and Deputy Vice-Chancellor, University of Manchester • Non-Executive Director of Manchester Science Partnerships Ltd • Non-Executive Director of UMI3 • Member of Innovation Platform advisory group to Universities and Science Minister Sam Gyimah • Member of RISE Advisory Group to European Commissioner Carlos Moedas • Chair of Steering Group of European Universities Association Council for Doctoral Education
Nic Gower	Group Non-Executive Director	• Director Furness Building Society [NED] • Director Seashell Trust • Governor Royal School Manchester
Chris McLoughlin	Group Non-Executive Director	• Director of Children's Services, Children's Safeguarding and Prevention, Stockport Metropolitan Borough council • Member of Association of Director of Children's Services Ltd • Chair of Greater Manchester Social Work Academy Board • Member of Greater Manchester Mental Health Partnership • Member of Greater Manchester Start Well Executive • Chair of Greater Manchester CAMHS Steering Group • Member of Greater Manchester Children and Young People Health and Wellbeing Board
Trevor Rees	Group Non-Executive Director	• Treasurer/Trustee (Manchester Literary and Philosophical Society) • Independent Co-opted member (Audit Committee at University of Manchester (not a Board Member)

BOARD OF DIRECTORS

REGISTER OF INTERESTS – April 2019

NAME	POSITION	INTERESTS DECLARED
Sir Mike Deegan CBE	Group Chief Executive	Board Member, The Corridor, Manchester Board Member, Manchester Academic Health Science Centre
Darren Banks	Group Executive Director of Strategy	Nominated Director for Manchester LCO Partnership Board Spouse - Head of Finance, Specialist Commissioning North of England (NHSE)
Peter Blythin	Group Executive Director of HR & Corporate Business	No interests to declare
Julia Bridgewater	Group Chief Operating Officer	Foundation Director of Multi Academy, All Saints Catholic Collegiate
Professor Jane Eddleston	Joint Group Medical Director	Chair of Adult Critical Care CRG [NHSE] Clinical lead for Healthier Together Programme [GM Theme 3]
Gill Heaton OBE	Group Deputy Chief Executive	Chair of the Manchester LCO Partnership Board
Professor Cheryl Lenney	Group Chief Nurse	Spouse – Director of Workforce & Organisational Development, Manchester Local Care Organisation
Miss Toli Onon	Joint Group Medical Director	No interests to declare
Adrian Roberts	Group Chief Finance Officer	No interests to declare

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Peter Blythin, Group Executive Director of Workforce & Corporate Business
Paper prepared by:	Alwyn Hughes, Trust Board Secretary
Date of paper:	May 2019
Subject:	Board Assurance Framework (April 2019)
Purpose of Report:	Indicate which by ✓ • Information to note • Support • Accept ✓ • Resolution • Approval • Ratify
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 is asked to accept the new BAF (April 2019) aligned to the MFT Strategic Aims and Key Objectives for 2019/20
Contact:	Name: Alwyn Hughes, Trust Board Secretary Tel: 0161 276 4841

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

THE BOARD ASSURANCE FRAMEWORK (April 2019)

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 corporate Executive committees, 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 (see **APPENDIX A**) is received and noted at least twice a year by the full Board of Directors and Trust Audit Committee.

2. MFT Strategic Aims

Key Priorities & Risks associated with the following Strategic Aims will be regularly reviewed at MFT Board Scrutiny Committees and the Group Audit Committee:

- *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

The new 2019/20 BAF has now been further developed and refined following a developmental review of Leadership & Governance arrangements using the 'Well Led' framework during the Summer 2018, an Internal Audit review of the BAF in October 2018 followed by key recommendations from a Task & Finish Group (consisting of Group Non-Executive Directors and Group Corporate Directors) during Q3 and early Q4 2018/19.

The refinements now included in the new 2019/20 BAF were presented to, and, approved by the Audit Committee in February 2019 and ratified by the Board of Directors in March 2019.

4. Recommendation

The Board of Directors is asked to accept the new BAF (April 2019) aligned to the MFT Strategic Aims and Key Objectives for 2019/20

APPENDIX A

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

THE BOARD ASSURANCE FRAMEWORK

(April 2019)

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 several key elements:

- **An inherent risk rating (Impact / Likelihood)** - Without Controls
- **Clearly defined Strategic Aims for 2019/20** -
- **Clearly defined principal risks to the Strategic Aims** - What is the cause of the risk?
- **Risk Consequences** - What might happen if the risk materialises?
- **Key existing controls** - What controls/systems are currently in place to mitigate the risk?
- **Gaps in controls** - What Controls should be in place to manage the risk but are not?
- **Assurance that risks are being reasonably managed** - What evidence can be used to show that controls are effectively in place to mitigate the risk?
- **Gaps in assurance** - What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?
- **Current risk rating (Impact / Likelihood)** - With Controls
- **Actions required** - Additional actions required to bridge gaps in 'Controls' & 'Assurance'
- **Progress** -
- **Target risk rating (Impact / Likelihood)** - Based on successful impact of Controls to mitigate the risk

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 with minimal disruption whilst ensuring that planned benefits are realised in a timely manner**	**Linked also to Group Risk Management Committee (GRMC) Risk(s) Reference Number(s):** MFT758; MFT764; MFT766; MFT760; MFT761; MFT763; MFT767

PRINCIPAL RISK (What is the cause of the risk?):

There is a risk that MFT may not be able to access sufficient resources to address the finance, clinical, estates and IM&T issues identified at NMGH through the finance counterfactual and due diligence processes.

Enabling Strategy: SINGLE HOSPITAL SERVICE

Group Executive Lead: EXECUTIVE DIRECTOR OF WORKFORCE AND CORPORATE BUSINESS

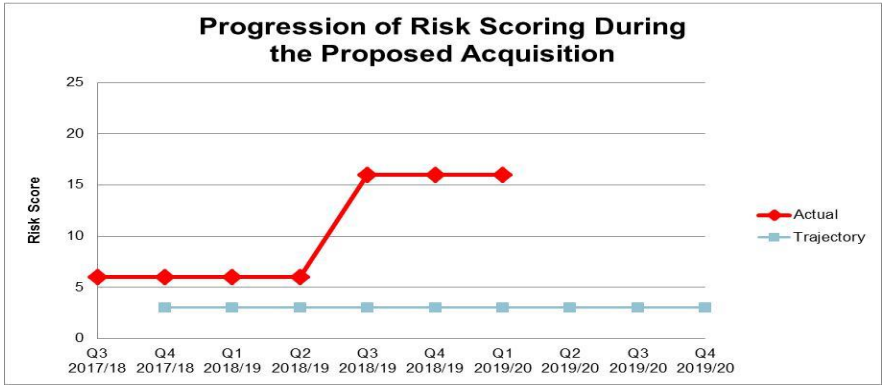
RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Negative and potentially destabilising impact on MFT.**
2. **Inability to deliver services at NMGH to the standard MFT would expect..**
3. **If funding is not secured other options would need to be considered by NHSI /E and Commissioners for delivering care at NMGH.**
4. **Existing difficulties with staff recruitment and retention compounding due to uncertainty about the transaction prompting further de-stabilisation of NMGH.**
5. **If service delivery at NMGH is compromised by uncertainty about the transaction, unplanned shifts in clinical activity to MFT might occur.**

Associated Committees:
MFT TRANSACTION MANAGEMENT GROUP
GROUP MANAGEMENT BOARD
BOARD OF DIRECTORS

Operational Lead: DEPUTY DIRECTOR, SHS PROGRAMME

Material Additional Supporting Commentary (as required):



Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*		ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
25 (5x5)	A.1 Senior level discussions with NHSE/ I and local commissioners on access to financial support. A.2 Further Due Diligence work commissioned on IM&T to understand the extent of the IM&T risk and identify future options. A.3 Further Due Diligence work being commissioned on Estates and Facilities to add to MFT's understanding of the risks associated with the NMGH site. A.4 Further Due Diligence work to be commissioned to develop understanding of PAHT's revenue position. A.5 Inclusion of caveats to Strategic Case on submission to NHS I to protect the interests of MFT. A.6 Regular briefings at NMGH and MFT staff engagement sessions. A.7 Complying with NHS I review of Strategic Case.	B.1 The process for accessing resources is unclear in light of the merger of NHSE and NHSI and the associated consequences of such a significant national reorganisation. B.2 It is unknown whether MFT's requirements, notably capital, will be prioritised ahead of other NHS Trusts requiring significant investment. B.3 Funding to enable the transfer of NMGH to MFT may take time to secure and therefore could impact negatively on the proposed transaction completion date of April 2020. B.4 Information provided by the Pennine Data Room on finances, IM&T and clinical services may not be accurate or complete which will impact of the Due Diligence and disaggregation processes. B.5 Existing governance processes within GMH&SCP do not facilitate timely decision making processes.	C.1 NHSE/I agrees an acceptable financial plan within the necessary timeframe. C.2 The IM&T acquirer Due Diligence enables MFT to prioritise the process for stabilising NMGH IM&T services and integrating NMGH within existing MFT systems. C.3 The acquirer estates Due Diligence enables MFT to prioritise work to develop a safer site at NMGH as soon as possible. C.4 The acquirer Finance Due Diligence enables MFT to complete an LTFM which takes account of the NMGH financial position. C5. Development of a comprehensive Post-Acquisition Plan.	D.1 The financial plan is either unacceptable or not offered within the appropriate time frame. D.2 The information provided by the Pennine Data Room to support the IM&T Due Diligence is incomplete/inaccurate leading to a sub-optimal Due Diligence reports by the potential acquirers. D.3 The financial information provided by the Pennine Date Room is incomplete/inaccurate affecting MFT's ability to produce a robust LTFM.	20 (5x4)	A.1 Continue discussions with NHSE/NHSI and local Commissioners about a financial plan to enable the safe transfer of NMGH to MFT. B.4 Continue to work with the Pennine Data Room to ensure that data provided is quality assured by PAHT. B.1 Develop a plan to be able to respond to any changes to NHSE/I's plans for the future of PAHT. A.6 Continue to keep MFT staff briefed on current position with the transaction. A.7 Agreement and comply fully with the NHS I review processes.	CEO, Chief Finance Officer, Executive Director of HR and Corporate Business	April 2020	MFT Board of Directors	Discussions with NHSE/NHSI underway. Weekly calls with Pennine Data Room on quality and completeness of data. Co-operating with GM oversight arrangement. MFT Transaction Management Group in place. Due Diligence progressing as planned. NHSI review of Strategic case underway.	**9 (3x3)**

1	**Strategic Aim: To complete the creation of a Single Hospital Service for Manchester with minimal disruption whilst ensuring that planned benefits are realised in a timely manner**	**Linked also to Group Risk Management Committee (GRMC) Risk(s) Reference Number(s):** **MFT758; MFT764; MFT766; MFT760; MFT761; MFT763; MFT767**

PRINCIPAL RISK (What is the cause of the risk?):

There is a risk that the acquisition of North Manchester General Hospital (NMGH) could have a negative impact on the rest of MFT's services.

Enabling Strategy:

SINGLE HOSPITAL SERVICE

Group Executive Lead:

EXECUTIVE DIRECTOR OF WORKFORCE AND CORPORATE BUSINESS

RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Demands on senior leaders to deliver the transfer of NMGH to MFT could mean a reduced focus on MFT including PTIP delivery.**

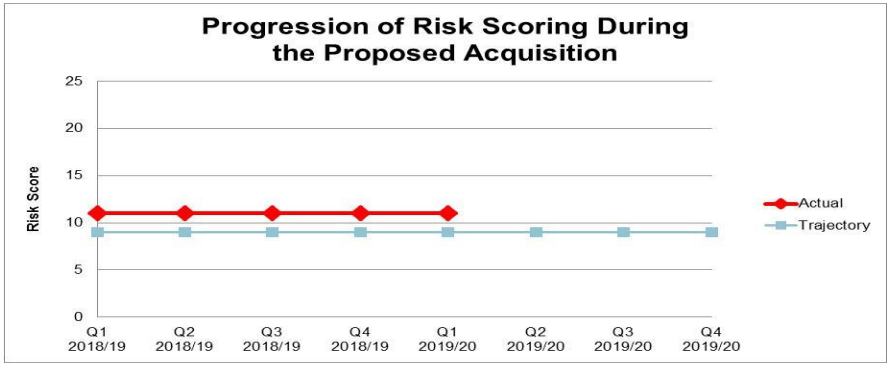
Associated Committee:

GROUP BOARD OF DIRECTORS

Operational Lead

DEPUTY DIRECTOR , SHS PROGRAMME

Material Additional Supporting Commentary (as required):



Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
12 (4x3)	A.1 Project funding secured through the Greater Manchester Transformation Fund (GMTF) to minimise demand on existing MFT resources during the transaction. A.2 Experienced team of managers appointed to the SHS Team to project manage the transaction and provide targeted support to core MFT teams. A.3 Regular dialogue maintained between senior MFT and Northern Care Alliance Executive Directors/Senior Managers to discuss key issues relating to NMGH. A.4 Clearly defined clinical and corporate disaggregation processes being implemented to enable senior MFT staff to understand the services being acquired through the transaction. A.5 Post Transaction Operational Group (PTOG) established jointly with SRFT to ensure MFT COO is aware of current and forthcoming operational changes affecting the NMGH site. A.6 Strategic Case contains an outline plan for managing NMGH. A.7 Integration Steering Group provides for integration activity. A.8 MFT Transaction Management Group oversees delivery of the Programme.	B.1 It is not known whether an appropriate financial plan to enable the transfer of NMGH to MFT.	C.1 Reaching a settled financial position through agreement with NHSE/I and Commissioners. C.2 Secure GM Transformation Funding to enable the infrastructure required to deliver the transaction. C.3. MFT internal governance arrangements working effectively including the sustained input of the SHS Team to support core leadership teams.	D.1 An agreed financial plan is still not agreed.	**12 (4x3)**	A.8 Work of the MFT Transaction Management Group to continue alongside focussed discussion at EDT. A.1 Deliver metrics linked to the Manchester Investment.	Executive Director of HR and Corporate Business	April 2020	MFT Board of Directors	Staff engagement event at NMGH 10 April. Planned programme of meetings with MFT Corporate Directors and Senior Clinicians. Monthly meetings with NMGH Senior Leadership Team. North Manchester Strategy Board in place.	**9 (3x3)**

2	Strategic Aim: To improve patient safety, clinical quality and outcomes	Linked also to Group Risk Management Committee (GRMC) Risk(s) Reference Number(s): MFT001672; MFT001150; MFT000236; MFT001671; MFT002369; MFT000137

PRINCIPAL RISK (What is the cause of the risk?): If the Quality and Safety Strategy is not delivered then harm may occur to patients

Enabling Strategy: **QUALITY AND SAFETY STRATEGY**

Group Executive Lead: **JOINT GROUP MEDICAL DIRECTOR**

RISK CONSEQUENCES (What might happen if the risk materialises?):

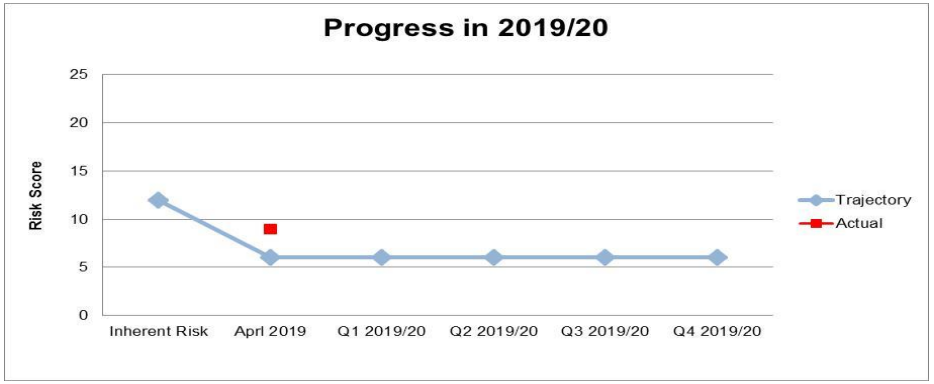
1. **Increase in serious harm to patients**
2. **Poor safety culture (including leadership) undermines Trust performance**
3. **Failure to eradicate 'Never Events'**
4. **Reputational damage because of safety concerns**
5. **Poor staff experience**
6. **Regulatory consequence**

Associated Committee: **QUALITY AND SAFETY COMMITTEE**

Operational Lead: **DIRECTOR OF CLINICAL GOVERNANCE**

Material Additional Supporting Commentary (as required):

The patient safety commentary detailed here covers all aspects of patient safety including but not limited to, clinical outcomes, infection control, clinical incidents (including never events), mortality review and harm free care.



Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
12 (3x4)	A.1 Freedom to Speak Up (F2SU) programme and personnel A.2 Quality and Safety Strategy and related policies A.3 Trust Governance structure – including Quality and Performance Scrutiny Committee, Infection Control Committee and other specialist groups A.4 AOF monitoring A.5 Patient Safety Training Programme – e.g. Infection Control, Human Factors and clinical mandatory training A.6 Root Cause Analysis (RCA) Training Programme A.7 Trust alert circulation process A.8 Trust incident investigation process – to include focussed investigations such as IPC and Falls A.9 Shelford Safety Leads forum for sharing learning	B.1 Policy controls weak B.2 F2SU not fully embedded B.3 Governance structure still in development B.4 PST Training not mandatory for all staff B.5 No capacity to deliver this to all staff B.6 No current evaluation of impact of PST or RCA training B.7 General Patient Safety training not included in mandatory training packages – including induction B.8 Lack of links with University and Training Schools on PST B.9 Currently no formal outputs from Shelford Forum B.10 Lack of patient involvement in investigation and feedback to staff B.11 Mechanistic circulation and response to alerts without follow up and audit programme B.12 Lack of Trust wide visible Patient Safety Champions B.13 Patient safety commitment not fully embedded into recruitment practice B. 14 Variation in compliance with clinical policies and guidelines	C.1 Trust incident reporting system data (incident information including harm level, frequency, type of incident and duty of candour information) C.2 Trust clinical and internal audit systems C.3 Staff survey C.4 Regulatory inspection processes C.5 Internal quality assurance processes (Ward accreditation, Quality Review) C.6 AOF and leading and lagging patient safety metrics reporting – including harm free care, infection control and never events	D.1 Incident reporting system may not capture all harm – can be a cumbersome process D.2 Staff survey indicates lack of feedback from incident reporting and investigation – may impact on reporting levels D.3 Staff survey does not adequately capture full understanding of patient safety culture D.4 Patient safety metrics not yet fully developed or reported on D.5 Actions following harm not always evaluated or reviewed D.6 Lack of full understanding of finance and performance cost of harm in relation to claims, lost bed days etc	**9 (3x3)**	D.2 Undertake Trust wide Patient Safety Culture Survey B.6 Define processes for on-going evaluation of safety culture C.5 Develop patient information leaflet on 'When things go wrong' B.4 Obtain accreditation for PST D.4 Develop an in-house Patient Safety Champion qualification – PST / RCA + Patient Safety Project D.5 Implement revised process following 'Never Event' to include a panel review similar to the Emergency Bleep Meeting concept – consider NED lead for this process D.3 Undertake Trust wide patient safety training needs analysis B.7 Build the requirements of this analysis into the mandatory training framework B.13 Include statement on commitment to patient safety in all Trust contracts D.2 Develop post-investigation feedback questionnaire for staff and patients D.4 Set clear aims in relation to reduction of harm aligned with NHS Patient Safety Strategy – Deterioration, Sepsis, NEWS, medication safety, IPC, maternity, falls pressure ulcers, nutrition and mental health C.1 Appoint Trust Compliance Officer to oversee alert circulation, response, review and follow-up B.3 Define CSG/CAC/CGC roles in standardisation of clinical practice	Medical Director's / Chief Nurse / Director SHS and Group Director of Workforce and Corporate Business	March 2020	Quality and Performance Scrutiny Committee	1. Trust Compliance Officer appointed	**6 (3x2)**

2	Strategic Aim: To improve patient safety, clinical quality and outcomes	Linked also to Group Risk Management Committee (GRMC) Risk(s) Reference Number(s): MFT001493; MFT 001701; MFT001708

PRINCIPAL RISK (What is the cause of the risk?):

Underachievement of National Standards for planned care could impact on clinical outcomes and patient experience.

Enabling Strategy:

QUALITY & SAFETY STRATEGY

TRANSFORMING CARE FOR THE FUTURE STRATEGY

Group Executive Lead:

GROUP CHIEF OPERATING OFFICER

RISK CONSEQUENCES (What might happen if the risk materialises?):

1. Increase risk of serious harm to patients
2. Poor patient experience
3. Risk to Hospital capacity, income plans
4. Reputational damage to Trust
5. Poor staff experience
6. Low system confidence

Associated Committee:

QUALITY & SAFETY COMMITTEE

OPERATIONS & TRANSFORMATION GROUP

Operational Lead:

HOSPITAL / MCS CHIEF EXECUTIVES

Material Additional Supporting Commentary (as required):

Indicator	Target Risk	Actual Score Dec 18	Actual Score Jan 19	Actual Score Feb 19	Actual Score March 19	Actual Score April 19
Cancer 62 day	12	16	16	16	16	16
18 weeks RTT	16	20	20	20	20	20
Diagnostic 6 week wait	12	16	16	16	16	16

Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
20 (5x4)	A.1 The Accountability Oversight Framework (AOF). A.2 Board Assurance Report. A.3 Reporting to Trust Committees A.4 Annual contracting round. A.5 Annual Capacity and Demand planning round. A.6 GM and Trust Access Policy. A.7 Trust Transformation Programme A.8 Hospital replication of AOF process, and supporting operational management and oversight structures A.9 Operational reporting readily available through the HIVE A.10 Escalation processes in place i.e. A&E, cancelled operations A.11 MFT Transformation programme which feeds into Hospital Transformation and Efficiency forums, with reporting of progress to OTOG and Quarterly updates to the Board of Directors. Tracking key metrics through the AOF process and Wave. A.12 Opportunity packs to support annual planning process identifying efficiencies against benchmarked peers for theatres, LoS, Outpatients.	B.1 Best practice pathways across multiple sites. B.2 limited standardisation of processes across MFT to support the patient access policy. B.3 Capacity shortfalls requiring reliance on private sector. B.4 Fit for purpose PAS B.5 Live validation and Data Quality Cleansing. B.6 Competency Based training for Administration and Clerical Staff. B.7 Interruption of diagnostic/ elective pathways during peak holiday periods. B.8 Critical care constraints impacting on activity. B.9 National Campaigns for cancer driving demand. B.9 Primary care demand management. B.10 Workforce availability, vacancies to deliver activity B.11 Ability to routinely measure adherence to and progress towards fully embedding SAFER, elective and outpatient standards as data is not automated. B.12 Different reporting systems and processes limit the ability to effectively utilise up to date benchmarking data and to identify consistent opportunities	C.1 Reporting to the Executive Board and Committees C.2 Monthly AOF outputs. C.3 Minutes/Papers from meetings underpinning the access standards i.e. Cancer Committee. C.4 Trust Capacity Board/ Hospital Activity plans. C.5 Internal/external audit of data quality. C.6 Risk register C.7 Monthly forecasting and planning for diagnostics. C.8 Quarterly transformational reports. C.9 Quarterly updates on progress against Hospital / MCS capacity plans. C.10 Getting It Right First Time Programme to focus on removing unwarranted variations in clinical practice C11. Clinical Standards Groups focus on ensuring patients receive high quality experience and outcomes, standardised across MFT locations	D.1 Trust ERS performance oversight, and training. D.2 GM Capacity and demand for risk specialities. D.3 NHSI best practice review of Cancer and RTT.	16 (4x4)	B2 - 5, 7, 9RTT Taskforce to remain in place throughout 2019/20 D.1 Optimisation of ERS in line with transparent capacity management. D.1, D2 Appoint Trust role responsible for corporate oversight of ERS performance, training, compliance. B.6 Introduce electronic competency training for A&C Staff booking, validating and managing waiting lists. B1, B9 Appoint dedicated project management to review and embed national cancer pathways. D.2 GM ongoing review of high risk/ high demand specialities. D.3 NHSI support to Cancer and RTT pathways	Julia Bridgewater	March 2020	Quality & Performance Scrutiny Committee	B2 - 5, 7, 9 Reduction of +52 week waits in 18/19 Implementation of PAS tactical solutionCommenced outpatient transformation work with ENT D.1-2 - Additional resource secured and recruitment process in progress. B.6 - Trust wide training in progress, awaiting agreed electronic competency in line with appraisal process. B1,B9 – Additional resource secured and recruitment in progress D.2 GM Four Eyes review completed, to be presented to Provider Federation Board. D.3 NHSI team met with Trust representatives in March and plan agreed A.12 Annual transformation plan developed for Board sign off in May.	12 (3x4)

2	**Strategic Aim:** To improve patient safety, clinical quality and outcomes	**Linked also to Group Risk Management Committee (GRMC) Risk(s) Reference Number(s):** MFT 001707; MFT000694; MFT000219

PRINCIPAL RISK (What is the cause of the risk?):
Underachievement of National Standards for A&E 4 hour waiting standard could impact on clinical outcomes and patient experience.

Enabling Strategy:
QUALITY & SAFETY STRATEGY
TRANSFORMING CARE FOR THE FUTURE STRATEGY

Group Executive Lead:
GROUP CHIEF OPERATING OFFICER

RISK CONSEQUENCES (What might happen if the risk materialises?):

1. Increase risk of serious harm to patients
2. Poor patient experience
3. Risk to Hospital capacity, income plans
4. Reputational damage to Trust
5. Poor staff experience
6. Low system confidence

Associated Committee:
QUALITY & SAFETY COMMITTEE
OPERATIONS & TRANSFORMATION GROUP

Operational Lead:
HOSPITAL / MCS CHIEF EXECUTIVES

Material Additional Supporting Commentary (as required):

Indicator	Target Risk	Actual Score Dec 18	Actual Score Jan 19	Actual Score Feb 19	Actual Score March 19	Actual Score April 19
A&E 4 hour Standard	12	20	20	20	20	20

Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
20 (5x4)	A.1 The Accountability Oversight Framework (AOF). A.2 Board Assurance Report. A.3 Reporting to Trust Committees A.4 Annual contracting round A.5 Annual Capacity and Demand planning round. A.6 Manchester Urgent Care and Transformation Board, supported by Operational Delivery Group. A.7 Daily SITREP Reporting A.8 Daily Executive Reporting – EDT. A.9 Patient Flow Boards at MRI, Wythenshawe. A.10 Stranded patient monitoring and escalation calls to the LCO A.11 Weekly Urgent Care meeting with COO/ Hospital Directors. A.12 GM Tableau system reporting – Escalation Status. A.13 Operational reporting readily available through the HIVE A.14 MFT Transformation programme which feeds into Hospital patient flow boards, with reporting of progress to OTOG and Quarterly updates to the Board of Directors. Tracking key metrics through the AOF process and Wave.	B.1 Workforce to match demand. B.2 Estate restrictions. B.3 Reliance on partners to mobilise capacity releasing schemes. B.4 Market forces limiting care home capacity. B.5 Out of Area assessments by Local Authority. B.6 Changes to external partners models of care delivery.	C.1 outputs from MRI / Wythenshawe improvement programmes and Patient Flow Boards. C.2 External support from ECIST Wythenshawe LOS/DTOC and MRI LOS/Discharge. C.3 Weekly External meetings with MLCO to manage stranded patients to agreed targets. C.4 Reporting to the Executive Board and Committees and AOF outputs. C.5 Minutes/Papers from meetings underpinning the urgent standards i.e. Urgent Care Board, Operational Delivery Group C.6 Weekly ED assurance meeting papers and actions. C.7 MRI/ PED estate plans managed through Estates and Facilities C.8 Ambulance Turnaround time C.9 Individual action plans and trajectories in place to support recovery of standards. C.10 Plans to support bank holiday periods. C.11 Quarterly transformational reports. C.12 Quarterly updates on progress against Hospital / MCS capacity plans. C13. Getting It Right First Time Programme to focus on removing unwarranted variations in clinical practice C.14. Clinical Standards Groups focus on ensuring patients receive high quality experience and outcomes, standardised across MFT location	D.1 Dedicated Major Trauma ward to expedite polytrauma patients out of A&E. D.2 Local Authority accepting local assessment. D.3 External surge demand management	20 (5x4)	**D**.1 Major Trauma ward with dedicated consultant rota. D.2 GM system wide policy agreement for internal social workers to assess out of area patients. B.1 Job planning and mutual aid between sites. C.5 Evaluation of steaming pilots at RMCH/ Wythenshawe with long term models agreed. D.3 Manchester Urgent Care Board action plan, aligned to the GM plan. D.3 MRI/Wythenshawe supporting GM deep Dive work in relation to identifying system opportunity for Same Day Emergency Care	Julia Bridgewater	March 2020	Quality & Performance Scrutiny Committee	D.1 Business Case in progress, case mix agreed. Ward to open in June at MRI. D.2 MFT Representatives contributed to workshops to develop system policy. B.1 Annual job planning round, focused work being undertaken at Wythenshawe. C.5 Planned for next ODG 01.05.19 D.3 MFT representatives support the Board with cascading of relevant actions through MFT operational structures. D.3 Meetings with NHS Elect to undertake a clinical audit arranged for June. A.14 Annual transformation plan developed for Board sign off in May.	**12 (3x4)**

2	**Strategic Aim: To improve patient safety, clinical quality and outcomes**	**Linked also to Group Risk Management Committee (GRMC) Risk(s) Reference Number(s): n/a**

PRINCIPAL RISK (What is the cause of the 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: **QUALITY & SAFETY STRATEGY**

Group Executive Lead: **GROUP CHIEF NURSE**

RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Adults and children at risk of abuse or neglect may come to harm**
2. **Failure to comply with statutory and regulatory safeguarding standards**

Associated Committee: **SAFEGUARDING COMMITTEE**

Operational Lead: **DEPUTY CHIEF NURSE**

Material Additional Supporting Commentary (as required):

Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
15 (5x3)	A1. Safeguarding Governance Structures in place. A2. Safeguarding policies and procedures. A3. Trust Safeguarding Teams actively support staff. A4.Directors of Nursing/Midwifery/Healthcare Professionals accountable for safeguarding within each hospital/MCS/ MLCO. A5. Named Doctors and Named Nurses provide professional support and advice to staff. A6. Senior representation at MSCB and MSAB and underpinning Leadership/Executive Groups to support statutory duty to cooperate. A7. Safeguarding adults and children's training programme in place as per Intercollegiate guidance underpinned by learning from SCRs/SARs/ DHRs. A8. Safeguarding Supervision process A9. Learning Disability flag in place to alert Matron review. A10 Reports provided to statutory meetings if Trust staff are unable to attend. A11. Child Protection Information Sharing System (CP-IS) in place in all relevant areas except SMH maternity services. A12 AOF monitoring (MLCO)	B1. Mental Capacity Act (MCA) assessments and Deprivation of Liberty Safeguards (DoLS) are of inconsistent quality B2. DoLS applications are often not authorised by Local Authority due to lack of capacity B3. Level 2 and 3 Safeguarding training compliance is below the required threshold of 90% B4. The Trust is not compliant with the recent changes to Statutory Intercollegiate Guidance, which requires increased numbers of staff to receive level 3 adult safeguarding training B5. LD Specialist Nurse Capacity is limited B6. LD and/or Autism Strategy not finalised	C1. Annual Safeguarding Report to Board of Directors. C2. Hospital/Managed Clinical Service/MLCO annual Safeguarding Work Programme, monitored by Safeguarding. C3. Hospital/MCS/ MLCO annual safeguarding assurance processes to assess compliance with CQC requirements. C4. Completion of SCR actions - reported to the Safeguarding Committee. C5. Local Safeguarding Children's Board Section 11 audit - reported to the Safeguarding Committee. C6.Submission of MSAB Annual Assurance statement and supporting evidence. C7. Trust incident reporting system data C8. Regulatory inspection process C9. Training compliance data C10. Annual safeguarding audit programme C11. Safeguarding supervision data	D1. Prevent training compliance below threshold D2. No central system to record all invitations to strategy meetings and case conferences	**10 (5x2)**	B1. Deliver MCA and DoLS training to relevant staff B1. Audit the quality of MCA assessments and DoLS applications B2. Submit DoLS applications in accordance with statutory requirements B3. Deliver targeted safeguarding training to meet Intercollegiate requirements B4. Review LD Specialist Nurse capacity and develop Business Case to increase capacity to meet patient needs B5. Finalise and launch a System-wide LD and/or autism Strategy B5. Deliver the Trust's LD work plan D1. Target Prevent training to non-complaint areas D2. Work with the Local Authority to agree a process for invitations to strategy meetings and case conferences to be recorded centrally	Assistant Chief Nurse (Safeguarding)	March 2020	Safeguarding Committee	B1. Competencies matched to roles in accordance with revised Intercollegiate Guidance and staff groups prioritised to receive training. B1. Training capacity increased. B1. DoLS audits undertaken and actions identified to improve quality and compliance with DoLS criteria. B2. DoLS applications increased following audits. B3.Ongoing programme of safeguarding training delivered B4. Increased training capacity to deliver level 3 adult safeguarding training B6 MLCO Chief Nurse leading development of system-wide LD Strategy B6. Revised LD governance structure presented to Safeguarding Committee in April 2019 B6. LD work programme being updated	**8 (4x2)**

2	Strategic Aim: To improve patient safety, clinical quality and outcomes	Linked also to Group Risk Management Committee (GRMC) Risk(s) Reference Number(s): MFT00213; MFT000218

PRINCIPAL RISK (What is the cause of the 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:
QUALITY & SAFETY STRATEGY
ESTATES STRATEGY

Group Executive Lead:
CHIEF OPERATING OFFICER

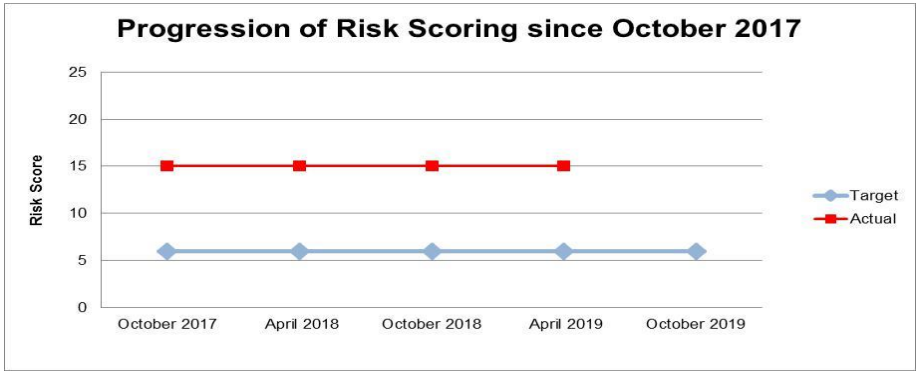
RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Inability to use public, staff or clinical areas as intended, leading to inability to provide treatment as planned**
2. **Potential impact for harm to staff, patient of public**

Associated Committee:
CEO FORUM

Operational Lead:
GROUP DIRECTOR OF ESTATES AND FACILITIES

Material Additional Supporting Commentary (as required):



Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
15 (3x5)	A.1 Detailed business continuity plans to mitigate the impact of any failure A.2 Multiple redundancy and layered systems to prevent the escalation of an issue (eg fire alarms; fire doors and sprinkler system; HV backup generation). A.3 Agreed maintenance regimes to ensure the infrastructure is maintained to the required level A.4 Internal & external reviews of systems and processes to highlight gaps and required actions	B.1 Not all maintenance regimes have been adhered B.2 Not all infrastructure schematics accurately represent the 'as built' estate B.3 Given above points redundancy systems may not operate as planned B.4 Sodexo on the ORC have migrated to a new Computer Aided Facilities Management (CAFM) system for Hard FM that will take a period to bed in. B.5 Some controls are reactionary, based on minimising impact should an issue occur	C.1 Ongoing certification (internal or external as required) of actions completed by the team undertaking the remedial actions reducing the number of outstanding defects. C.2 Schematics are being updated on a periodic basis to reflect the as built environment C.3 The old ORC CAFM system will remain in operation for circa 12 months to ensure continuity. C.4 External audit carried out of CAFM and hard FM policies and procedures. Highlighted areas requiring further work & those that were compliant	D.1 Survey and remedial works take a significant period to complete & until complete full assurance cannot be gained. D.2 Some schematics remain outdated in the review period and the update process will take several years to complete D.3 The new CAFM system will need to run for 12 months to give full assurance as some tasks are yearly D.4 The external audits highlighted areas of further work which is being carried out but full assurance cannot be gained until works are complete	15 (3x5)	D.1 Complete surveys and agree programme of remedial works by site and infrastructure system D.2 Infrastructure schematics updated in line with the survey and remedial work D.4 External audit agreed for June (covering May data) to identify any remaining gaps. Periodic focus thereafter in relation to comparison between old & new CAFM outputs D.4 External audit agreed for June (covering May data) to identify any remaining gaps in FM policy and procedure	Chief Operating Officer	July 2019 for key assurance tasks. Remedial actions will run for a prolonged period (circa 24 months)	CEO Forum	Survey and remediation work on track Schematics being updated on an as needed basis External audits agreed and arranged for June	**6 (3x2)**

2	Strategic Aim: To improve patient safety, clinical quality and outcomes	Linked also to Group Risk Management Committee (GRMC) Risk(s) Reference Number(s): MFT000359

PRINCIPAL RISK (What is the cause of the risk?): Inability to access the patient health record at the point of care, or poorly maintained health records may cause patient harm and poor patient experience.

Enabling Strategy:
MFT GROUP INFORMATICS STRATEGY

Group Executive Lead:
GROUP CHIEF FINANCE OFFICER

RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Increase in serious harm to patients**
2. **Poor patient experience**
3. **Poor safety culture (including leadership) undermines Trust performance**
4. **Reputational damage because of safety concerns**
5. **Lower staff morale**
6. **Regulatory and Information Governance consequences**
7. **Financial penalty and damage**

Associated Committee:
GROUP INFORMATION GOVERNANCE BOARD

Operational Lead:
GROUP CHIEF INFORMATICS OFFICER

Material Additional Supporting Commentary (as required):

Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
16 (4x4)	A.1 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. A.2 Improve visibility of electronically captured patient information by providing access through one system. A.3 Creation of Case Notes reduced to 5 areas and the PAS district number has replaced the manually allocated case note number for ORC, to become the unique identifier in the system. A.4 Clinic preparation for ORC has moved to ORC Health Records Hub 3rd Floor RMCH. A.5 New sets of case notes now labelled with barcodes to facilitate tracking. A.6 Obstetric notes will be retained in the Health Records Hub (3rd Floor RMCH) from Sep 2018. A.7 Commencement of Terminal Digit Filing within the Gorton Library. A.8 Performance Indicators now being presented to the Group Information Governance Board.	B.1 Best practice Records Management standards are not followed. B.2 Fulll KPI suite not yet embedded into operational practice. B.3 Full EPR not in place.	C.1 Trust incident reporting system data (incident information including harm level, frequency, type of incident and duty of candour information). C.2 Internal quality assurance processes (Health Records KPI suite).	D.1 Accurate tracking of the location of the case note, particularly once delivered to Hospitals.	16 (4x4)	**B**.1 Best Practice Standards for Records Management implemented through Health Records Improvement Programme. Best Practice Standards for Records Management implemented through Health Records Improvement Programme . D.1 To support the Hospitals in ensuring that case note paperwork is filed appropriately in the case note so it is available to clinician. This includes scanning the loose filing. Informatics is showing as the owner of this action as they are facilitating this work on behalf of the Hospitals who own this risk issue in relation to Health Records. B.3 Tactical EPR Roadmap identified to support journey to full EPR implementation.	Director of Digital Delivery	December 2019	Group Informatics Strategy Board (Performance Metrics are reported to Group Informatics Strategy Board	• Significant progress made on a range of Actions completed 2018/19. • 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. • Work programme commenced to scan loose filing and surface the images in Chameleon. • Deployment of scanners to improve tracking of case notes is planned over the next month. • Commenced review of the impact to patient experience when the case note is missing and evidence of harm.	**6 (3x2)**

2	Strategic Aim: To improve patient safety, clinical quality and outcomes	Linked also to Group Risk Management Committee (GRMC) Risk(s) Reference Number(s): MFT000363

PRINCIPAL RISK (What is the cause of the risk?): If there are malicious attacks to IT system(s), vulnerabilities could compromise or disable access to systems and or data.

Enabling Strategy:
MFT GROUP INFORMATICS STRATEGY

Group Executive Lead:
GROUP CHIEF FINANCE OFFICER

RISK CONSEQUENCES (What might happen if the risk materialises?):

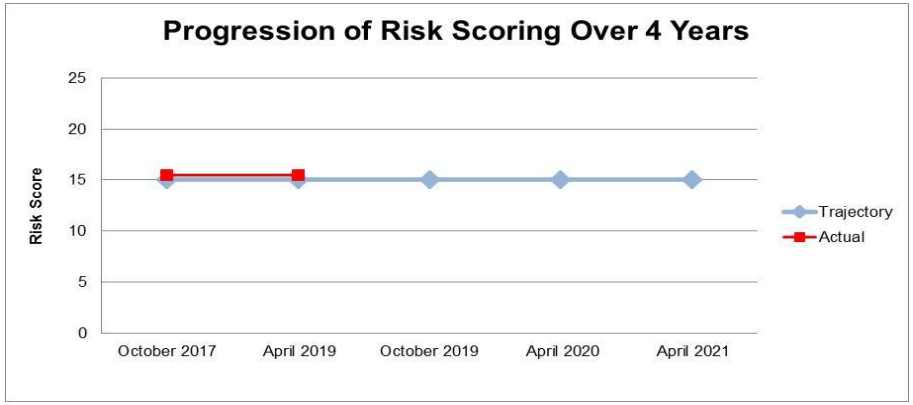
1. **Delivery of patient care could be affected by loss of access to systems and/or data leading to patient harm.**
2. **Patient experience could be adversely impacted (e.g. wait times increased) by loss of access to systems and/or data.**
3. **Financial damage.**
4. **Reputational damage.**
5. **Staff morale.**

Associated Committee:
GROUP INFORMATICS STRATEGY BOARD

Operational Lead:
GROUP CHIEF INFORMATICS OFFICER

Material Additional Supporting Commentary (as required):

Please note there is a national mandate that Cyber risk scoring remains at 15, despite work being undertaken to reduce severity.



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15 (5x3)	A.1 Appropriate Controls are in place to manage the threat of Cyber attack and other IT vulnerabilities and security threats.	B.1 Regular reviews are undertaken to manage any gaps in control & mitigate any emergent risk.	C.1 Independent assurance scheduled at regular intervals to ensure best practice in addressing cyber threat and other IT security vulnerabilities	D.1 Emerging Cyber Risk may mean gap in assurance through non-availability of specialist knowledge at point of risk.	15 (5x3)	A.1 Implementation of the Group Informatics Cyber Security Action Plan, which will track and monitor all ongoing Actions at a detailed level. This will ensure continuous monitoring in line with ongoing and emerging risks at a national and global level.	Group Chief Informatics Officer	Ongoing	Group Informatics Strategy Board	• 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 Plus Action Plan updates submitted to NHS Digital for ratification.	**6 (3x2)**

2	Strategic Aim: To improve patient safety, clinical quality and outcomes	Linked also to Group Risk Management Committee (GRMC) Risk(s) Reference Number(s): n/a

PRINCIPAL RISK (What is the cause of the risk?): Failure to deliver medical workforce workstreams (consolidated risk)

Enabling Strategy: **WORKFORCE STRATEGY**

Group Executive Lead: **JOINT GROUP MEDICAL DIRECTORS**

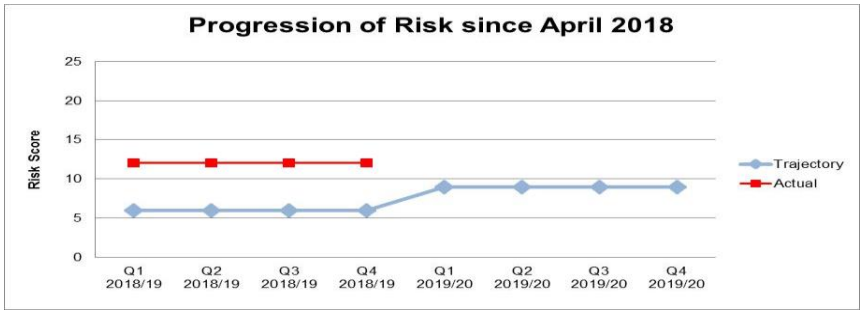
Associated Committee: **WORKFORCE & EDUCATION COMMITTEE**

Operational Lead: **CHIEF OF STAFF / GROUP ASSOCIATE DIRERCTOR OF WORKFORCE**

RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Patient safety & quality of care risk if unable to fill medical shifts/vacancies**
2. **Inequity of care delivered at weekends v weekday**
3. **Loss of control on medical agency & internal bank spend**

Material Additional Supporting Commentary (as required):



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12 (4X3)	A1. Group Executive Sponsors of Medical Workforce Workstreams A2. Hospital/MCS Executive teams A3. HR Scrutiny Committee oversight A4. Finance scrutiny committee oversight A5. Hospital Review meetings A6. Accountability Oversight Framework (AOF) A7. Medical Directors' Workforce Board A8. Workforce Systems Programme board A9. LNC Liaison A10.Job Planning & Medical Leave Policy A11.Medical Workforce Electronic systems (job planning, rotas etc) A12.Internal Turnaround governance programme including WAVE A13.Management of Direct Engagement supplier A14. 7DS Joint Assurance Group A15. 7DS action plan A16. Locum and agency dashboards A17. Guardian of Safe working (GOSW)	B1. Consistency in approach of Hospitals/MCS to management of temporary medical staffing B2. Consistency in approach to use of Medical Agency suppliers across group B3. Key medical workforce processes (job planning, leave etc)require alignment across Group) B4. Medical Workforce systems not fully rolled out across Group B5. Medical workforce dashboards not fully in place and information not shared between systems B6. No electronic means of recording the 7DS standards. B7. 7DS Joint Assurance Group needs review to ensure meeting needs of new MDT Structure B8. Guardian of Safe Working (GOSW) post vacant	C1. NHSI weekly agency report C2. NHSE Monitoring reports C3. Percentage of consultant job plans on electronic system C4. Reducing agency/locum spend C5. Reduction in medical vacancies/unfilled shifts C6. Medical Workforce AOF Metrics C7. Audits of 7DS standards by Hospital/MCS C8. GOSW reports C9. Hospital/MCS Review meetings – risk/mitigation plans	D1. Medical Workforce dashboards need refinement and to be aligned to Hospital/ MCS and KPIS D2. GOSW reports do not cover non training posts	**12 (3X4)**	B1. Develop and expand MFT Medical Bank B1. Further develop and expand Internal recruitment programme B2. Introduce single Group wide Medical Agency Tier and Cascade process B3. Roll out new MFT job plan policy and leave policy B4. Develop job plan training guide for clinical leaders B4. Provide regular reports on job plan status to Hospitals/MCS B4. Complete the roll out of the Allocate Medical Workforce systems (job planning, e-rota) and embed into culture B4. Submit application to NHSI as part of their Capital Technology Bids process to accelerate MFT workforce systems strategy B5. (and D1) Develop and roll out new dashboards for Medical temporary staffing B6. Review potential to include 7DS standards 2 and 8 in existing MFT IT systems in advance of full EPR deployment B7. Review the Terms of the 7DS Joint Assurance Board B8. Recruit new GOSW and ensure improved engagement with all stakeholders D2. Develop GOSW reports to include non training	Group Medical Directors Team & Group HR Directors' team	March 2020	Human Resources Scrutiny Committee		**9 (3X3)**

3	Strategic Aim: To improve the experience of patients, carers and their families	Linked also to Group Risk Management Committee (GRMC) Risk(s) Reference Number(s): n/a

PRINCIPAL RISK (What is the cause of the 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:
QUALITY AND SAFETY STRATEGY;
NURSING, MIDWIFERY & AHP STRATEGY

Group Executive Lead:
GROUP CHIEF NURSE

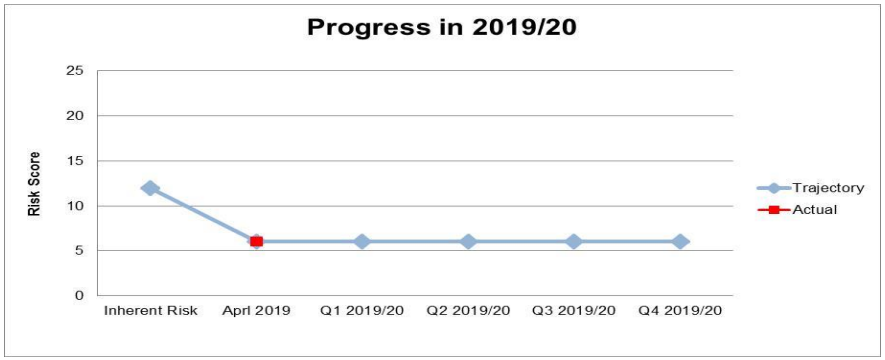
RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Adverse patient experience**
2. **Increased complaints**
3. **Failure to comply with regulatory standards**
4. **Damage to Trust reputation**

Associated Committee:
QUALITY AND SAFETY COMMITTEE;
PROFESSIONAL BOARD

Operational Lead:
CORPORATE DIRECTOR OF NURSING

Material Additional Supporting Commentary (as required):



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12 **4x3**	A1. Corporate and hospital/MCS/ MLCO Quality governance and delivery structures. A2. Patient Environment of Care Group oversees delivery of work programme and monitors impact. A3. Contract monitoring focused on patient experience outcomes. A4. Monitoring and reporting systems in place for complaints, concerns and compliments. A5. MFT Compliments, Complaints and Concerns Policy A6. Complaints management guidance provided to Hospitals/Managed Clinical Services. A7. Accountability Oversight Framework (AOF) monitoring. A8. Improving Quality Programme (IQP). A9. What Matters to Me (WMTM) Patient Experience programme A10. Clinical accreditation programme. A11. Nutrition and Hydration Strategy	B1. WMTM patient experience programme not fully embedded in all areas. B2. IQP not fully embedded in all areas. B3. Nutrition and Hydration Strategy not fully embedded	C1. Internal quality assurance processes (Clinical Accreditation programme, Quality Reviews) with annual Accreditation report to BoD C2. AOF metrics reporting C3. Quarterly and annual complaints reports C4. Quality of Care Round data C5. WMTM patient experience survey data C6. National patient survey data/reports C7. Regulatory inspection processes C8. Friends and Family Test data C9. Joint compliance audits with Sodexo C10. PEAT inspections C11. Reports to Professional Board	D1. Below average scores in national patient surveys for quality of food and discharge experience D2. Variation in AOF scores across the Trust	**6** **3x2**	B1. Matron (Quality & Patient Experience) to support areas where WMTM is not yet embedded B2. Matron (Quality & Patient Experience) to support areas where IQP is not yet embedded B3. WTWA, MRI and RMCH to establish local nutrition groups B3. SMH, MREH and CSS to establish nutrition as a standing agenda item within quality and safety meetings B3. Hospitals/MCS/MLCO to develop and deliver nutrition and hydration implementation plans B3. Establish escalation processes where patients' nutrition and hydration needs are not being adequately met D1. Deliver Environment of Care work programme D2. Develop and deliver Hospital/MCS/MLCO action plans to drive improvement supported corporate services as required.	Chief Nurse's Team	March 2020	Quality and Performance Scrutiny Committee	B1. Matron (Quality & Patient Experience) in post and working with Hospital/MCS teams to embed WMTM B2. Matron (Quality & Patient Experience) in post and working with Hospital/MCS teams to embed IQP D1 Environment of Care work programme progressing D2 Hospital/MCS/MLCO action plans monitored at the AOF meetings	**6** **3x2**

4	Strategic Aim: To Achieve Financial Sustainability	Linked also to Group Risk Management Committee (GRMC) Risk(s) Reference Number(s): MFT000992

PRINCIPAL RISK (What is the cause of the risk?):
Going into 2019/20, the underlying operating deficit position at Hospital level, when combined with the new year's efficiency challenge, has resulted in an overall delivery challenge of £62m of productivity and efficiency improvements required within 2019/20 financial year.

Enabling Strategy:
MFT CONSTITUTION & LICENCSING REQUIREMENTS

Group Executive Lead:
CHIEF FINANCE OFFICER

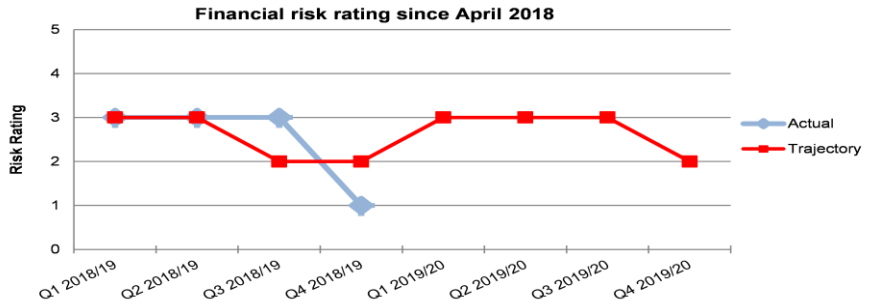
RISK CONSEQUENCES (What might happen if the risk materialises?):

Breach of Control Total leading to loss of Sustainability Funding would significantly jeopardise the ability to invest in and sustain improvements for patients.

Associated Committee:
FINANCE SCRUTINY COMMITTEE

Operational Leads:
HOSPITAL FINANCE DIRECTORS

Material Additional Supporting Commentary (as required):



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20 (5x4)	A1 2019/20 Control totals at hospital/MCS level have been agreed at Finance Scrutiny Committee (FSC) A.2 The Group CFO and Group COO continue to meet with Hospital leadership teams to gain assurance in respect of the deliverability of the 2019/20 plans from the very start of the financial year. A.3 This iterative process will continue through the first quarter with the Group CFO and Group COO providing further challenge as required. A.4 Hospitals' performance against their agreed 2019/20 control totals will continue to be reported on a monthly basis at Hospital Management Boards and reviewed in the Group Executive Team, with formal reporting bi-monthly to Group Management Board and the Board of Directors. A.5 The Board Finance Scrutiny Committee will review the evidence of effectiveness of Hospitals' 2019/20 delivery plans at the end of the first quarter. There will be no further expansion of the 2019/20 capital programme without satisfactory financial performance having been achieved in this first quarter A.6 All delivery plans continue to benefit from structured Quality Impact Assessments by the Hospital/MCS, which are further QA'd at Group level	None	C.1 An extensive framework of review, challenge and escalation is fully embedded within the organisation C.2 Each month the Hospitals/MCS are assigned an AOF rating against the finance domain based on their performance, which determines the level of progress recognised, intervention and support required	None	20 (5x4)	None	Group Chief Finance Officer / Hospital/MCS FDs	Ongoing	Finance Scrutiny Committee		**12 (3x4)**

4	Strategic Aim: To Achieve Financial Sustainability	Linked also to Group Risk Management Committee (GRMC) Risk(s) Reference Number(s): MFT000920

PRINCIPAL RISK (What is the cause of the risk?): The Trust remains at a lower level of digital maturity that its ambition.

Enabling Strategy:
MFT GROUP INFORMATICS STRATEGY

Group Executive Lead:
GROUP CHIEF INFORMATICS OFFICER

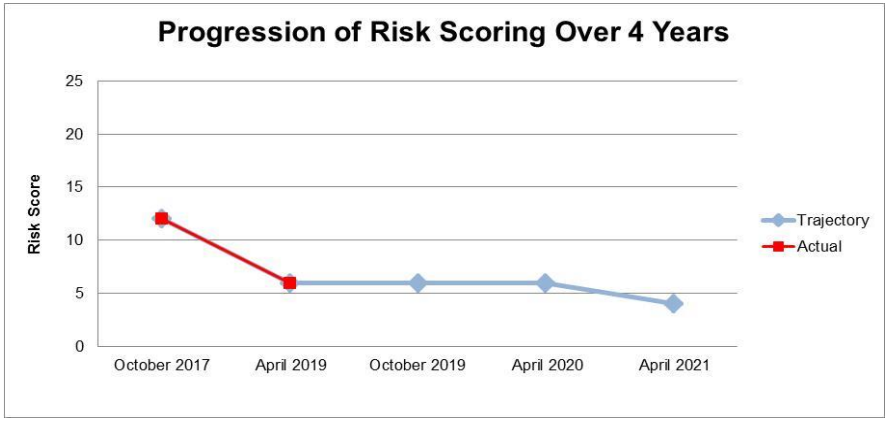
RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Inability to deliver against Trust strategies.**
2. **Inability to deliver benefits associated with transformational programmes of work.**
3. **Poor patient care and or experience.**
4. **Reputational damage.**
5. **Financial loss.**
6. **Low staff morale.**

Associated Committee:
GROUP INFORMATICS STRATEGY BOARD

Operational Lead:
Group CIO, Corporate Directors, and Hospital CEOs.

Material Additional Supporting Commentary (as required):



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12 (4x3)	A.1 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 Approvals.	B.1 Changes in the external landscape.	C.1 Introduction of SHS Informatics Governance in 2018/19 C.2 Group Management Board approval made in January 2018 to go to Open Procurement for the strategic EPR solution. C.3 Monitoring against HIMSS digital maturity Index. C.4 Regular updates to Hospitals and Group . C.5 Informatics Membership on Boards. C.6 Informatics PTIP Reporting	D.1 The significant workload to understand the landscape of the MFT organisation and the planned programmes of work.	**6 (3x2)**	C.2 Procure and implement strategic EPR solution for MFT organisation . C.2 Cross section of staff to participate in Innovation Council. A.1 Appropriate engagement with Workforce Committee and wider Trust,, to ensure staff are skilled to meet the needs of our digital organisation. A.1 Operational readiness work programme is in place to support the cultural change. A.1 Continued monitoring of the delivery roadmap for the EPR tactical work until the strategic solution is implemented.	Group Chief Informatics Officer	Ongoing	Group Informatics Strategy Board	• Robust Monthly Monitoring against plans. • Good development work with both EPR Tactical Business cases going through the approval process. • EPR Innovation Council implemented. • HCCIOs appointed. • New MFT Informatics Strategy Approved by GISB and progressing through Trust governance.	4 (2x2)

5	**Strategic Aim:** To develop single services that build on the best from across all our hospitals	**Linked also to Group Risk Management Committee (GRMC) Risk(s) Reference Number(s):** n/a

PRINCIPAL RISK (What is the cause of the 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:
GROUP SERVICE STRATEGY / CLINICAL SERVICES STRATEGIES (in development), GROUP QUALITY STRATEGY, GROUP WORKFORCE STRATEGIES

Group Executive Lead:
GROUP DIRECTOR OF STRATEGY

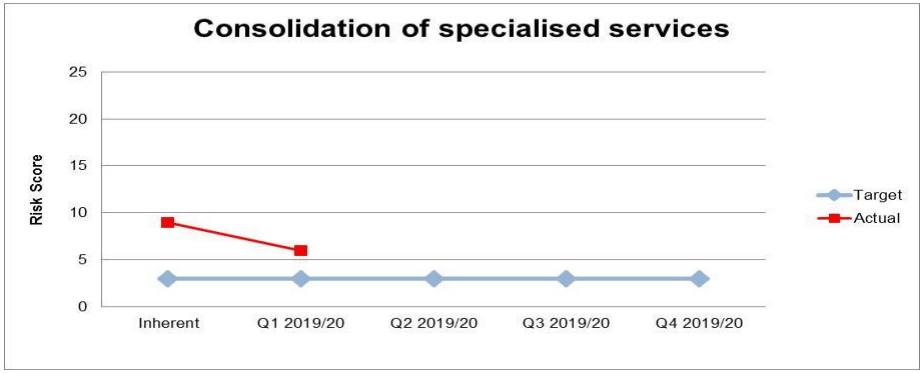
RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Loss of Service**
2. **Reduction in a range of services (offered within GM)**
3. **Damage to reputation**
4. **Loss of staff**
5. **Reduction in research opportunities**

Associated Committee:
GROUP SERVICE STRATEGY COMMITTEE

Operational Lead:
DIRECTORS OF STRATEGY

Material Additional Supporting Commentary (as required):



Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
9 (3X3)	A.1 Involvement in the GM Partnership forums to provide a united voice on maintaining GM-based services. A.2 Involvement in strategic clinical networks A.3 Regular discussions with NHS England Medical Director Representation through the Shelford group A.4 Active involvement in Operational Delivery Networks A.5 Regular meetings with NHSE North established	B.1 Management capacity within corporate hospital and MCS teams to identify ongoing risks and issues against each of our specialised services (as flagged through quality surveillance reviews and other national and local reviews) B.2 Lack of Group wider review of compliance against service specifications	Award of: C.1 National tender for Auditory Brainstem Implantation - one of only two providers in the country. C.2 CAR-T designation for adults and children C.3 Northern Paediatric MS service (MFT lead with Alder Hey and Newcastle), Genomics Lab Hub C.4 Outcome of 18/19 quality surveillance reviews. C.5 Outcome of Peer Reviews	D.1 No Gaps in Assurance	**6 (3X2)**	B.2 Completed the annual surveillance reviews across ORC and Wythenshawe sites and have made overall assessment of areas of compliance across the Group. Planned outcome – Have a Trust wide view of compliance across all specialist services.	Group Governance Team	July 2019	GSSC	Underway	**3 (3x1)**
						B.2 Work through areas of non-compliance with hospitals and MCSs as part of annual planning. Planned outcome – All hospital and MCS annual plans for 19/20 will include plans for addressing compliance issues in specialised services.	Hospitals / MCS	Ongoing	GSSC	Ongoing	
						B.2 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. Planned outcome – Risk rated list of specialised services under NHSE review for prioritisation and further action	Group Strategy Team	Q3 19/20	GSSC	To commence	
						A.5 Maintenance of control - maintain regular dialogue with NHSE contacts regarding portfolio of national clinical service reviews. Planned outcome – Strategy team to remain informed regarding NHSE clinical service review priorities and timescales.	Group Strategy Team	Ongoing 19/20	GSSC	Ongoing	

5	**Strategic Aim:** To develop single services that build on the best from across all our hospitals	**Linked also to Group Risk Management Committee (GRMC) Risk(s) Reference Number(s):** n/a

PRINCIPAL RISK (What is the cause of the risk?): There is a mismatch between MFT and Greater Manchester Health & Social Care Partnership plans for the development of services

Enabling Strategy: **GROUP SERVICE STRATEGY / CLINICAL SERVICES STRATEGIES (in development)**

Group Executive Lead: **GROUP DIRECTOR OF STRATEGY**

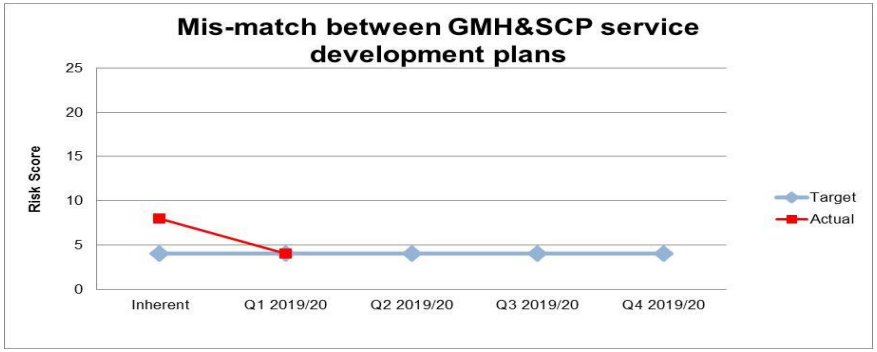
RISK CONSEQUENCES (What might happen if the risk materialises?):

1. Loss of united voice for GM

Associated Committee: **GROUP SERVICE STRATEGY COMMITTEE**

Operational Lead: **DIRECTORS OF STRATEGY**

Material Additional Supporting Commentary (as required):



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8 (4X2)	A.1 MFT representatives on GM boards inc Health and Care Board, Partnership Executive Board, Provider Federation Board, Chairs' group, HR, Directors of Finance, Directors of Strategy, Directors of Ops, JCB Executive Group etc. A.2 MFT representatives on Improving Specialist Care (ISC) Board, ISC Executive, ISC Clinical Reference Group A.3 PFB enables providers to engage as a group within GM A.4 Process in place for GM decision making which involves and recognises the Trust's decision making requirements A.5 Development of MFT group and individual clinical service strategy, takes GM decisions into account to form coherent strategies for the Trust that align with GM decisions. A.6 Involvement of key GM stakeholders in development of Group and Clinical Service Strategies	B.1 Complete MFT Group and Clinical Service Strategies	C.1 MFT designated lead provider for specialist emergency care and emergency general surgery (Healthier Together) C.2 MFT (Wythenshawe) designated lead provider for urology cancer surgery (ISC) C.3 MFT designated lead provider for Haematological Malignancy Diagnostics Services across GM C.4 GM PACS procurement in alignment with MFT aims C.5 Positive response to outcome of MFT Group service strategy and wave 1 clinical service strategies from key GM stakeholders	D.1 Outcome of GM decisions re ISC in scope services D.2 Response from GM stakeholders to MFT clinical service strategy for waves 2 and 3 and the managed Clinical Services	**4 (4X1)**	A.1 Maintenance of control - Ensure regular MFT representation at all GM meetings	MFT Strategy team	On-going	GSSC	Mapping of all meetings and MFT coverage underway	**4 (4X1)**
						B.1 Finalise MFT group clinical service strategy	MFT Strategy team	Q1	GSSC	First draft of MFT group clinical service strategy completed and being shared with key GM stakeholders for comment.	
						D.2 Complete underpinning clinical service level strategies engaging with GM stakeholders in development.	MFT Strategy team	Q1	GSSC	Clinical services strategies due to be completed by end of Q1. Development process has included key GM stakeholders	

7	**Strategic Aim:** To develop our workforce enabling each member of staff to reach their full potential.	**Linked also to Group Risk Management Committee (GRMC) Risk(s) Reference Number(s):** MFT000948

PRINCIPAL RISK: (What is the cause of the risk?): Failure to deliver high quality safe care due to the inability to recruit, retain and engage the current and future workforce of MFT.

Group Executive Lead:
GROUP EXECUTIVE DIRECTOR OF WORKFORCE AND CORPORATE BUSINESS

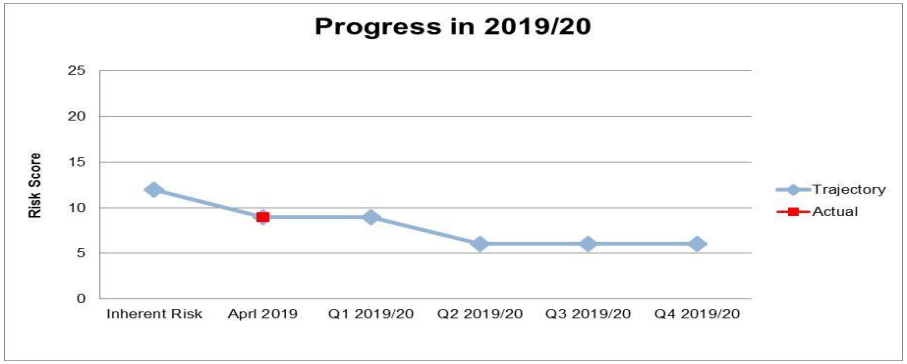
Associated Committee:
WORKFORCE & EDUCATION COMMITTEE

Operational Leads:
Deputy Group Director of Workforce and OD
Associate Director of Workforce Quality and Governance
Associate Director of Inclusion and Community

Material Additional Supporting Commentary (as required):

RISK CONSEQUENCES

1. **Inability to attract, source and recruit staff**
2. **High temporary staff costs**
3. **Low morale, engagement and wellbeing**
4. **Higher number of employee relation cases**
5. **Poor patient experience**
6. **Regulatory consequences**
7. **Damage to MFT reputation**
8. **Failure to deliver services**



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12 (3x4)	A.1 Emergent Workforce Strategy and related policies A.2 Trust Governance structure – including Human Resources Scrutiny Committee A.3 AOF monitoring A.4 Mandatory Training programme A.5 Workforce Plans A.6 MFT Operational Plan A.7 Equality, Diversity and Human Rights Strategy A.8 Workforce Technology Framework A.9 Leadership and Culture Strategy	B.1 Some policies still under development B.2 Workforce Strategy to be approved B.3 Mandatory Training Programme still needs embedding B.4 Workforce systems programme in its infancy B.5 Inadequate funding in training and development to match current and forecast demand B.6 Apprenticeship policy still to be embedded B.7 Employee Health and Wellbeing Service framework to be approved B.8 Limited intelligence informing workforce plans relating to global influences B 9 Ensuring the basics are delivered	C.1 Realignment of Workforce related strategies providing one strategy aligned to Trust service clinical strategy C.2 Trust Workforce systems and reporting eg eWIP C.3 Trust external and internal audit systems C.4 Staff survey and pulse checks C.5 Regulatory inspection processes and standards C.6 Internal quality assurance processes (Ward accreditation, Quality Review) C.7 AOF C.8 External accreditations C.9 Hospital/MCS reviews C.10 ISG Board reviews PTIP progress C.11 Agreed objectives for the Executive Director of Workforce and Corporate Business C.12 Review of HR Scrutiny committee arrangements completed and revised assurance process agreed C.13 Increased Executive presence at various key committees eg: TJNCC, HRD group, Workforce technology/Informatics Board	D.1 Limited interoperability of Workforce systems D.2 Competing priorities impacting on engagement in workforce agenda D.3 Workforce metrics not yet fully developed or reported on D.4 Vacancies in corporate Workforce Team D 5 Currently no formal outputs from Shelford HRD Forum D.6 Partial and time limited investment which may impact on delivery of Workforce Strategy D.7 Capacity to deliver competing large scale strategic change	**9 (3x3)**	B.2 Implement Workforce Strategy and enabling framework plans D.1 Implementation of Workforce Technology Framework D.2 Clear terms of Reference and membership to ensure attendance and commitment at relevant committees ensuring engagement D.3 Develop full range of workforce metrics as part of balanced scorecard D.4 Resourcing plan for corporate Workforce Team B.1 Complete policy reviews B.8 Scope and research global partnerships/organisations with exemplary workforce initiatives for shared learning and insights C.13 Refresh of the Workforce, Education Committee	Workforce Team	March 2020	Human Resources Scrutiny Committee		**6 (3x2)**