NHS
Manchester University
NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS' MEETING

Meeting Date: 10th September 2018

(Held in Public)

121/18 Apologies for Absence

Apologies were received from Mr B Clare, Mrs M Johnson, and, Miss T Onon

The Chairman welcomed Mr Nick Smith and Ms Nicki Speakman from the Care Quality Commission (CQC) who were in attendance as observers of the Board of Directors for the afternoon.

122/18 Declarations of Interest

There were no declarations of interest received for this meeting.

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

123/18 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

124/18 Minutes of the Board of Directors Meeting held on 9th July 2018

The minutes of the meeting held on the 9th July 2018 were agreed as a correct record.

125/18 Matters Arising

The Board reviewed the actions from the Board of Directors meeting 14th May 2018 and noted progress.

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

126/18 Group Chairman's Welcome and Opening Remarks

i) The Chairman was delighted to welcome Professor **Jane Eddleston**, as the new Group Joint Medical Director (working alongside Miss Toli Onon) following the retirement of Professor Bob Pearson.

ii) The Chairman reminded the Board of Directors that the MFT Annual Members' Meeting would be held on Tuesday, 25th September 2018 and will include a market place event with stands from across the MFT Hospitals & Managed Clinical Services (MCS).

iii) The Board noted that MFT Governor elections had commenced (one vacancy in the Rest of Greater Manchester constituency and two vacancies in the Rest of England and Wales constituency). It was also noted that two new Nominated Governors would also be appointed to the Council of Governors. The Chairman confirmed that the five new Governors would be announced at the forthcoming Annual Members Meeting later in the month.

iv) The Chairman reported that a Governor Workshop had been held on 28th August 2018. She explained that the session was very interactive, lively, engaging and well received by participating Governors. Key areas covered during the session included the North Manchester General Hospital (NMGH) Acquisition, Clinical Strategy (with Senior Clinicians present sharing their vision on the configuration of services going forward), feedback from the Independent External Auditors, and, a very informative session with representatives from the Manchester Local Care Organisation (MLCO).

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

127/18 Group Chief Executive's Report

(i) The Chief Executive reported that the Trust continued to experience an unprecedented level of demand on services from last Winter through into the Summer months. The Board recognised how much the organisation's workforce had responded to this heightened challenge and continued to deliver safe and responsive services to patients and their families. The Chief Executive wished to thank everyone for 'going the extra mile; day in and day out'.

(ii) The Chief Executive referred to the inquest held the previous week into the incredibly sad death of a young child in the Royal Manchester Children's Hospital (RMCH). He explained that the Trust had recognised from the outset that the organisation had profoundly failed the child and his family. He also explained that the apologies offered to the family had been both profound and sincere, and Professor Bob Pearson (the former Joint Group Medical Director) had reiterated the Trust's sincere condolences and apologies to the family in a public statement he gave to the media at the end of the Inquest. The Joint Group Medical Director also confirmed that the key themes and lessons learnt from this extremely sad event had been shared and embedded widely throughout the organisation. It was also noted that the Coroner had acknowledged the work which had been undertaken in the Trust to embed the key lessons learnt since this tragic event.

(iii) The Chief Executive reported that formal notification had been received from the CQC of their impending inspection in October 2018 (more from the Group Chief Nurse later on the agenda).

(iv) The Chief Executive reported that an open procurement process has begun with interested suppliers for the future Electronic Patient Record solution that met MFT requirements. He explained that the Trust's future EPR would provide an integrated Trust-wide electronic patient record solution, which would include patient administration functionality.

(v) The Board was advised of a launch event for the newly established Clinical Standards Groups was held on 27th July 2018. The Chief Executive explained that the three CSGs would now be responsible for the development of clinical standards and supporting the clinical strategy for the services in scope (Medicine, Surgery and Heart & Lung). He also explained that the CSGs would facilitate the delivery of the best patient experience and care outcomes by developing clinical standards to support the patient pathway that reduce unwarranted variation and encompass safe, high quality care underpinned by evidence.

(vi) The Chief Executive reported that a ground-breaking partnership between academia, industry and the NHS working with global diagnostics firm QIAGEN had been announced. He explained that this was a joint project which would create and support up to 1,500 jobs – adding almost £150m to Manchester's economy over a decade. It was noted that QIAGEN's base would be in the new Citylabs complex on the Oxford Road campus. An update on the development would be presented to a Board Seminar in the near future.

(vii) The Chief Executive reported that In July, the Trust had launched its values and behaviours framework following extensive engagement with more than 5,000 staff, patients and volunteers. The Deputy Director of Workforce & OD explained that initial engagement sessions and hospital roadshows focussed around understanding the values that matter most to staff and these were refined into four value sets, namely, Everyone Matters; Working Together; Dignity and Care; and, Open and Honest. The Deputy Director of Workforce & OD also explained that to help make this more memorable, an overarching values statement for MFT had been developed: ***'Together Care Matters'*** (with an overarching V&B Steering Group ensuring that the V&B is embedded throughout MFT inc. a new V&B Video).

Decision:	Verbal Report Noted Update on the QIAGEN development to be presented to a Board Seminar	**Action by:** n/a Medical Director (R&I) & Trust Board Secretary	**Date:** n/a 8th October 2018

128/18 Operational Performance

Board Assurance Report

The Joint Group Medical Director reported that all core priorities for patient safety were currently being met with the exception of Never Events. It was confirmed that in response, a range of actions were underway and would include the review of the Group Risk – Never Events (3226). It was noted that a separate report on 'Never Events' would be received later on the agenda (ref: Minute 130/18 below).

In response to a question from Dr Benett regarding the comparison between the MRI and Wythenshawe mortality position, the Joint Group Medical Director explained that there was an extensive Mortality Review process in place across the whole organisation and if required, more detailed 'deep dives' were undertaken if further assurance was sought. The Chairman also reminded the Board that 'Mortality' featured as an agenda item on the Quality & Performance Scrutiny Committee as required.

The Group Chief Nurse confirmed that whilst the Q1 (2018/19) Complaints Report would feature as a separate agenda item (ref: Minute 130/18 below), the most up-to-date information confirmed that there were 281 ongoing (active) cases of which 154 were between 0-25 days; 58 between 26-40 days, and 69 were over 41 days. It was also noted that particular focus was directed to complaints waiting more than 41 days and it was confirmed that whilst significant improvement in performance had been secured in Wythenshawe Hospital, the focus was now on the MRI (with support from corporate teams); with the number of complaints >41 days reduced to 40. It was also noted that the aim was to ensure that the MRI's performance was at a level witnessed pre-merger in 2017.

In response to a question from Mr Rees regarding 'Compliments Received' within the Trust (via formal routes and informal in wards/departments), discussion centred on the +/- benefits of capturing such data and the mechanism for achieving this within the finite administrative resources available.

In conclusion, it was agreed that the Group Chief Nurse would explore the advantages (+/-) of enhancing the current process of capturing and analysing Compliments and present a report on the findings to the Quality & Performance Scrutiny Committee (on behalf of the Board of Directors). Professor Georghiou also suggested that it would be helpful to also identify themes around 'Compliments' in order to highlight and share areas of 'good practice'.

The Group Chief Operating Officer provided an overview of the Trust's operational performance highlighted within the report and along with the most up-to-date information (where this was available). Particular attention was drawn to the Diagnostic performance standard (6wks) and the good level of attainment secured (1.59% compared to 3-4% a few months previously) despite a 3% increase in demand. It was noted that the Trust was 'on-track' to achieve the 1% standard by March 2019.

The Group Chief Operating Officer explained that achieving the Cancer 62 day performance standard remained a challenge (83.2% against target of 85%). She reported that pathways were being reviewed in the MRI and a 'Perfect Month' was being planned (with a focus on lower GI cancer). It was noted that the aim was to return to the agreed (and back to 85%) by end October 2018. In response to a question from the Group Chairman, it was confirmed that a report on the outcome of the 'Perfect Month' would be presented to the Quality & Performance Scrutiny Committee in December 2018.

The Board noted the A&E performance against the 4hrs standard at the end of August 2018 (89.5%) which supported the GM position to achieve over 90%. It was also noted that the position in Q2 (2018/19) was currently 88% with the Trust aiming to secure 90% by end September 2018 (although it was recognised that this was a significant 'ask' with only 3 weeks remaining). The Chief Operating Officer explained that the focus was on continuing to develop internal processes both the Wythenshawe and Oxford Road sites. She also confirmed that the two sites were actively sharing best practice in order to maintain patient safety across the Group. The Board noted that there was also a significant amount of focused work with both the Mental Health Trust and the MLCO (further details on the MLCO collaborative activity later on the agenda)

The Chief Operating Officer described the RTT position and confirmed that (with the exception of 30 known patients waiting for breast reconstruction) the Trust remained on trajectory to treat all patients waiting more than 52wks (250) by the end of September 2018. It was noted that the number of patients waiting for breast reconstruction would be reduced to 15 by end March 2019.

It was also noted that an extraordinary meeting of the Quality & Performance Scrutiny Committee, on behalf of the Board of Directors, had been held on the 9th July 2018 with a focus on the Trust's RTT position. Professor Dame Sue Bailey (Chair of the QPSC) confirmed that Update on the RTT position was a standing item on the Quality & Performance Scrutiny Committee Agenda.

In response to two questions from Mr Rees, the Group Chief Operating Officer clarified that there was an error in the report and the 4hrs A&E indicator for the MRI should not be a green. She also confirmed that detailed planning for the breast reconstruction patients had been undertaken (mindful of the mulita-disciplinary and complex nature of the surgery). It was also noted that there had been a successful consultant recruitment campaign in this highly specialised service with two new consultants expected to start in post in November 2018 & January 2019.

In response to a question from Dr Benett around cancelled operations and the number of operations re-scheduled within 28 days, the Group Chief Operating Officer agreed to present further breakdown and analysis of the information available at the Quality & Performance Scrutiny Committee.

The Group Deputy Director of Workforce & OD provided an overview of three key areas of activity highlighted in the report, namely, Attendance, Appraisal & Mandatory Training. It was noted that work was ongoing throughout the Group to improve the Attendance performance with a focus on developing clear improvement plans and tangible outcomes within agreed trajectories. The Board noted that whilst there was good compliance with Corporate Mandatory Training, work continued with the Hospitals/MCS to improve Clinical Mandatory Training compliance. Similarly, it was noted that Appraisal compliance throughout the organisation for was >90% for Medical Staff and within 2% for Non-Medical Staff. In response to questions from Mr Amaechi, the Group Deputy Director of Workforce & OD explained that the Trust was aiming to re-invigorate key workstreams to improve Attendance and Appraisal; with a particular emphasis, for example, on the 'quality' of Appraisals not just a focus on the volume of staff receiving an appraisal.

The Executive Director of Strategy confirmed that the Trust was now at the stage where differential reports against each Hospital/MCS were available. It was noted that further discussion was underway to determine how the metrics (and key milestones set out in the Hospital/MCS Annual Plans) are captured in the Accountability Oversight Framework (AOF). Further work is underway to refine process with the hospitals.

In response to a question from Mr Rees, it was also confirmed that a similar exercise was underway in identifying the metrics to be adopted in the AOF for the MLCO. It was noted that the MLCO Scrutiny Committee would be developing this over the coming months. Discussion also centred on the development of the AOF and the threshold for when further corrective action(s) an interventions may be required by the Board of Directors in the event that certain metrics remained unchanged over a period of time.

The Board noted the Board Assurance Report (May 2018)

Decision:	Report to the Quality & Performance Scrutiny Committee on the advantages (+/-) of enhancing the current process of capturing and analysing 'Compliments' within the Trust.	Action by: Group Chief Nurse	Date: 3rd December 2018
Decision:	Report on the outcome of the 'Perfect Month' (Cancer) to be presented to the Quality & Performance Scrutiny	**Action by:** Group Chief Operating Officer	**Date:** 3rd December 2018
Decision:	Report on cancelled operations and the number of operations re-scheduled within 28 days to the Quality & Performance Scrutiny Committee.	**Action by:** Group Chief Operating Officer	**Date:** 3rd December 2018
Decision:	Report on 'Absenteeism' to the HR Scrutiny Committee.	**Action by:** Group Executive Director of Workforce & OD	**Date:** 18th December 2018

Progress Report on the Single Hospital Service (SHS)

The Director of Single Hospital Service provided an update on the progress being made to implement the Manchester Single Hospital Service (SHS) as part of the overarching Manchester Locality Plan. He covered key themes including post-merger integration and project two, the proposed transfer of North Manchester General Hospital (NMGH) to Manchester University NHS Foundation Trust (MFT).

The Board was advised that integration activity across MFT continued to make significant progress with the main focus on the implementation and planning for the more complex strategic programmes of work due to deliver in years 1 and 2, post-merger. It was also noted that the progress of integration activity, including oversight and management of the anticipated merger benefits, continued to be closely monitored and reported on by the SHS Integration Management Office (IMO).

The Director of Single Hospital Service explained that progress against the Manchester Investment Agreement improvement targets was also being tracked and this involved regular reports to the ISG, direct contact with operational teams, as well as liaison with Hospital / Managed Clinical Service Chief Executives.

The Board noted that the first formal reporting against these objectives was presented on 1st August 2018 and involved two early integration targets: the Urgent Gynaecology Surgery List and the reduced waiting time for access to kidney stone removal procedures. It was confirmed that both trajectories met their agreed targets. The Board noted the further details on both of these programmes of work highlighted in the report presented.

The Director of Single Hospital Service also advised the Board that KPMG had recently concluded an audit of the Post-Transaction Integration Plan and related matters. He was pleased to confirm that the audit concluded that the SHS Programme had established effective governance and oversight with regards to tracking and monitoring of integration deliverables and benefits. He also explained that the SHS Team was committed to maintaining robust oversight and assurance practices throughout the integration programme as noted by KPMG.

The Board noted the updates on the key progress for some of the main programmes of work underway, namely, Urology (waiting times for kidney stones removal procedures); joint Multidisciplinary Teams (MDTs) across all MFT sites for key clinical groups including hip/knee, and shoulder/elbow; New shared pathway for Acute Coronary Syndrome (ACS) now being implemented across MFT.; additional urgent gynaecology surgery lists across Wythenshawe and Saint Mary's Hospital in place. The Director of Single Hospital Service also explained (and provided examples) that the organisation was also continuing to discover 'emergent benefits' whereby additional benefits were realised as projects continued to progress and services began to integrate.

The Director of Single Hospital Service also confirmed that integration planning for year 2 and beyond was underway which included a re-fresh of the Post Transaction Integration Plan (PTIP). He also reported that as part of the integration work, a year one post-merger report was currently being produced to evaluate the first year of operation of the new organisation and this report would be shared widely.

The Board received an update on the second phase of the SHS Programme: the proposed acquisition of North Manchester General Hospital (NMGH) by MFT. The Director of Single Hospital Service confirmed that the agreed transaction process was continuing to be managed in line with the NHS I national transaction guidance. Particular attention was drawn to the work of the Manchester Health and Care Commissioning and the North East Sector Commissioners who are leading processes to develop a service model for acute services at NMGH and the other PAHT sites, respectively. It was noted that GMH&SCP was also working to support this process.

The Director of Single Hospital Service explained that MFT had started the process of familiarisation with the clinical services at NMGH and he described the approach, including face to face meetings between the SHS team and clinical leads at NMGH. It was particularly noted that this work would support the ongoing development of the Strategic Case and would feed into the due diligence processes.

The Board was advised that work to undertake vendor due diligence was progressing and a shared approach to acquirer due diligence is being agreed. It was also noted that the SHS Team had met the MFT Council of Governors on 28th August 2018 to provide key updates on the progress of the proposed acquisition. It was also noted that the session served as an opportunity for the Council of Governors to learn more about the services and footprint of NMGH. The Director of Single Hospital Service explained that such meetings afforded the opportunity to consider the important role Governors have with regard to considerations to be made by the Board of Directors about the proposed transfer of NMGH to MFT.

The Board was also advised that a staff engagement plan for NMGH had been developed and sessions open to all staff at NMGH continued to be scheduled; with the first session having taken place on 11th July 2018 and a subsequent session was planned for 12th September 2018.

The Board of Directors noted the work underway to progress the post-merger integration plans along with the position of the proposed transfer of North Manchester General Hospital as part of NHS Improvement's plan for the dissolution of Pennine Acute NHS Trust.

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

Chief Finance Officer's Report

The Group Chief Finance Officer reported that the financial performance for the first four months of the year was a bottom line deficit (on a control total basis excluding Provider Sustainability Fund) of £7.7m (1.4% of operating income). He explained that the Trusts' financial performance was assessed with PSF excluded.

The Board noted that the Trust was very narrowly within the delivery plan profile submitted to NHS Improvement. The Group Chief Officer explained that the underlying deficit of £7.7m over 4 months represented a run rate deficit of £1.9m per month which was not compatible with delivery of a £12m deficit excluding PSF over the year as a whole.

The Group Chief Finance Officer pointed out that the reported position across the Turnaround programmes highlighted that insufficient delivery plans had been developed. He reminded the Board that Hospitals/MCS' had aggregate Trading Gap targets of £66.5m. He also explained that to date, delivery plans totalling £44.4m had been identified up to delivery standard, with a further pipeline of around £6m currently in development across Hospitals/MCS'.

The Board also noted that agency spending now exceeded the ceiling set by NHSI for MFT by over 25% and this represented the worst performance by the Trust since the inception of the agency ceiling. The Group Chief Finance Officer explained that actual agency spending had increased by 8% over these 4 months compared to 2017/18. He summarised that insufficient control over medical agency and locum costs, together with slippage in delivery of savings plans, continued to represent material risks to sustained delivery in 2018/19 financial year.

The Chairman & Group Chief Finance Officer reminded the Board that the Trust's current financial position and key areas of focus had been discussed in detail at the recent Finance Scrutiny Committee (attended by all Board members) on 5th September 2018.

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

129/18 Strategic Review

Update on Key Strategic Developments

The Group Executive Director of Strategy provided an update on a range of key strategic issues which were currently being progressed. Particular attention was drawn to the work which had begun nationally on developing the NHS 10 Year Plan, with the announcement of a number of work streams along with leads from arms-length bodies and provider CEOs. It was noted that Sir Mike Deegan (Group Chief Executive, MFTO would be leading the *'Efficiency and Productivity'* work stream along with Jeremy Marlow, NHSI's Executive Director of Operational Productivity. It was further noted that once all work streams had been set up, engagement was expected to begin in September 2018, with working groups defining their outputs in October 2018 for the Plan to be published in November 2018. It was reported that the previously announced NHS Assembly would then oversee the implementation of the Plan.

The Group Executive Director of Strategy provided an overview of key developments across Greater Manchester including status of the remaining Theme 3 projects in the transformation and design stage. He also provided an update on MFT-led transformation projects including Vascular; Breast cancer; Paediatrics; Respiratory; Cardiac; and, Critical care and anaesthetics.

The Board also received an update on the MFT service strategy development. Particular attention was drawn to the overarching group service strategy. The Group Executive Director of Strategy explained that views had been sought from a wide range of parties and individuals in order to inform the content of the service strategy. He described some of the examples including a workshop with the Council of Governors to discuss key questions related to the strategy; smaller workshops with individuals identified as innovators across the Trust to inform key themes in the strategy; and, engagement with external stakeholders including MHCC, Trafford CCG, specialist commissioning, the LCO, Health Innovation Manchester, the Biomedical Research Centre, and Health Education England. He also explained that a survey had been distributed to all staff to gather views and the results were now being analysed. The Board noted the work of the Group Service Strategy Committee (GSSC) and also that a communications strategy for the programme had been developed and had been shared with GSSC which addressed how the Trust would engage internally and externally.

The Group Executive Director of Strategy highlighted the progress made on the clinical service strategies. He described the two of the three workshops held for each of the wave one clinical services and confirmed strong attendance from individuals both internal and external to MFT, and high levels of engagement. It was noted that Workshop 3 for each wave one service would be taking place over the following few weeks and a number of focused groups and 1-2-1 sessions with key stakeholders had taken place for each wave one service to discuss particular topics and challenges (a session on the wave 1 clinical services with the Council of Governors took place on 28th August 2018). It was further noted that engagement sessions with colleagues from North Manchester General Hospital representing each wave one service were currently being arranged and would take place over the coming weeks.

The Group Executive Director of Strategy also confirmed that planning for waves 2 and 3 and folding in the Managed Clinical Services were currently underway and the recruitment process for clinical leads for waves 2 and 3 would commence from 28th August 2018.

The Board of Directors is noted the report and in particular the updates on the GM Theme 3 transformation programme (and constituent projects), and, progress on the development of an overarching group service strategy and the clinical service strategies.

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

<u>Update on the Manchester Local Care Organisation (MLCO)</u>

The Chief Executive (MLCO) provided the latest update from the MLCO on Internal Governance; Regulatory Assessment; Partnering Agreement Update; Memorandum of Understanding Development; North Manchester Community Services Transfer; Joint working with Partners; and, New Care Models.

The Board noted that the MLCO had now fully established its internal governance arrangements which included the establishment of an MLCO Quality and Safety Committee and a Clinical Advisory Group. Work to ensure that there was alignment between MLCO governance structures and MFT's was now also complete, with MLCO senior officers now forming part of a number of MFT committees. It was also noted that the MFT Finance Scrutiny Committee's inaugural meeting would be held on 12th September 2018.

The Chief Executive (MLCO) confirmed that the MLCO, as with the rest of the Group, would be subject to regulatory assessment in Autumn 2018. He explained that in preparing for this, it was timely to acknowledge that the MLCO was established through the signing of a Partnering Agreement which defined MLCO's responsibility for delivering a range of community health and adult social care services. The Board noted that in support of the regulatory assessment, MLCO had mobilised supporting governance arrangements, including monthly SHINE meetings chaired by the Chief Executive (MLCO) which fed directly into arrangements put in place by MFT.

The Chief Executive (MLCO) reported that as the original terms of establishment, it was agreed that the Partnering Agreement would be subject to review and a working group, comprised of senior representation from the respective signatories to the Partnering Agreement, continued to have oversight of this work stream. He also explained that the MLCO was currently working with a range of partners across the Manchester system, and was in the process of developing a number of MOU's to formalise various working relations that would be required to enable MLCO to operate effectively, including, the Voluntary, Community & Social Enterprise; North West Ambulance Service; and, the Manchester Primary Care Partnership.

The Board was advised by the Chief Executive (MLCO) that following the transfer of North Manchester Community Services contract to MLCO via Manchester University Foundation Trust on April 1st 2018, the TUPE transfer of staff associated with the contracts happened on July 1st 2018. It was confirmed that the transfer would be supported by a service level agreement between relevant parties, which was in the process of development and any emerging issues would be managed through agreed governance arrangements.

The Chief Executive (MLCO) drew attention to the MLCO's continued development of collaborative relationships with a range of partners across the Manchester system. Particular attention was drawn to a joint project of work with the MFT to identify the system challenges, and the short and longer term opportunities to help address the operational challenges being faced on the MRI site in relation to numbers of patients attending the site and the current number of inpatients. The Board was advised that this work was jointly led by the MRI's CEO and Medical Director, and, the MLCO's Chief Operating Officer and Director of Adult Services. The Chief Executive (MLCO) explained that to date the work, the success of which had been contingent on MLCO co-ordinating a system response, had seen a significant number of complex patients supported to a more suitable place of care. He also explained that it was also establishing a joint prioritised programme of work to change systems and processes to sustainably manage patient flow into and out of hospital.

The Board also noted the continued progress in developing new Care Models which the MLCO was responsible for mobilising, through the key phases of business case, design, mobilisation, implementation and evaluation. It also noted the priority for 2018/19 was threefold, namely, High Impact Primary Care; Manchester Community Response; and Integrated Neighbourhood Teams.

The Board noted the latest update report from the MLCO.

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

130/18 Governance

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

The Group Chief Nurse reported that the Trust had now received formal notification of the announced CQC inspection of Hospital and MLCO Services. It was confirmed that the dates of the inspection(s) would be between w/c 1st and w/c 22nd October 2018. It was also noted that the Group Well-Led Review would be undertaken w/c 5th November 2018. It was reported that the ratings would be applied as per CQC guidance, across the core services for Safe, Caring, Effective, Responsive and Well-led. The Group Chief Nurse explained that they would be aggregated up to give an overall rating. She also confirmed that the Well-led assessment rating would be presented separately.

The Board noted the arrangements for the NHSI 'Use of Resources' review which will inform the assessment of the Well-led domain. The Group Chief Nurse explained that the date of assessment was yet to be confirmed.

The Group Chief Nurse reminded the Board that a component part of the CQC comprehensive inspection as the key line of enquiry 'Well-led' KLOE. She also reminded the Board that in addition, based on the CQC's key lines of enquiry for its well-led domain, was the NHS Improvement requirement to undertake a self-assessment exercise (NHSI Developmental Review of Leadership and Governance). The Board noted that the process included a self-review by a Foundation Trust's Board of Directors. An appraisal of the self-assessment was undertaken by an external, independent party with recommendations for consideration by the Board of Directors and subsequent translation into a Board's development plan and other action plans as appropriate.

The Board was advised by the Group Chief Nurse that in keeping with the process and timelines outlined to the Board of Directors in early July 2018 a number of stages of the Well Led review exercise had now been successfully completed, namely, a Group level desk-top review against the eight Well-Led KLOEs and NHS I supporting guidance (signed-off by the Board of Directors in July 2018); a Hospital/MCS Well-Led Self-Assessment (also signed-off by the Board of Directors in July 2018); an external, independent objective assessment of Group level Leadership and Governance arrangements (KPMG commissioned to undertake the work entitled 'Post Transaction Integration Plan Follow-up') and progress made since the Reporting Accountant work undertaken in preparation for the merger back in September 2017; a second external, independent objective assessment of the Hospital/MCS level Leadership and Governance arrangements has now also been completed. It was noted that the aim of this exercise was to review how the local Hospital/MCS leadership and governance arrangements worked within the Group to ensure appropriate oversight and accountability.

The Group Chief Nurse explained that the results of the internal self-assessments and external, independent reviews and the subsequent improvement plan which was approved by the BoD August 2018. This would be submitted to NHSI as evidence to support the NHSI requirement to complete a Developmental Review of Leadership and Governance using the Well Led framework.

The Board noted that a summary overview of the MFT Well Led Assessment, key recommendations and Action Plan would be received by the Board of Directors at its next meeting in November.

In response to a question from Mr Rees, the Group Chief Nurse confirmed that the NEDs would receive information on the CQC's timetable for expected NED interviews in November 2018.

In conclusion, the Board noted the contents of the report as presented and the preparations in progress for receiving the CQC inspectors, for the announced inspection of all core services from 2nd October to 8th November 2018.

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

Q1 Complaints Report (2018/19)

The Group Chief Nurse presented an overview of the Quarter 1, 2018/19 complaints report for MFT covering the period 1st April – 30th June 2018. It was noted that during Quarter 1, 2018/19, work continued to integrate the Trust's complaints functions and develop a single set of performance metrics which would enable comparisons to be made between the Hospitals/Managed Clinical Services (MCS) and the Manchester Local Care Organisation (MLCO) across the Group.

The Group Chief Nurse explained that an integral part of the integration had involved the reporting alignment of Formal Complaints to Hospitals/ MCS/MLCO for services they managed across all Hospitals. She also explained that the subsequent changes in reporting had either a positive or negative impact on the number of formal Complaint received for some areas, as formal Complaints were now aligned to the relevant MCS MLCO.

The Board noted that during Quarter 1, 2018/19, there were a total of 461 new formal complaints received and this compared to 420 received in Quarter 4, 2017/18, 408 received in Quarter 3, 2017/18 and 400 formal complaints received in Quarter 2, 2017/18. The Group Chief Nurse explained that there was a 9.76% increase in formal complaints (increase of 41 in number) received in Quarter 1, 2018/19 compared to Quarter 4, 2017/18. She also explained that whilst the natural variation was considered when reporting, the number of complaints received was being monitored by the Assistant Chief Nurse and if the increasing trend continued into Quarter 2, a detailed analysis would be undertaken, by each of the Hospital/ MCS/ MLCO teams.

The Board also noted the activities and numerical variances within individual Hospitals/MCS as presented in the report and was advised that the increase in the number of complaints received by MRI was currently being investigated.

The Group Chief Nurse was also pleased to report that the significant improvement in reduction of complaints responses over 41 days related predominantly to the reduction in the number of unresolved cases at Wythenshawe Hospital following the implementation of an improvement programme as previously reported to the Board of Directors. The Board also noted that there was an increase (positive) in the proportion of complaints closed within 25 days with 36.7% of the total complaints closed in Quarter 1, 2018/19 compared to 26.4% of the total closed in Quarter 4, 2017/18. However, there was an increase (negative) of 2.6% of cases closed at 41 days or more days between Quarter 4 and Quarter 1.

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

The Board was made aware that the Parliamentary and Health Service Ombudsman (PHSO) introduced a new clinical standard in August 2018 (the 'Ombudsman's Clinical Standard') in an attempt to provide greater clarity and predictability as to how the PHSO consider the appropriateness of care and treatment. The Group Chief Nurse confirmed that the 'Ombudsman's Clinical Standard', had been circulated to the Hospital/ MCS/ MLCO senior teams to circulate to clinicians so that they were fully informed of the approach the Ombudsman took when investigating complaints about clinical care and treatment.

In response to a question from Mr Gower on the suggested spike in 'Appointment Delays' highlighted as a theme within the Complaints Report, it was agreed that a further report would be presented on 'Appointment Delays' to the Quality & Performance Scrutiny Committee.

Professor Dame Sue Bailey suggested that it would be of benefit to introduce further 'deep dives' around selected themes highlighted within the Complaints Report at future Quality & Performance Scrutiny Committees (themes to be built-into the Committee's dynamic Work Programme). Dr Benett also highlighted some of the key areas of focus within the Complaints Scrutiny Group.

The Board noted the information within the report and the ongoing integration and development of the complaints system during Quarter1, 2018/19.

Decision:	Q1 Complaints Report (2018/19 noted	**Action by:** n/a	**Date:** n/a
Decision: Up	Report on 'Appointment Delays' to the Quality & Performance Scrutiny Committee.	**Action by:** Group Chief Nurse	**Date:** 5th February 2019

Report on 'Never Events' Action Plans to Mitigate Risk of Recurrence

The Joint Group Medical Director presented a report on the organisation's 'Never Events' (NEs) Action Plans. The Board was reminded of the NEs national definitions and that MFT's NEs Framework had been updated in January 2018; with a number of changes to existing definitions/guidance and key changes having been communicated throughout the organisation and risk assessments also been completed. The Joint Group Medical Director explained that NEs were included on the MFT Accountability Oversight Framework under the Patient Safety section and in 2017-18, there had been seven (7) NE's reported (2 from the legacy CMFT, 1 from the legacy UHSM and 4 from MFT). She also reported that since April 2018, there had been a further 4 Never Events reported.

The Joint Group Medical Director provided an overview of the NE's experienced in 2017/18 (3 wrong site surgery; 2 Retained Foreign Objects; 1 wrong route medication; and, 1 Connection to air instead of oxygen) along with the location of the events, key findings and themes, and, a summary of the investigation recommendations and associated action (plans).

It was particularly noted that the key recommendations were focussed on reviewing Safe Surgery, Sedation and Consent policies, review of risk assessments, development of Local Safety Standards for Invasive procedures and education and awareness raising across the Trust. The Joint Group Medical Director explained that a multi-disciplinary workshop had been held in April 2018 and a programme of work was being undertaken following this and learning from NEs incidents had been shared across the organisation and included a range of articles in Safety Matters @MFT and Safety One Liners. The Board was also advised that following the recent NE's (since April 2018), the risk score was being reviewed.

The Board noted the information and the actions planned to mitigate risk of recurrence with an update report to be presented to the Board on progress (with actions) in 3 months.

Decision:	Report Noted and update on NEs to be presented to the Board in three months.	**Action by:** Joint Group Medical Director	**Date:** 14th January 2019

Update Report on the 'Freedom to Speak Up' Programme (2018)

The Deputy Director of Workforce and OD presented a report which outlined the work undertaken to deliver the Freedom to Speak Up Programme (F2SU) in MFT including the changes made to implement the new guidance issued by NHS Improvement in May 2018. She also explained that the report also included the number of cases raised with the Freedom to Speak up Guardian for the period October 2017 to March 2018.

The Board was reminded that the national office required that all Trust's report information on concerns raised at least twice a year. The Deputy Director of Workforce and OD confirmed that six concerns had been raised with the Freedom to Speak up Guardian since October 2017 with five out of the six raised anonymously. It was noted that two had elements of patient safety/quality and four had elements of bullying/harassment. It was also noted that one indicated they had suffered detriment due to the concern they were raising. Out of the six cases of concerns raised, it was noted that three were now closed.

The Board was advised that the greatest number of concerns raised were by nurses and the majority of the cases were raised by staff based at Wythenshawe; however this may have been attributed to a greater awareness on the Wythenshawe site of how to raise a concern due to the visibility of on-site posters advertising F2SU.

The Deputy Director of Workforce and OD described the role and responsibilities of both the Board of Directors, and, the Hospitals/MCSs. She also reported that a recruitment campaign had been launched on the 18th July 2018 with training and the programme launch planned for September 2018. The Board noted that due to the overwhelmingly positive response to the recruitment campaign, 30 applicants would be interviewed over three days in August and September with the aim of recruiting up to 20 Champions across the Group.

The Deputy Director of Workforce and OD explained that a communication plan was in place to promote the new FTSU Guardians and publicise the names of the successful champions. A training programme has been developed to support the Champions in delivering their responsibilities. The Board was advised that a second wave of targeted recruitment would take place in September/October to fill any identified gaps from the first round of recruitment.

The Deputy Director of Workforce and OD outlined the reporting cycle for Freedom to Speak Up and confirmed that the Board of Directors would receive two reports a year in September and March. It was also noted that MFT was currently undertaking a review of the work to date on F2SU using the NHSI review toolkit. Once completed, any gaps identified would be built into the development programme and performance measures would be developed linked to the staff survey. It was acknowledged that once established, the Group may experience an increase in the number of concerns raised, demonstrating staff would know how to contact and feel able to speak to the F2SU Guardian/Champion. It was recognised that this would be viewed as a positive performance measure for the F2SU programme.

Dr Benett confirmed that the approach and framework now highlighted within the report was a very exciting way forward for the organisation.

In conclusion, the Board supported the role of Champions across MFT and noted the report on concerns raised through the Freedom to Speak up Champion from the 1st October 2017.

Decision:	FTSU Report noted	**Action by:** n/a	**Date** n/a

Report on the Patient Experience Annual Review (inc. Patient Surveys; Friends & Family Test, and, 'What Matters to Me')

The Group Chief Nurse presented a report which provided a summary overview of the results of the mandatory national surveys that had been published in 2018, including the Emergency Department Survey (2016), the Children and Young Peoples Survey (2016) the Maternity Survey (2017) and the Adult National Inpatient Survey (2017). She explained that as the surveys were completed prior to the establishment of MFT in October 2017, separate reports were published by the Care Quality Commission (CQC) for the former Central Manchester University Hospitals NHS Trust (CMFT) and former University Hospital of South Manchester NHS Foundation Trust (UHSM).

The Board noted that alignments were made in the analysis where this was possible and comparisons were made with other Shelford Group Trusts, specialist Trusts (where appropriate) and with the Trust's own *'What Matters to Me'* patient experience survey data. It was also noted that the interval between completion of the surveys and publication of the reports for all participating Trusts meant that there was a time lag before the comparative data included in the report became available to inform local analysis.

The Group Chief Nurse explained that there were many positive elements of patient experience identified by the both the national and local survey results. She also explained that the findings of the national surveys also showed that the Trust generally fell within the average range for almost all factors that influenced patient experience when compared to other Trusts. It was noted that areas that persistently received low scores in previous national surveys, such as food and cleanliness, had shown slight improvement but scores remained comparatively low and an extensive work programme continued to drive improvement.

The Board also noted that the report included an update regarding activity undertaken to align reporting and improve the response rate to the *Friends and Family Test,* which provided an additional mechanism by which patients could feed back about their experience. The Board was reminded that in October 2017, the Board had agreed that *'What Matters to Me'* (WMTM) would continue to be developed as the approach to patient experience across the newly formed MFT. The Group Chief Nurse also explained that the report provided an update on the positive progress of the WMTM work programme which supported continuous improvement of the quality of individualised patient experience. She described the next stage of the programme to embed this approach, with the aim of realising the benefits of delivering a high quality, efficient and effective, personal experience for each patient or service user.

The Board noted the content and conclusion of the report as presented.

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

Report on the Gosport inquiry Report

The Joint Group Medical Director presented an overview of a report which detailed the findings of an independent panel set up to investigate concerns raised by families and nursing staff at the *Gosport War Memorial Hospital* from 1991 onwards.

Particular attention was drawn to the main findings of the independent panel and an analysis of the position at MFT in respect of the potential for this practice to have arisen in the past or in the future.

The Board noted that the 'Gosport Report' had also been presented to the Group Quality and Safety Committee in August 2018 and a number of questions had been raised in response and it had been agreed that the questions would be reviewed both by the Hospitals/MCSs and by the corporate Medical and Nursing Teams.

In summary, the Joint Group Medical Director confirmed that a review of the current reporting and oversight on mortality, clinical outcomes and patient experience indicators indicated that the situation that arose at the *Gosport War Memorial Hospital* could not happen at MFT. She explained that the Trust and its legacy organisations had in place, for approximately ten to fifteen years, a process of triangulation of information which would identify the patterns. It was noted that these included, but were not limited to Mortality data review (SHMI and HSMR); Mortality case review; Clinical Audit; a Freedom to Speak Up programme; Trust incident and investigation policies (including the option to report anonymously); PALS and complaints processes (including thematic analysis and reporting); Clinical effectiveness metrics; Staff surveys (including Pulse Check); and, external review of cases and clinical incident reports. The Board noted the further detail contained in the body of the report as presented.

The Joint Group Medical Director explained that whilst it was not possible to say with absolute certainty that events such as these could not have taken place historically at any of the MFT hospital sites (or legacy organisations), there was no evidence apparent of high levels of concern being raised. She also explained that many of the hospitals within the Group were large training centres, not stand alone services such as Gosport which also mitigated the risk of such an event.

The Board was reminded that external bodies had reviewed NHS Trusts regularly since 1993 (when the NHS Litigation Authority commenced their assessment of clinical risk standards) and all of the component parts of the Trust had had systems such as incident reporting and analysis in place since that time.

The Board noted the assurance provided within the report as presented by the Joint Group Medical Director and that MFT Hospitals/MCS would monitor the improvements required at Hospital/MCS Quality and Safety committees and report on progress as part of their on-going patient safety reporting. A further update report would be presented to the Board of Directors in January 2019

Decision:	Report noted and assurance provided	**Action by:** n/a	**Date:** n/a
Decision: Report on Compliance with the Implementation of the Kirkup Recommendations	Progress Report on the Gosport improvement Programme at the Board of Directors meeting in January 2019	**Action by:** Joint Group Medical Director	**Date:** 14th January 2019

The Group Chief Nurse provided an overview of the Trust's compliance with the *'Implementation of the Kirkup Recommendations'.*

The Board was advised that as part of the dissolution process for Liverpool Community Health NHS Trust (LCH), MFT had been asked to takeover provision of the Sexual Assault Referral Service which LCH were commissioned to provide for Merseyside. It was noted that following a period of due diligence and contract negotiation with commissioners from NHS England and authorisation from NHS Improvement, the service had successfully transferred to MFT on the 1st of May 2017 where it had been managed and run by Saint Mary's SARC.

The Group Chief Nurse explained that correspondence received from the Delivery and Improvement Director of NHS I (Cheshire and Merseyside) in March and April 2018 requested assurance as to how the transfer of services addressed the recommendations highlighted in the Kirkup Review; namely recommendations 6.6 and 6.7.

In response to a request from NHSI to a number of questions, MFT had provided assurance on how it had reviewed the handling of previous serious incidents to ensure they had been properly investigated and lessons learned; an how it had reviewed the handling of disciplinary and whistleblowing cases urgently to ensure that they had been properly and appropriately resolved (MFT was also asked to ensure that staff were not placed back into working relationships previously the subject of bullying and harassment). The details of the assurance provided in the report as presented by the Group Chief Nurse were noted.

The Board of Directors noted the contents of the report presented by the Group Chief Nurse and confirmed that it had gained assurance that the actions taken by MFT on the transfer of SafePlace services were undertaken appropriately and safely, in line with the Kirkup recommendations.

Decision:	Report noted and assurance secured.	**Action by:** n/a	**Date:** n/a

Accept the Board Assurance Framework (September 2018)

The Board of Directors accepted the latest Board Assurance Framework (BAF) for September 2018 and was reminded that significant risks to achieving the Trust's key priorities are reviewed and reported on at the Group Risk Management Committee (GRMC) and across other boards and, where necessary, appropriate committees dependent on the risk rating. It was further noted that Trust Scrutiny Committees, on behalf of the Board of Directors, continued to actively utilise the BAF to inform and guide their key areas of scrutiny and especially targeted 'deep dives' into areas requiring further assurance.

The Deputy Director of Workforce and OD explained that following a developmental review of Leadership & Governance arrangements using the Well Led framework during the Summer, a Task & Finish Group would be convened in September 2018 to refine the format, content and operational effectiveness of the current BAF. She also explained that an update on the further development of the BAF would be presented to the Board of Directors in November 2018. The Board also noted that the Audit Committee would continue to focus on seeking assurance that the process outlined had been adhered to along with any gaps in control/assurances; the committee would also consider whether any actions were clearly identified to mitigate and/or reduce the risk(s).

Decision: To	Latest BAF (September 2018) accepted by the Board. Update on the further development of the BAF to be presented to the Board at the next meeting	**Action by:** Executive Director of Workforce & OD	**Date:** 12th November 2018

Note Committee meetings which had taken place:

- Group Risk Management Committee held on 2nd July, 2018
- Audit Committee held on 23rd May, 2018 and Part 2 meeting held on 4th April 2018
- Quality & Performance Scrutiny Committee held on 9th July and 6th August, 2018
- HR Scrutiny Committee held on 7th August, 2018
- Charitable Funds Committee held 9th July 2018
- Minutes of the EPR Task & Finish Group held 6th August 2018

131/18 Date and Time of Next Meeting

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

132/18 Any Other Business

There was no other business.

Present:	Mr J Amaechi	- Group Non-Executive Director
	Mr D Banks	- Group Director of Strategy
	Professor Dame S Bailey	- Group Non-Executive Director
	Dr I Benett	- Group Non-Executive Director
	Mrs J Bridgewater	- Group Chief Operating Officer
	Mrs K Cowell (Chair)	- Group 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
	Professor C Lenney	- Group Chief Nurse
	Mrs C McLoughlin	- Group Non-Executive 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
	Professor M McCourt	- Chief Executive, MLCO
	Mrs H Farrington	- Deputy Group Director of Workforce & OD
	Mr A W Hughes	- Director of Corporate Services/Trust Board Secretary
Apologies:	Mr B Clare	- Group Deputy Chairman
	Mrs M Johnson	- Group Director of Workforce & OD
	Miss T Onon	- Joint Group Medical Director

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING (Public)

ACTION TRACKER

Board Meeting Date: 10th September 2018			
Action	Responsibility	Timescale	Comments
Update on the QIAGEN development to be presented to a Board Seminar	Medical Director (R&I) & Trust Board Secretary	8th October 2018	
Update on Never Events to be presented to the Board of Directors	Joint Group Medical Director	14th January 2019	
Report to the Quality & Performance Scrutiny Committee on the advantages (+/-) of enhancing the current process of capturing and analysing 'Compliments' within the Trust.	Group Chief Nurse	3rd December 2018	
Report on the outcome of the 'Perfect Month' (Cancer) to be presented to the Quality & Performance Scrutiny	Group Chief Operating Officer	3rd December 2018	
Report on cancelled operations and the number of operations re-scheduled within 28 days to the Quality & Performance Scrutiny Committee.	Group Chief Operating Officer	3rd December 2018	
Report on 'Absenteeism' to the HR Scrutiny Committee.	Group Executive Director of Workforce & OD	18th December 2018	
Report on 'Appointment Delays' to the Quality & Performance Scrutiny Committee.	Group Chief Nurse	5th February 2019	
Update on the further development of the BAF to be presented to the Board at the next meeting	Executive Director of Workforce & OD	12th November 2018	
Progress Report on the Gosport improvement Programme at the Board of Directors meeting in January 2019	Joint Group Medical Director	14th January 2019	

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

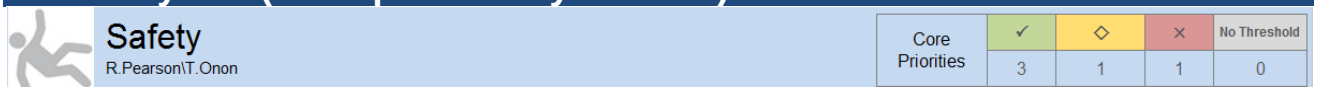
BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Directors
Paper prepared by:	Gareth Summerfield, Head of Information, Information Management, CMFT
Date of paper:	2nd November 2018
Subject:	**Board Assurance Report – September 2018**
Purpose of Report:	Indicate which by ✓ • Information to Consider ✓ • Support • Resolution • Receive
Consideration of Risk against Key Priorities:	The Board Assurance Report is produced on a monthly basis to inform the Board of compliance against key local and national indicators as well as commentating on key issues within the Trust.
Recommendations:	The Board of Directors is asked to Consider the content of the report
Contact:	Name: **Gareth Summerfield** Designation: **Head of Information** Tel No: **0161.276.4768** E-mail: Gareth.Summerfield@cmft.nhs.uk

> Board Assurance Narrative Report – Guidance Notes

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

Summary Bar (Example –Safety Domain)



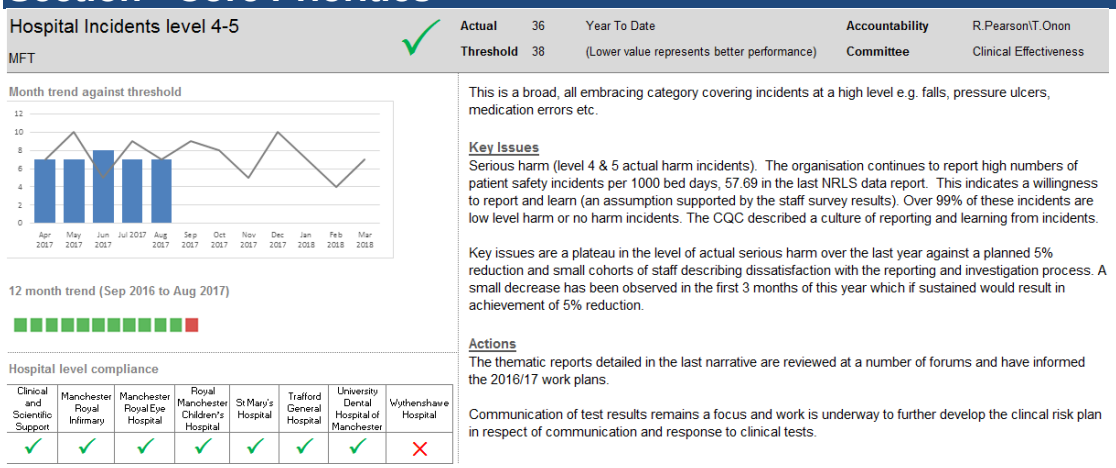
The bar at the very top of each page identifies the domain and accountability. To the right of the top bar is a summary of the core priority indicators associated with the domain. For the example of Patient Safety:

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

Headline Narrative

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

Section - Core Priorities



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

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

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

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

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

NHS
Manchester University
NHS Foundation Trust

> Board Assurance

September 2018

Safety

R.Pearson\T.Onon

Core Priorities	✓	◇	×	No Threshold
	3	0	3	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 has been four reported events.

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

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

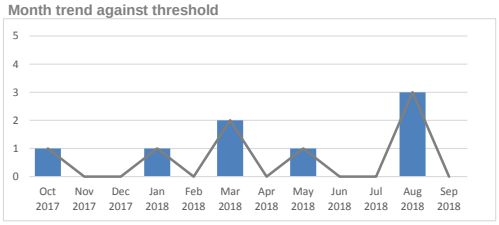
Safety - Core Priorities

Never Events

MFT

Actual	4	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	Trafford General Hospital	Wythenshawe Hospital
×	✓	✓	✓	✓		✓	×
3	0	0	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 has been 1 Never Event a misplaced NG Tube in Wythenshawe ICU.

Actions

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

Progress

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

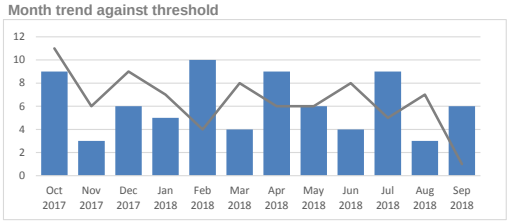
A new MFT Safe Procedure Policy ios currently out for consultation. Further work is now being undertaken Group wide on safer surgery checklists and item counts, this work will be reported to the Quality and Safety Committee.

Hospital Incidents level 4-5

MFT

Actual	37	Year To Date	**Accountability**	J.Eddleston\T.Onon
Threshold	33	(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	Trafford General Hospital	Wythenshawe Hospital
✗	✓	✗	✗	✓		✗	✓
2	8	4	7	0		4	12

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

Key Issues

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

The overall number of serious harm incidents ytd compared to the same period last year is just below the threshold. In terms of hospital sites the threshold is based on the same period last year and it can be seen that a small increase has been observed, 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.

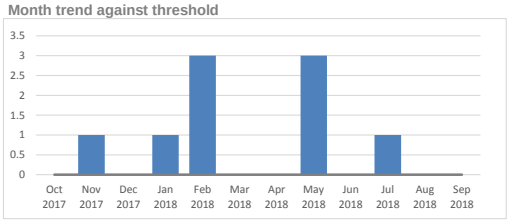
Thematic reports are reviewed at a number of forums and will inform the 18/19 work plans.

Mortality Reviews - Grade 3+ (Review Date)

MFT

Actual	4	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	Trafford General Hospital	Wythenshawe Hospital
✗	✓	✓	✓	✓		✓	✗
1	0	0	0	0		0	3

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

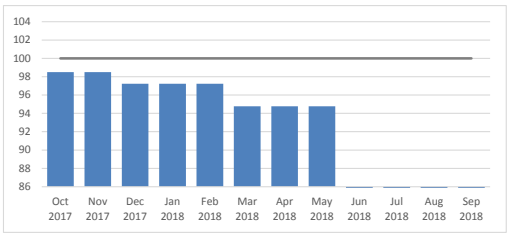
Key Issues

Actions

SHMI (Rolling 12m)

MFT

Actual	94.8	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

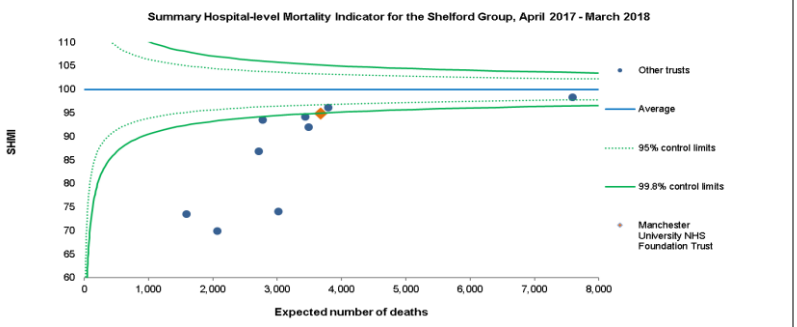
The Learning from Deaths process is currently under review and a Group wide Strategy and Policy is in development. This aims to address inconsistencies in both review and coding to improve learning and assurance processes. Guidance has now been recieved on Involving Families and Carers in the review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

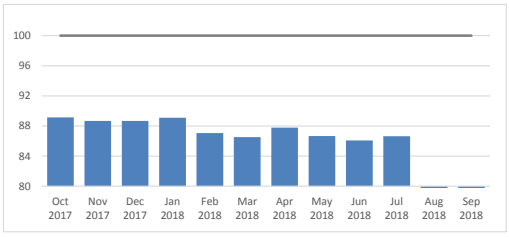
Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
NA	✓	NA	✗	NA		✓	✓
NA	96.0	NA	133.6	NA		76.0	93.9



HSMR (Rolling 12m)

MFT

Actual	86.6	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)

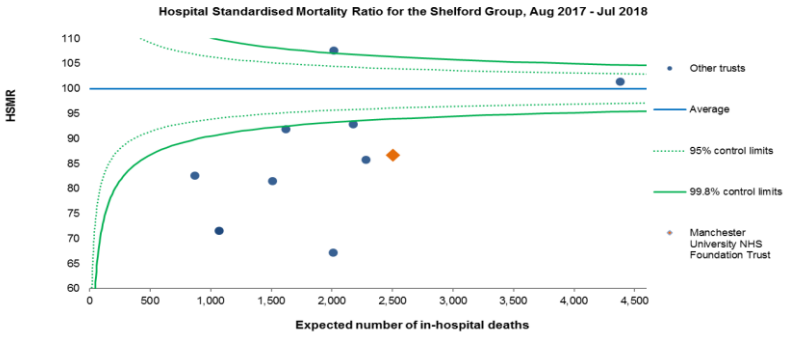
The Learning from Deaths process is currently under review and a Group wide Strategy and Policy is in development. This aims to address inconsistencies in both review and coding to improve learning and assurance processes. Guidance has now been recieved on Involving Families and Carers in the review 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	Trafford General Hospital	Wythenshawe Hospital
NA	✓	NA	✗	NA		✓	✓
NA	82.6	NA	122.0	NA		71.2	89.6

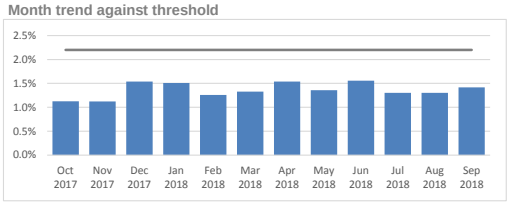


Crude Mortality

MFT

Actual	1.41%	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	Trafford General Hospital	Wythenshawe Hospital
NA	✓	✓	✓	✓	✓	✓
NA	1.8%	0.3%	0.3%	0.0%	0.5%	1.9%

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

Key Issues

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

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

Progress

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

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

> Board Assurance

September 2018

Patient Experience

C.Lenney

Core Priorities	✓	◇	×	No Threshold
	4	0	3	2

Headline Narrative

The number of new complaints received across the Trust during September 2018 was 114; compared to 132 in August 2018 and 160 in July 2018. Performance is monitored and managed through the Accountability Oversight Framework (AOF). At the end of September there were a total of 76 cases over 41 days old, compared to 90 cases at the end of August 2018 and 102 cases at the end of July 2018.

Extensive work has been undertaken during 2017/18 to develop complaints systems and processes, and work continues to align the Complaints/PALS management system, processes, recording and reporting across the Group. Accountability for specific aspects of complaints management has been devolved to Hospital Chief Executives and Directors of Nursing/Midwifery.

MFT continues to promote the Friends and Family Test (FFT) with 73.4% of respondents 'Extremely Likely' to recommend the service they received to their Friends & Family during September 2018, this compares to 75.7% in August 2018 and 75.9% in July 2018. This indicator will include respondents who are "likely" and "extremely likely" to recommend in future reports.

Infection prevention and control remains a priority for the Trust. The total number of attributable bacteraemias reduced from 19 in August 2018 to 10 in September 2018, however, the threshold remains zero. C. Difficile lapses in care remain below the Trust's threshold with 22 cases compared to a year to date threshold of 53 cases.

At the end of September 2018 there were 12 (14.5%) in patient wards/departments across the Group that had a registered nurse vacancy factor above 25%. This number has reduced from 20 wards in April 2018. Escalation and monitoring processes remain in place to ensure delivery of safe and effective staffing levels.

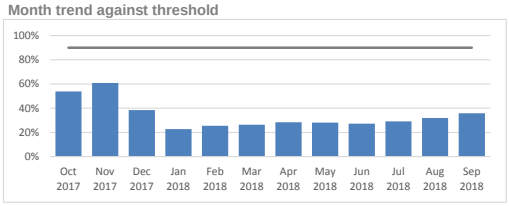
Patient Experience - Core Priorities

Percentage of complaints resolved within the agreed timeframe

MFT

Actual	30.1%	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	Trafford General Hospital	Wythenshawe Hospital
×	×	×	×	×		×	×
35.4%	15.6%	26.1%	27.0%	45.8%		41.7%	37.6%

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 agreed timeframe with the complainant is closely monitored and work is on-going to ensure timeframes are appropriate, agreed with complainants and achieved in all cases.

The overall MFT performance for September 2018 was 35.9%, compared to 31.9% in August 2018 and 29.1% in July 2018. In July 2018 the closure of complaints within the agreed timescales at Manchester Royal Infirmary (MRI) was 10.6% (YTD). The issue was identified and an improvement programme developed with a trajectory for improvement agreed. Closure of cases within agreed timeframe at MRI was 13.2% (YTD) in August 2018 and 15.6% (YTD) in September 2018.

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

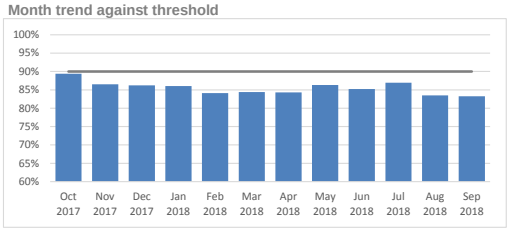
Performance is monitored and managed through the Accountability Oversight Framework (AOF).
MRI is currently receiving additional supported from the Corporate Nursing Team to increase compliance with this indicator.
Wytheshawe Hospital continues to progress a complaints improvement programme.

Nursing Workforce – Plan v Actual Compliance for RN

MFT

Actual	83.3%	Latest Period	**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	Trafford General Hospital	Wythenshawe Hospital
✗ (Site level currently unavailable)							✗
82.6%							84.4%

As part of Safer Staffing Guidance the Trust monitors wards compliance with meeting their planned staffing levels during the day and night. This KPI provides the overall % compliance across all wards within the Trust with meeting the planned staffing levels. The actual staffing includes both substantive and temporary staff usage.

Progress

At the end of September 2018 there were 12 (14.5%) in patient wards/departments across the Group that had a registered nurse vacancy factor above 25%. This number has reduced from 20 wards in April 2018.

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 a shortfall in nurse staffing levels occurs 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. Additional nursing assistant levels are increased in some areas to support this 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.

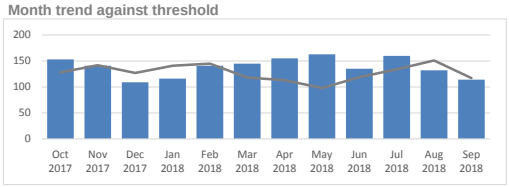
Acuity and dependency data is captured through Health roster SafeCare system with monthly reports provided to the Directors of Nursing to inform them of recommended staffing establishments.

Complaint Volumes

MFT

Actual	859	Year To Date	**Accountability**	C.Lenney
Threshold	732	(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	Trafford General Hospital	Wythenshawe Hospital
✗	✗	✗	✗	✗		✗	✓
53	247	82	102	62		86	170

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 September 2018 was 114, This compares to 132 in August 2018 and 160 in July 2018.

WTWA received the highest number of formal complaints in September 2018 with 36 complaints received. For comparison, WTWA received 44 during August 2018 and 47 during July 2018.

At the end of September 2018, there was a total of 76 cases over 41 days old, this compares to 90 cases at the end of August 2018 and 102 cases at the end of July 2018. The Hospital/ MCS with the highest number of cases over 41 days at the end September 2018 was MRI with 33 (43% of total) cases ongoing. MRI performance is monitored via the Accountability Oversight Framework (AOF) and supported by the Corporate Nursing team.

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

Actions

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

Progress

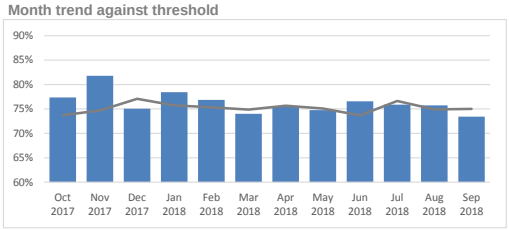
All Hospitals/ MCS have established their governance frameworks to focus on the management of complaints, specifically those that exceed 41 days with a view to expediting closure and identifying learning to inform future complaints management.

FFT % Extremely Likely

MFT

Actual	75.2%	Year To Date	**Accountability**	C.Lenney
Threshold	75.1%	(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	Trafford General Hospital	Wythenshawe Hospital
✗	✓	◇	◇	✓		◇	◇
73.1%	66.8%	70.0%	79.6%	87.3%		85.2%	78.8%

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 currently measures the % of inpatients 'extremely likely' to recommend the service but will be expanded to also include % "likely" to recommend in future reports .

Actions

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

Progress

The overall Trust Response Rate for Inpatients is 23.1% in September 2018; this compares to 20.2% in August 2018 and 20.6% in July 2018.

For Emergency Departments (ED) the response rate in September 2018 is 20.0% this compares to 14.9% in August and 15.0% in July 2018.

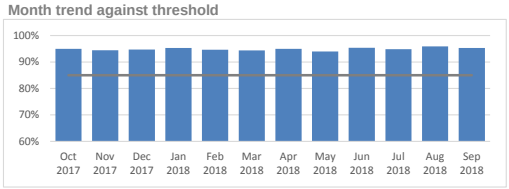
The Quality Improvement and Patient Experience Teams continue to work collaboratively with Hospitals / MCS, Wards and Departments to provide advice and support on FFT.

Food and Nutrition

Central and Trafford Sites Only

Actual	95.1%	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	Trafford General Hospital	Wythenshawe Hospital
✓	✓	✓	✓	✗		✓	✓
97.3%	93.6%	92.4%	96.4%	76.8%		94.0%	96.6%

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

Progress

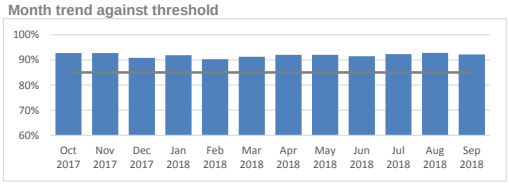
Improvement work continues at both Ward and Trust-wide level across all aspects of food and nutrition. Patient Dining Forums are established for ORC and WTWA and the Trust Improvement Programme Good to Great continues to be coordinated by the ORC Facilities Matron for Dining.

Pain Management

Central and Trafford Sites Only

Actual	92.1%	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	Trafford General Hospital	Wythenshawe Hospital
✓	✓	✓	✓	✓		✓	✓
96.0%	86.5%	87.0%	93.8%	90.9%		91.9%	96.0%

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

Progress

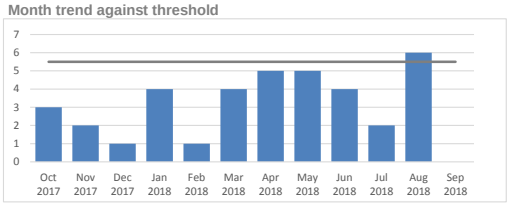
Work continues across the Trust to drive improvements in pain assessment and management.
The oversight for this work is now provided by the Deputy Director of Nursing, CSS who is currently leading work to establish a future plan. Performance against this KPI is monitored through the Trust Harm Free Care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

Clostridium Difficile – Lapse of Care

MFT

Actual	22	Year To Date	**Accountability**	C.Lenney
Threshold	53	(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	Trafford General Hospital	Wythenshawe Hospital
✓	✗	✓	✓	✓		✓	✓
1	8	0	0	0		0	13

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

Progress

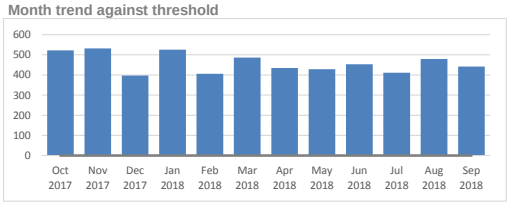
Wythenshawe site has a maximum annual threshold of 39 lapses in care: there have been 12 cases determined as lapses in care for the financial year 2018/2019, (3 in April, 2 in May, 3 in June, 2 in July,5 in August, 1 in September).
Oxford Road Campus and Trafford site has a maximum annual threshold of 66 lapses in care: there have been 9 cases that have been attributed as lapse of care for the financial year 2018/2019, (2 in April, 3 in May, 1 in June, 1 in July, 2 in August, 0 in September). There are a number of cases pending review from September.

PALS – Concerns

MFT

Actual	2649	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	Trafford General Hospital	Wythenshawe Hospital
-	-	-	-	-	-	-	-
132	770	250	227	250		279	569

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

Key Issues

A total of 442 PALS concerns were received by MFT during September 2018. This compares to 479 PALS concerns received during August 2018 and 411 PALS concerns received during July 2018. This is within the limits of normal variation and is monitored closely.

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

Actions

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

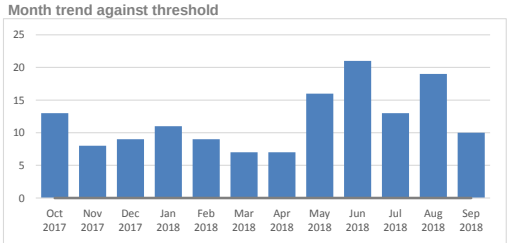
Work continues to reduce the time taken to resolve PALS enquiries with formal performance management of cases over 5 days in place.

All Attributable Bacteraemia

MFT

Actual	86	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	Trafford General Hospital	Wythenshawe Hospital
-	-	-	-	-	-	-	-
5	50	6	3	0		2	20

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

Progress

The Wythenshawe site have had 4 attributable MRSA bacteraemias since April '18, and 16 attributable E. coli bacteraemias.

Oxford Road and Trafford site have had 2 attributable MRSA bacteraemias since April '18, and 68 attributable E. coli bacteraemias.

> Board Assurance

September 2018

Operational Excellence

J.Bridgewater

Core Priorities	✓	◇	×	No Threshold
	6	3	2	0

Headline Narrative

• Diagnostic standard - sustained 6 months of improved performance, with September delivery of 1.88%, which is better than the national picture of 3.1% . Significant improvement in paediatric endoscopy which is no longer a risk to the target, and paediatric MRI, adult endoscopy remains a pressure due to work force challenges since August.

• A&E 4 hours - In September MFT delivered 86.72%, and Q2 87.46% against STF 90%. Following an improved performance in August, the Trust and GM experienced pressures in September, the two key areas of pressure are the adult EDs at MRI and Wythenshawe, with Flow and long length of stay an issue for MRI, and workforce pressures in ED for WTWA. A number of plans are in place to maintain patient safety, furthermore working with system partners relating to additional winter funding for adult social care, and joint working with GMMH, has seen a 20% reduction in breaches, for mental health patients at MRI compared to the same period in 2017.

• RTT - MFT performance remains static at 89.30% in September, which is better than the GM and National position. The Trust has seen an increase in the RTT waiting list, the national focus for 2018/19 is to maintain the waiting list size in March 19 compared to the previous year and the Trust is working with Commissioners on demand management.

• +52 week Waits - The Trust has delivered on its commitment to eradicate +52 week non-RTT breaches by the end of September, in addition breaches related to DIEP procedures have also reduced in line with trajectory. In June the Trust reported 293 breaches which reduced to 26 in September (DIEPs only). A taskforce and PMO remains in place to manage the programme of work related to RTT and waiting times.

• Cancer 62 Day - Performance against the cancer standard is challenged in the MRI Hospital and SMH, with strong performance at WTWA. The Trust reported 83.2% against the 85% standard for Q1, against a demand growth of 12% compared to the previous quarter and 21% increase compared to last year. A task force with MRI, CSS and the corporate performance team has been established to focus on improving timeliness of pathways, with MRI and CSS taking action to improve capacity. NB. national changes to the reallocation of treatment and breaches is likely to impact on provider performance from Q3, despite no real change to pathways, and is a risk to MFT.

• cancelled operations >28 days - MFT has achieved 2.66% performance in Q1 , and remains in top three highest performing acute Trusts in GM.

•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

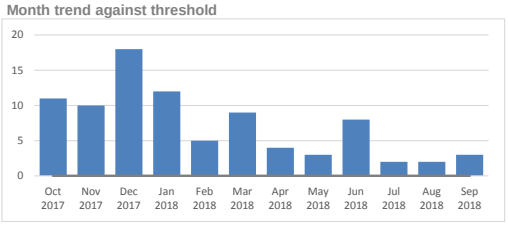
Actual 22 Year To Date

Threshold 0 (Lower value represents better performance)

Accountability J.Bridgewater

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	Trafford General Hospital	Wythenshawe Hospital
✓	×	✓	✓	✓		✓	×
0	15	0	0	0		0	7

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.

Progress

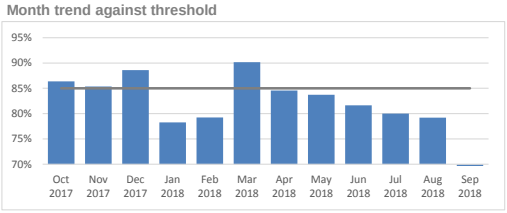
• There are three reported 28 day breaches for September across the Trust, 2 breaches occurred at MRI and 1 at Wythenshawe Hospital general surgery.
• MFT continues to perform strongly against this target, within the top three acute Trusts in GM.

Cancer 62 Days RTT

MFT

Actual	79.6%	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	Trafford General Hospital	Wythenshawe Hospital
NA	✗	NA	✗	NA		✗	✓
NA	66.1%	NA	57.1%	NA		68.3%	90.6%

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, 12% increase in Q1 verses winter and 21% increase compared to the same period last year.

• Capacity is affected in services where there are known national workforce shortages particularly radiology.

Actions

• Oversight and Monitoring by Hospital Cancer Boards.
• Assurance and challenge through AOF
• Senior Corporate monitoring and escalation of delays in patient pathway on cancer PTL
• Task force established with MRI, CSS and Corporate Performance team to support the review of cancer pathways at MRI.

Key Hospital/MCS Actions:

• Speciality level recruitment of workforce to match demand.
• Pathway developments - Lower Gastro Intestinal pilot of the national optimal pathway started 15/10/18, MFT leading Lung diagnostic sector group
• SMH reviewing the cancer pathway and developing an action plan and recovery trajectory.
• Increasing diagnostic scan and reporting capacity - outsourcing where required.
• Working with Hospitals/MCS to tailor information to support the management of pathways and waiting times.

Progress

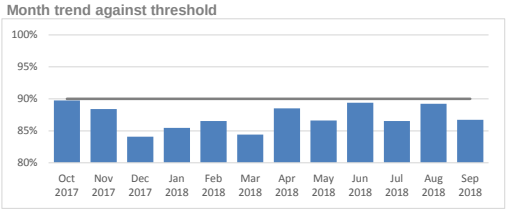
•The Trust is underperforming against the 62 day standard although this has remained stable despite significant increase in demand.
• Q1 provisional MFT performance 83.26% with tumour specific action plans in place monitored through Hospital/MCS Cancer Boards.
• There is good performance at Wythenshawe
• The GM region is also experiencing increased pressure with demand growth in Q1 of 18% compared to last year, which is impacting on performance across a number of providers.
• Improvement in radiology reporting for CT has been seen as a result of additional outsourced capacity.
• Shadow monitoring of the new national reallocation rules in July indicated a marginal drop in performance and is a risk for all providers from Q3 when the changes in the national reporting rules will come into effect.

A&E - 4 Hours Arrival to Departure

MFT

Actual	87.46%	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	Trafford General Hospital	Wythenshawe Hospital
NA	✗	✓	✓	✓		✓	✗
NA	79.4%	96.0%	97.0%	99.8%		99.6%	79.9%

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

Key Issues

• Acuity of patients with a high proportion of patients (45%) 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.
• Stranded patient data suggests 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.

Actions

▪ Weekly Urgent Care Assurance meeting, chaired by Deputy COO/Director Performance.
▪ Hospitals have a number of plans in place that are being progressed to support resilience including:
  - 2018/19 Capacity Plans
  - Transformation plans and patient flow improvement boards
  - 30, 60, 90 day actions linked to urgent care reviews undertaken across MRI and WTWA
  - In addition winter plans are being developed, aligned to national and regional guidance, which were presented to the Capacity and Efficiency Group in October.
▪ In October additional Adult Social Care funding for winter has been confirmed, it is imperative this delivers additionality within the system and focuses on reducing stranded patients. MFT is working with the Manchester Local Care Organisation and system partners to support the development of plans.
▪ Working with system partners and the LCO to reduce long length of stay and improve discharge.
▪ Joint working with GMHH, task force established, working to improve ambulatory pathways and timely assessment of patients.
▪ Capital upgrade to Wythenshawe, MRI, and PED.
▪ MFT representation at GM Action on A&E events.

Progress

• The Trust reported 87.46% Q2 against STF threshold of 90%.
• MFT reported 86.72% for September.

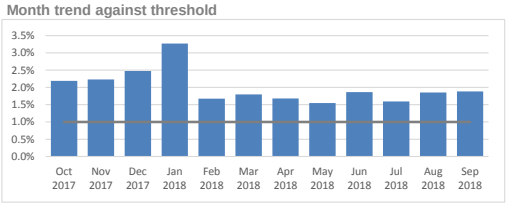
Diagnostic Performance

MFT

Actual 1.9% 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	Trafford General Hospital	Wythenshawe Hospital
◇	✗	◇	◇	NA		NA	✓
1.1%	6.7%	6.0%	6.7%	NA		NA	0.0%

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

- Ability to secure additional consultant anaesthetic capacity for paediatric MRI.
- Capacity to meet demand in adult Endoscopy.
- Ability to secure ad hoc sessions and workforce to increase 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.
- Interim actions being undertaken in adult endoscopy to increase capacity in September and October to reduce breeches including WLI and use of external provider.
- Implementation of the business case for the 3rd MRI scanner.
- Monthly forecasting in place, and weekly oversight meetings to identify issues early and escalate as appropriate.

Progress

- Significant improvement sustained over the last 6, but further step change improvement of circa 0.7% required to achieve the 1% standard.
  Significant improvement within paediatric endoscopy which is no longer a risk for the standard with marginal breaches.
- Significant improvement in paediatric MRI breaches in line with trajectory, but continued improvement required in the remainder of Q3.
- Despite improvements up until July, workforce pressures from August has resulted in a risk to delivery of the standard in October.

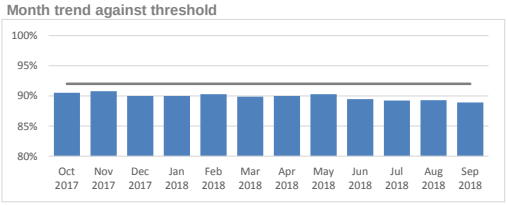
RTT - 18 Weeks (Incomplete Pathways)

MFT

Actual 88.9% 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	Trafford General Hospital	Wythenshawe Hospital
◇	✓	✗	✗	✓		◇	◇
89.6%	92.3%	85.9%	83.6%	93.0%		88.7%	87.8%

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.

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.

Progress

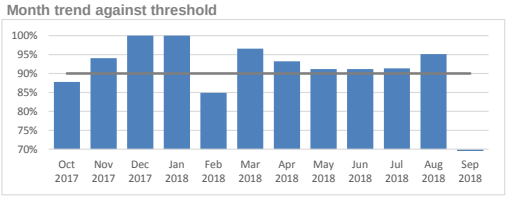
- The Trust has successfully delivered its commitment to eliminate the non-RTT breaches from September onwards.
- A significant improvement has been made from 293 +52 week waits in June to 26 in September, which relate to DIEP procedures only. A recovery trajectory remains in place for DIEPs which forecasts a further reduction to a maximum of 15 by the end of March 19.
- Trust RTT performance whilst below the standard, September 89.3%, is better than national position.
- Trust waiting list has increased by 6.97% since March 18.
- MFT reported RTT performance of 89.30% for September.

Cancer 62 Days Screening

MFT

Actual	93.6%	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	Trafford General Hospital	Wythenshawe Hospital
NA	✗	NA	NA	NA		NA	✓
NA	66.7%	NA	NA	NA		NA	96.2%

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

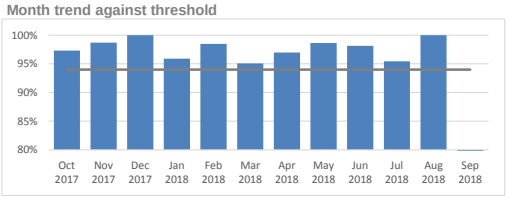
The Trust achieved this target. - One patient breach for patient choice, missed CT appointment.

Cancer 31 Days Sub Surgical Treatment

MFT

Actual	97.6%	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	Trafford General Hospital	Wythenshawe Hospital
NA	✓	NA	✗	NA		✓	✓
NA	96.6%	NA	75.0%	NA		100.0%	100.0%

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

Key Issues

The Trust met the target for Q1.

Actions

Actions taken as per the 62 day standard.

Progress

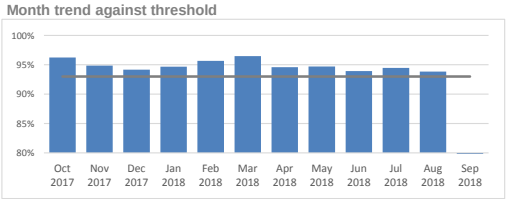
Forecast continued performance against this standard - 2 patient breaches at SMH, one patient was complex and required agreed treatment plan with Christie, the second complex patient from Tameside.

Cancer Urgent 2 Week Wait Referrals

MFT

Actual	94.2%	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	Trafford General Hospital	Wythenshawe Hospital
NA	✓	✓	✗	✓		✗	✓
NA	93.6%	100.0%	88.4%	100.0%		92.3%	95.8%

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

Key Issues

Increased demand in 2 week wait referrals continues to place pressure on MFT cancer services.
Significant increase of 12% in Q1 compared to the previous quarter.

Actions

Collaborative actions taken with speciality teams to strengthen performance and increase the volume of patients seen within 7 days, within the workforce available.
GM have recognised the increase in demand is significant across the region and are reviewing the demand profile.

Progress

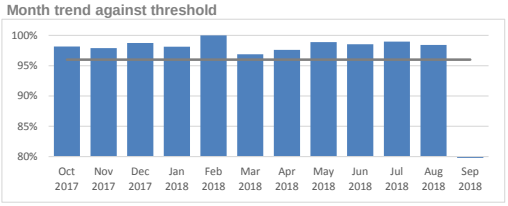
Weekly PTL's attended by the Trust Cancer Manager to provide expertise and monitoring against the target.
Patient choice and capacity pressures at SMH. Escalation to Director of Operations SMH.

Cancer 31 Days First Treatment

MFT

Actual	98.7%	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	Trafford General Hospital	Wythenshawe Hospital
NA	✓	✓	✗	NA		✓	✓
NA	97.8%	100.0%	95.0%	NA		100.0%	99.2%

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

Key Issues

The Trust has achieved this standard.

Actions

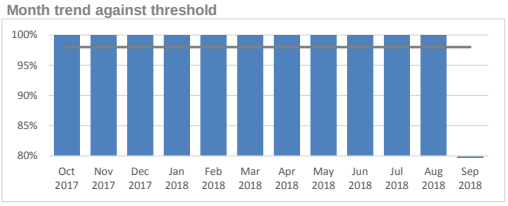
Actions taken as per the 62 day standard.
SMH - one patient breach.

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	Trafford General Hospital	Wythenshawe Hospital
NA	✓	NA	NA	NA		NA	✓
NA	100.0%	NA	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

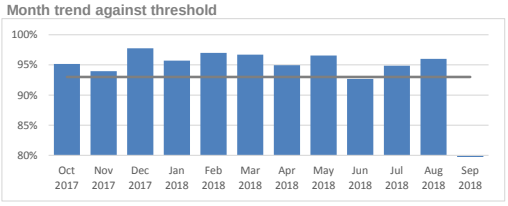
Actions taken as per the 62 day standard.

Cancer 2 Week Wait - Breast

MFT

Actual	95.4%	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	Trafford General Hospital	Wythenshawe Hospital
NA	NA	NA	NA	NA		NA	✓
NA	NA	NA	NA	NA		NA	95.4%

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 over achieved by (+2.4%) against the national standard of 93%.
There was one patient breach in July due to ongoing clinical treatment.

NHS
Manchester University
NHS Foundation Trust

> Board Assurance

September 2018

Workforce and Leadership

M.Johnson

Core Priorities	✓	◇	×	No Threshold
	3	1	7	3

Headline Narrative

The Trust launched its flu vaccination campaign on the 1st October. The programme is a partnership of hospital teams, corporate nursing and the Employee Health & Wellbeing to provide front line teams with protection from this years flu strain. The Employee Health & Wellbeing team have recorded 3,500 staff having being vaccinated in the first week of the campaign.

September saw the completion of the recruitment and training of the Trust's Freedom to Speak UP Champions with the programme launched across the Trust to coincide with the national speak out campaign in October.

Preparation for the annual MFT Excellence awards are now underway.

The third cohort of the Affina Team Coaches have been trained / assessed.

Workforce and Leadership - Core Priorities

Attendance

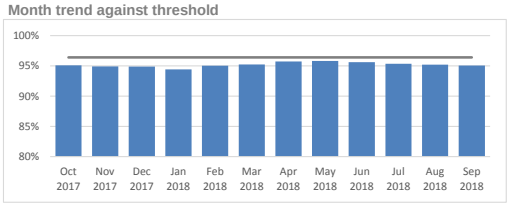
MFT

×

Actual 95.1% Latest Period **Accountability** M.Johnson

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	Trafford General Hospital	Wythenshawe Hospital
×	×	×	×	×		×	×
95.9%	95.0%	95.3%	95.1%	95.4%		93.6%	94.2%

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 September has fallen slightly to 95.1% compared to the previous months figure (95.2%)

The attendance rate was higher last year (September 2017) at 95.4%.

Actions

Information on the action plans to improve attendance was presented to the HRSC (Human Resources Scrutiny Committee) in October.

In the Manchester Royal Infirmary weekly scrutiny meetings continue to track absences where a central spreadsheet has been created to record all sickness cases that are not on the absence manager system yet.

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

Actions plans have been put in place via the Accountability Oversight Framework.

Trust Mandatory Training - Clinical

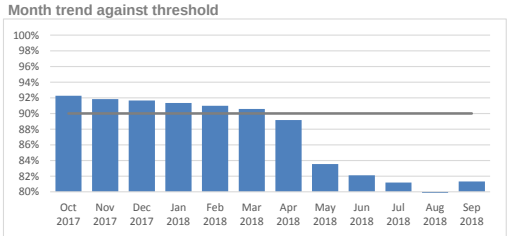
Central and Trafford Sites Only

×

Actual 81.3% Latest Period **Accountability** M.Johnson

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	Trafford General Hospital	Wythenshawe Hospital
×	×	×	×	×		×	NA
85.3%	78.6%	75.0%	88.9%	79.5%		82.3%	NA

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

Key Issues

Compliance increased by 2.3% across the Trust in September.

This is the first month this calendar year where overall compliance has increased rather than decreased.

Actions

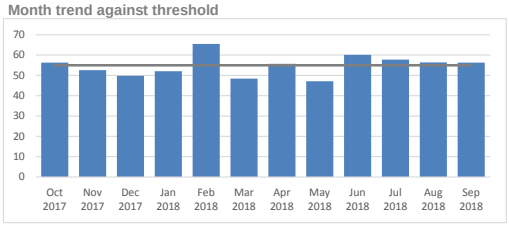
The Group Executive Director of Workforce and OD has written to the CEOs of those hospitals that are not achieving target compliance to request assurance that they have plans in place in order to address this compliance issue at the earliest opportunity. The OD&T and Workforce Development teams are providing regular reports and support to hospitals to ensure improvements in compliance are made quickly. The Hospital HRDs are ensuring that their management teams are prioritising Clinical Mandatory training compliance improvements as a matter of urgency.

Time to fill vacancy

MFT

Actual	56.3	Latest Period	**Accountability**	M.Johnson
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	Trafford General Hospital	Wythenshawe Hospital
✗	✗	✗	✓	✗		✗	✓
66.3	57.6	68.1	50.7	81.8		81.6	46.8

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

Key Issues

Group wide, the Time to Fill figure (which doesn't include Staff Nurses) has fallen from 56.4 days and now stands at 56.3 days for September.

Actions

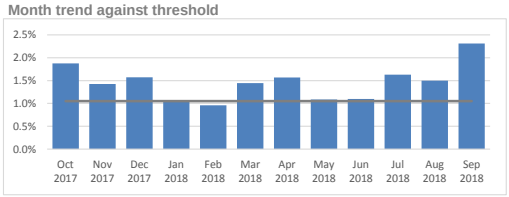
'Time to Hire' for September 2018 is 56.3 working days on average, which excludes Band 5 nursing booked start dates and in comparison to the previous month, the Trust figure has almost stayed the same. This is 1.3 working days over the Trust target and efforts will continue to drive this figure down to ensure new employees are in post as quickly as possible. September saw an increase in the number of candidates who confirmed start dates with MFT, with 100 additional candidates being cleared to commence in post, compared to the previous month. Overall there were 672 new starters in September, 414 of which were candidates joining the Trust from outside of the Trust. Further diagnostic work is about to be undertaken to review the recruitment process to maximise any opportunities for improvement to reduce time to fill to posts.

B5 Nursing and Midwifery Turnover (in month)

MFT

Actual	2.31%	Latest Period	**Accountability**	M.Johnson
Threshold	1.05%	(Lower value represents better performance)	**Committee**	HR Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
✗	✗	✗	✗	✓		✓	✗
2.57%	2.23%	1.84%	4.54%	0.88%		0.44%	1.99%

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

Key Issues

The turnover for the month is 2.31% against a monthly target of 1.05% This B5 Nursing and Midwifery turnover figure is higher than the same reporting period last year which was 1.74% (Sep 2017).

Actions

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

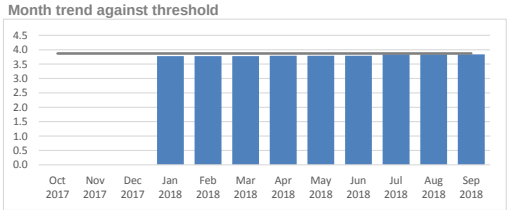
- Retention Strategies developed within each Hospital/MCS
- Divisional work streams focusing on wellbeing/staff focus groups/take a break
- Nursing and Midwifery extended induction for new starters
- Roll-out of 12 hour shifts for staff who wish to condense their hours over a shorter working week
- Identifying new roles within the unregistered workforce to support careers/skills escalator
- Band 5 rotation programmes introduced in RMCH, MRI and WTWA

Engagement Score (quarterly)

MFT

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

Month trend against threshold



Hospital level compliance

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

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

Key Issues

Staff Engagement scores for Q2, taken from the Q2 Pulse Survey, which closed on 23rd September, will be available in mid-October. The overall Group staff engagement score from the 2018-19 Q1 Pulse Check was 3.84.

Actions

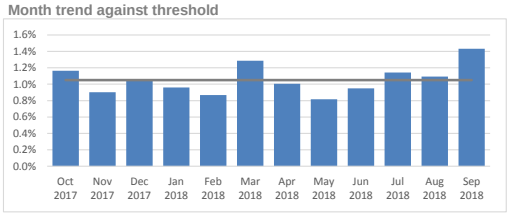
The 2018-19 Q2 Pulse Check results will be disseminated as soon as possible once they are received. The 2018 NHS Staff Survey launched on 2nd October and will remain open until 30th November. Updates on Group and Hospital/MCS/ Corporate response rates for the Staff Survey will be issued on a weekly basis.

Turnover (in month)

MFT

Actual	1.43%	Latest Period	**Accountability**	M.Johnson
Threshold	1.05%	(Lower value represents better performance)	**Committee**	HR Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
✗	✗	✓	✗	✗		✓	✗
1.76%	1.40%	0.78%	1.49%	1.25%		0.63%	1.46%

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 1.43% compared to 1.09% for the previous month. As part of the annual cycle turnover does usually increase in September and in September 2016 and 2017 also stood above target.

Actions

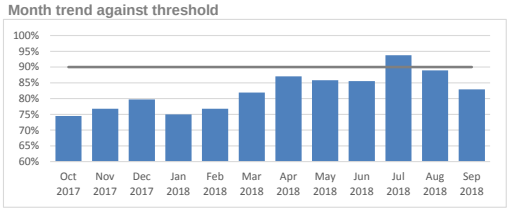
Staff engagement sessions for all staff are planned for the MRI, Clinical Scientific Services and the Children's Hospital.

Appraisal- medical

MFT

Actual	82.9%	Latest Period	**Accountability**	M.Johnson
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	Trafford General Hospital	Wythenshawe Hospital
◇	✗	✗	✗	✗		✗	✗
85.7%	0.0%	84.3%	85.4%	85.2%		84.4%	80.2%

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

Key Issues

Medical appraisal compliance for the Group fell by 6% in September and is now 82.9% - 7.1% below target. None of the Hospitals / Corporate Divisions are achieving target compliance.

Actions

All Hospitals are currently working to plans that were presented to the HR Scrutiny committee in June.

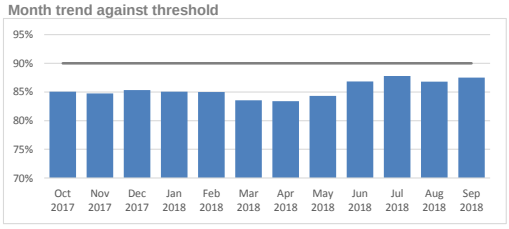
The negative trend in compliance has been highlighted with all HRDs.

Appraisal- non-medical

MFT

Actual	87.5%	Latest Period	**Accountability**	M.Johnson
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	Trafford General Hospital	Wythenshawe Hospital
◇	✓	◇	✓	✓		◇	✓
88.2%	91.8%	88.3%	93.4%	90.5%		87.5%	92.8%

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

Appraisal compliance for the Group in September increased by 0.7% to 87.5%.

Actions

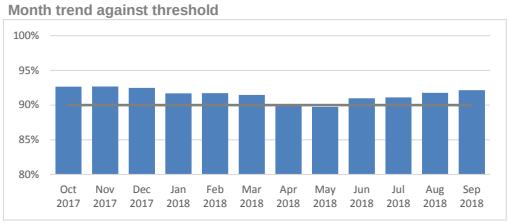
All Hospitals are currently working to plans that were presented to the HR Scrutiny Committee and have provided assurance that they are still on target to achieve 90% or above compliance by March 2019

Level 1 CSTF Mandatory Training

MFT

Actual	92.2%	Latest Period	**Accountability**	M.Johnson
Threshold	90.0%	(Higher value represents better performance)	**Committee**	HR Committee

Month trend against threshold



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 September for the Group has seen compliance increase by 0.4% to 92.2%

Actions

Detailed monthly reports are being shared with HRDs.

Hospital level compliance

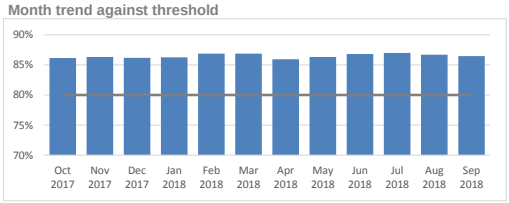
Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
✓	✓	✓	✓	✓		✓	✗
93.3%	91.5%	90.5%	94.8%	91.6%		93.8%	89.5%

Nurse Retention

MFT

Actual	86.5%	Latest Period	**Accountability**	M.Johnson
Threshold	80.0%	(Higher value represents better performance)	**Committee**	HR Committee

Month trend against threshold



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

Key Issues

Nursing retention now stands at 86.5% which is a slight decrease from the previous month's figure (86.7%)

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 86.5%.

Hospital level compliance

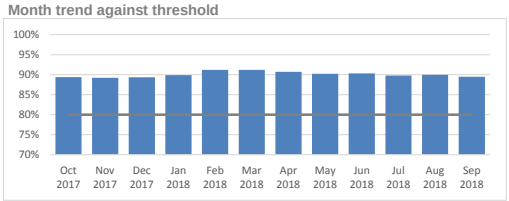
Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
✓	✓	✓	✓	✓		✓	✓
89.8%	83.3%	84.6%	86.5%	90.0%		88.6%	85.5%

BME Staff Retention

MFT

Actual	89.5%	Latest Period	**Accountability**	M.Johnson
Threshold	80.0%	(Higher value represents better performance)	**Committee**	HR Committee

Month trend against threshold



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

Key Issues

We continue to track BME staff which for September was 89.5% for BME staff and 88.8% for White Staff.

Action

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

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
✓	✓	✓	✓	✓		✓	✓
91.1%	87.5%	93.1%	88.8%	93.2%		82.3%	90.3%

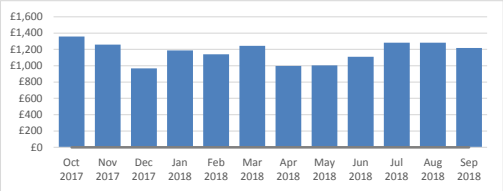
Medical Agency Spend

MFT

Actual £1,218.0 Latest Period **Accountability** M.Johnson

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	Trafford General Hospital	Wythenshawe Hospital
-	-	-	-	-	-	-	-
£22.4	£587.2	£70.0	£1.5	£111.4		£222.2	£207.2

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 September 2018 the total value of Medical and Dental agency staffing was £1,218k.

Actions

Each Hospital/Managed Clinical Service is reviewing their agency spend and identifying exit plans for each long term agency worker and plans for recruitment or transition to bank. There are a number of workstreams relating to Temporary staffing currently progressing which include additional pay/bank rates harmonisation; negotiation of agency commission rates to demonstrate a reduction and to move as many agency shifts to bank where possible, ensuring appropriate cover to meet service requirements, as Patient safety remains the priority.

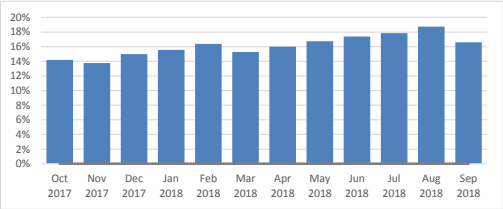
Qualified Nursing and Midwifery Vacancies B5 Against Establishment

MFT

Actual 16.6% Latest Period **Accountability** M.Johnson

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	Trafford General Hospital	Wythenshawe Hospital
-	-	-	-	-	-	-	-
12.0%	20.4%	13.6%	10.4%	13.6%		29.7%	18.0%

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 September 2018 there were 658.4 wte (16.6%) staff nurse/midwife/ODP (band 5) vacancies across the Trust Group This a reduction of 85.2wte band 5 vacancies of from the previous month.

Actions

There are circa 350 nurses and midwives due to graduate or currently registered , with conditional job offers and whose appointments are being processed through the Trust recruitment process. The trust continue to recruit nurses from overseas. There will be 13 international nurses starting in the Trust in October 2018.

A schedule of recruitment events has been developed to ensure the Trust group is now aligned to a Trust wide recruitment strategy.
Recent events have been held at the Wythenshawe site and Oxford Road Campus which saw over 200 delegates attend the recruitment events.

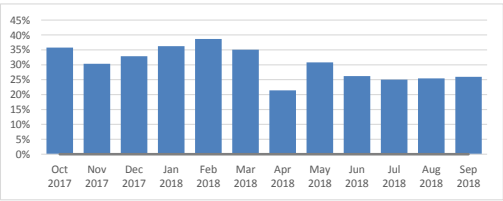
% BME Appointments of Total Appointments

MFT

Actual 26.0% Latest Period **Accountability** M.Johnson

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

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
-	-	-	-	-	-	-	-
28.1%	32.9%	22.2%	19.9%	38.4%		33.0%	28.7%

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

Key Issues

Black and Minority Ethnic (BME) appointments now stands at 26.0% which is an increase compared to the previous month's figure (25.5%)

Actions

The Trust having applied the Workforce Race Equality Standard definition of BME, rather than the EHRC definition (as defined in the explanation above) has shown a drop in scores. Whilst some areas of the Trust are showing recruitment of BME staff at over 35% other areas are below 20%. Further investigation into these areas in now underway.

Manchester University NHS Foundation Trust

> Board Assurance — September 2018

Finance
A.Roberts

Core Priorities	✓	◇	×	No Threshold
	0	1	0	0

Headline Narrative

- Please see agenda item 5.2

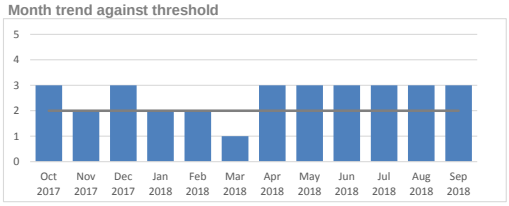
Finance - Core Priorities

Regulatory Finance Rating

MFT

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

Month trend against threshold

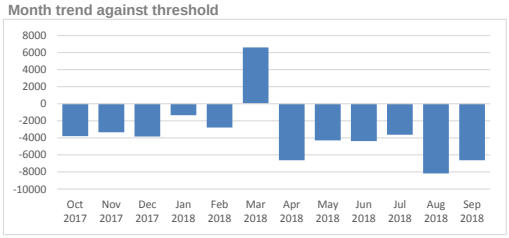


The regulatory finance rating identifies the level of risk to the ongoing availability of key services. A rating of 4 indicates the most serious risk and 1 the least risk. This rating forms part of NHSI's single oversight framework, incorporating five metrics:
- Capital service capacity
- Liquidity
-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

Operational Financial Performance

Actual -£33,763 Year To Date | **Threshold** | **Accountability** A.Roberts | **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	Trafford General Hospital	Wythenshawe Hospital
×	×	◇	×	×		×	×

Strategy

Core Priorities	✓	◇	×	No Threshold
	1	1	0	0

Headline Narrative

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

Strategy - Core Priorities

Agreed 5-year strategy in place

MFT

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

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

Hospital level compliance

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

Agreed annual plan for 2017-18

MFT

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

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

Hospital level compliance

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

Progress against delivery of service strategy milestones in annual plan

MFT

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

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

Hospital level compliance

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

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Julia Bridgewater, Chief Operating Officer
Paper prepared by:	M. Swanborough, Director of Corporate Resilience
Date of paper:	30th October 2018
Subject:	Overview of Trust Winter Plan for 2018/19
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Resolution • Approval
Consideration of Risk against Key Priorities:	a. Delivery of safe and effective care across the 2018/19 winter period b. Achievement of national standards for urgent care across the 2018/19 financial year c. Maintain staff wellbeing across winter period
Recommendations:	The Board of Directors is asked to note the report
Contact:	Name: M Swanborough, Director of Corporate Resilience Tel: 0161 701 5641

v5

1. Introduction

This report provides an overview of the Trust's plan for the 2018/19 winter period. It sets out the key initiatives that will support the management of increases in demand and the associated challenges of winter across the Trust's hospitals.

This year's Winter Plan has been developed for the Trust based on lessons learnt over the course of the last three winters, along with findings from the NHSI Review of Winter 2018/19. The plan covers all MFT clinical and support services and hospitals, and aims to ensure that, where services might be impacted by the winter period, plans are in place to ensure patients remain safe through periods of increased demand and that there is minimal delay or disruption to patient experience.

2. Lessons learnt from the winter of 2017/18

The winter of 2017/18 presented significant challenge for the NHS, with one of the worst flu outbreaks since 2010, long periods of adverse weather (in February and March) and major surges in attendances and admissions, along with increased length of stay and delayed discharges. The NHSI Review of Winter 2017/18 reinforces these challenges faced by NHS Trusts and impact winter challenges had on operational performance.

These challenges were also apparent across MFT hospitals, with higher levels of activity, higher acuity of patients and increased length of stay, particularly in the stranded and super-stranded categories. From discussions with Hospital teams, a number of lessons learnt were identified. These included:

- Need for greater engagement and coordination with external partners to support transfers of care and timely discharges, with increased focus on stranded and super-stranded patients.
- Ability to flex additional bed capacity to manage major surges in demand.
- Ability to manage surges in emergency attendances and ambulance arrivals at certain periods of the day.
- Reinforcement and continued use of SAFER standards across wards

These discussions also identified areas of good practice and key initiatives that supported improvements in flow across the winter period, including:

- Initiation of twice weekly Multi-Agency Discharge Events (MADE) in the MRI
- Tracking and targeting of stranded and super-stranded patients working with the LCO
- Use of capacity escalation areas and additional clinical staffing
- Implementation of internal divert processes for ambulances between MRI and Wythenshawe Hospital, as part of escalation
- Adoption of the flu campaign across hospitals

These lessons learnt and areas of good practice have been incorporated into the 2018/19 Winter Plan.

3. Aims of the 2018/19 Winter Plan

The Winter Plan takes a Trust approach, with measures to address the increases in demand for services. The aim of this plan is to ensure that we keep patients safe, through the delivery of safe and effective care as well as maintaining service delivery and reducing length of stay through minimising delays in discharge. The plan also focuses on supporting staff retention and well-being over this period.

4. Key risks to the delivery of the 2018/19 Winter Plan

There are a number of key risks relating to the delivery of the 2018/19 Winter Plan, including capacity, staffing, performance and working with external partners. The table below provides an overview of some of these risks and impact on service delivery. These risks will be managed and mitigated as part of the implementation and ongoing delivery of the Winter Plan.

Areas	Identified risks
External partners	• LCO winter plans are to be finalised • The plans to support the additional social care funding are currently in draft • Ability of social care services to maintain provision of services to allow for timely discharge and transfer of patients from MFT hospitals
Elective activity	• National directive to reduce elective activity may impact on patient waiting times and performance • Ability to manage elective capacity across winter period and subsequent impact on RTT performance
Performance	• Ability to achieve national urgent care standards and targets across winter period and resultant impact on patient experience • Loss of resultant STF funding linked to A&E performance delivery
Staffing	• Recruitment and retention of staff across winter period • Flu coverage and potential levels of staff sickness across hospitals • Ability to maintain consistent clinical services and business continuity due major flu pandemic • Staff resilience and wellbeing over winter period

Key Initiatives of the 2018/19 Winter Plan

Supporting the Trust's Winter Plan, each of MFT's hospitals, along with Clinical and Scientific Services (CSS), have completed a detailed winter plan. These plans are aligned the aims and include a range of initiatives focused on the areas of bed and ward capacity, service enhancements and changes, patient flow and discharge management, communication and working with partners and workforce and staff wellbeing.

The table below provides an overview of some of the key initiatives that form part of this plan:

Hospital	Key initiatives
Group and Trust wide	• Staff flu vaccine programme • Staff recruitment, retention and staff wellbeing • Winter communication and engagement plan, with staff, patients, public and external partners • Revision of system escalation, with clarity of roles and responsibilities and reporting to Greater Manchester Partnership and CCG • Continuation of weekly Urgent Care Assurance meetings with hospital Directors of Operations • Adult social care funding targeting stranded patients and delayed discharges
Manchester Royal Infirmary	• Use of existing bed capacity, with opening of additional bed capacity for escalation • Establishment of Frailty Service within ambulatory unit • Dedicated additional clinical staffing within Emergency Department (ED) Minors Unit • Expansion of A&E Rapid Assessment Unit • Reinforcement of SAFER standards across wards and specialities, including early discharges and stranded patients
Wythenshawe, Trafford, Withington and Altrincham Hospitals (WTWA)	• Opening of additional bed capacity for escalation • Review of bed capacity and increase transfer of patients to Trafford General Hospital • Increased clinical time for consultants in ED • GP and Advanced Nurse Practitioner streaming within ED • Additional clinical staffing within Urgent Care Centre • Extended hours of ambulatory care units across weekends • Expansion of Integrated Discharge Hub to include Stockport Council social work staff
Royal Manchester Children's Hospital	• Additional consultant and two middle grade clinical fellows in Paediatric ED • Additional administrative cover within Paediatric ED • GP sessions within Paediatric ED • Commencement of additional Paediatric Respiratory Consultant
Clinical and Scientific Services	• Additional imaging lists at weekends and evenings and additional reporting sessions • Pharmacy support to escalation wards and areas • Additional allied health professionals across A&E and wards

Saint Mary's Hospital	• Continued focus on stranded patients • Agreement of escalation processes use of bed capacity by MRI
Manchester Royal Eye Hospital	• Agreement of escalation processes use of bed capacity by MRI • Continued management of elective programme, with daily review of patients and capacity

The delivery of the Winter Plan will be overseen by the Chief Operating Officer, with reporting through to the Trust's Operations and Transformation Oversight Group. The Plan will also form part of the 2018/19 Manchester & Trafford Urgent and Emergency Care (UEC) Delivery Board Winter Plan.

5. Recommendation

The Board of Directors are asked to note the contents of the report.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Julia Bridgewater, Chief Operating Officer
Paper prepared by:	Vanessa Gardener, Chief Transformation Officer
Date of paper:	25th October 2018
Subject:	Transforming Care for the Future Q2 Progress Report 2018/19
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support ✓ • Resolution • Approval
Consideration of Risk against Key Priorities:	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 of Directors are asked to note and support the MFT Transforming Care for the Future Programme 18/19 Quarter 2 report.
Contact:	Name: Vanessa Gardener Tel: 01617015115

Manchester University
NHS Foundation Trust

Transforming Care for the Future

2018/19 Quarter 2 Report

Vanessa Gardener, Chief Transformation Officer
October 2018

Contents

Manchester University NHS Foundation Trust

Overview

Manchester University NHS Foundation Trust

The MFT Transformation Strategy was approved by the Board of Directors on 19 September 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

Manchester University
NHS Foundation Trust

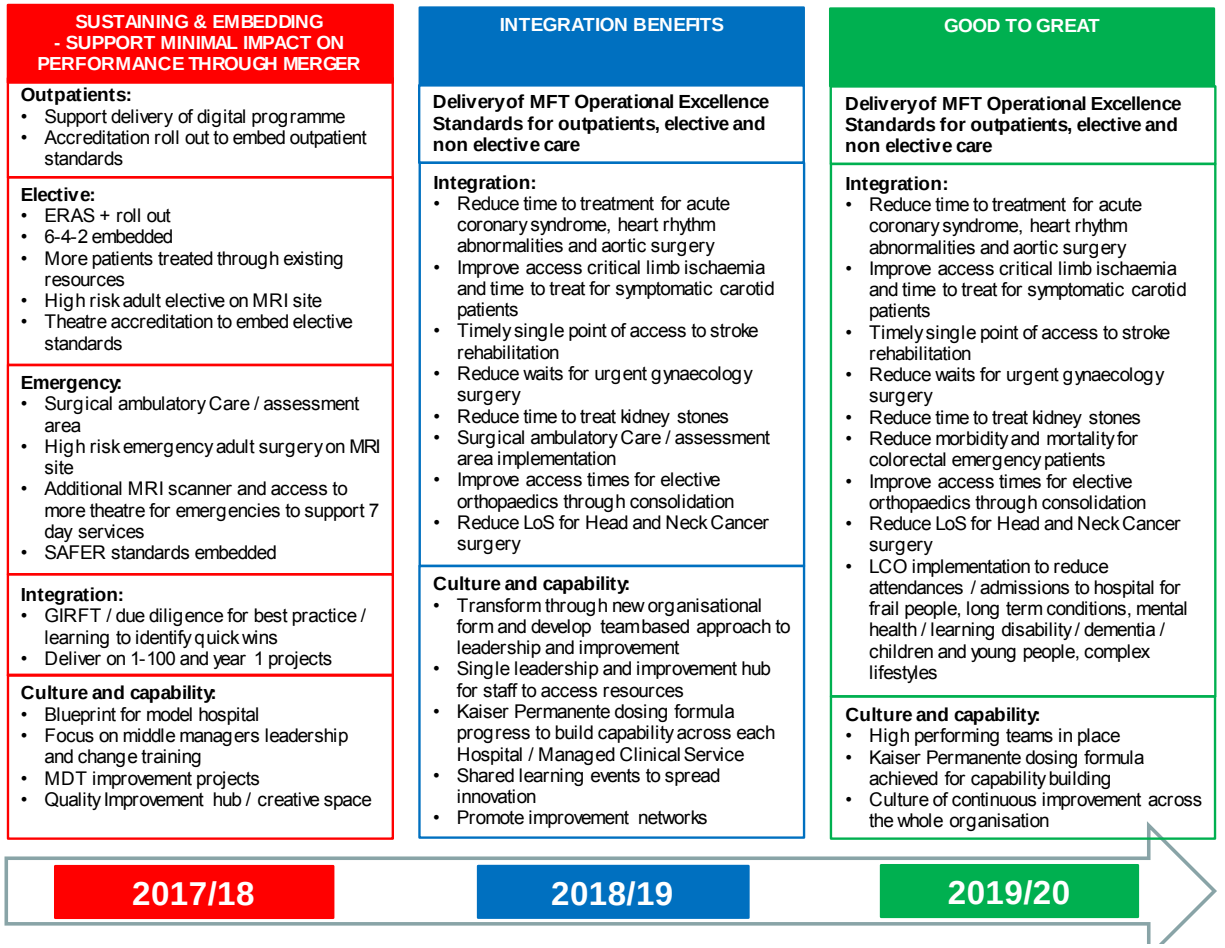
The Roadmap

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 Q2 Progress against agreed objectives

	Objective	Q2 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.	✓ Lessons Learnt from Urgent Care Reviews shared across MRI & Wythenshawe Hospitals ✓ Planning FabChange 70 Event 17-19 October sharing improvement projects nationally
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	✓ Refreshed Elective Standards table top exercise completed across all Hospitals ✓ Digitalising Outpatients Simulation Exercise carried out September 2018 ✓ SAFER review undertaken as part of Urgent Care Review across MRI with focus on board rounds
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	✓ Leadership & Improvement framework approved ✓ Review of urgent care pathways across MRI undertaken with recommendations supporting the patient flow transformation programme
4	Monitor Group progress through the Accountability Oversight Framework (AOF) measures and accreditation scores	✓ Use of Resources (UoR) Clinical Service metrics monitored through the AOF ✓ Audit of MFT Standards across all Hospitals to review progress and governance
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
6	Ensure implementation of the first phase of the general surgery Healthier Together consolidation	✓ Implementation of ambulatory care for general surgery patients at MRI
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	✓ 63 multidisciplinary staff underway with Affina Team Coach training programme ✓ 32 teams 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)	✓ 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
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	✓ MFT Values & Behaviours framework launched and shared through programme boards
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	✓ 130 staff trained in improvement methodologies ✓ Training Plans developed for Hospitals ✓ NACs programme Cohort 12 underway, 75 clinical leaders on programme ✓ Values & Behaviours framework shared at all Programme Boards
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	✓ Supporting Clinical Standard Group (CSG) Leads, identifying training needs and providing advice and direction to support programme delivery, using national best practice and Getting it Right First Time (GIRFT) recommendations to build the programme. Current programme includes clinic consent, non-invasive ventilation and venous thromboembolism (VTE). ✓ GIRFT approach agreed through Clinical Advisory Group and support provided to MRI to facilitate clinical discussions

MFT Operational Excellence Standards

Manchester University NHS Foundation Trust

OUR COMMITMENTS FROM JULY – SEPTEMBER 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

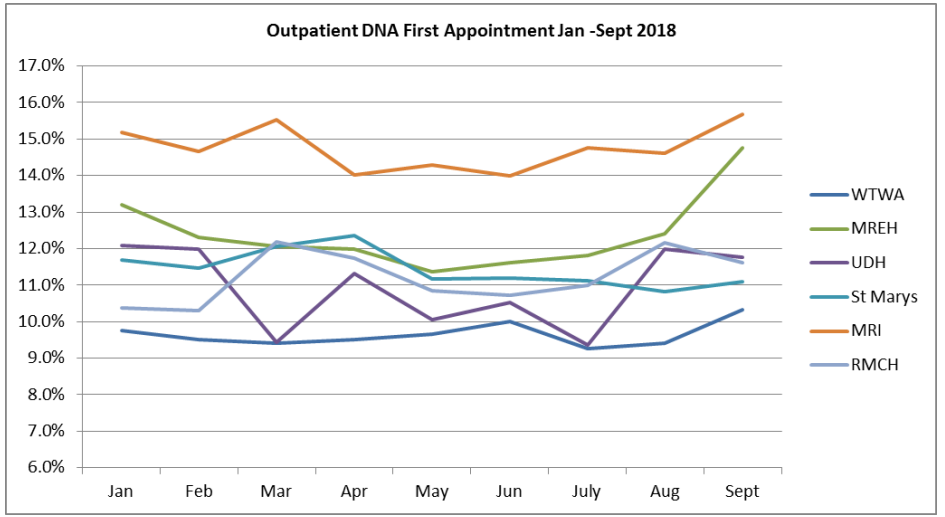
An **outpatient simulation exercise** was carried out in September 2018 to bring to life for staff all the **new technologies** that are being implemented across outpatient areas during 2018/19. This was well attended and gave staff an **insight into the overall patient journey** from point of referral using e-referral, text/digital reminders to the clinic setting with self check in kiosks, clinical correspondence and voice recognition.

Outpatient Simulation Exercise

PROGRESS DURING QUARTER 2:

An **audit of the MFT operational excellence standards** has been completed during September to review progress against improvement plans across all Hospitals. Overall there continues to be a focus across **Hospitals to deliver and embed the standards** and key performance metrics are routinely tracked through operational teams, eg DNAs, clinic utilisation, theatre productivity. Governance arrangements are in place or in the process of being established given changes in leadership and structures across the hospitals/Managed Clinical Services. Group level monitoring is through the Accountability Oversight Framework with key metrics on outpatient did not attends, theatre touch times and length of stay thresholds.

Despite the focus there remains a **challenge with outpatient Did Not Attends** (DNAs) across the Group with MFT continuing to be an outlier when benchmarked against peers. Across all hospitals new **DNAs remain higher** than follow-up DNAs with the **MRI having the highest DNA rate**. Wythenshawe continue to be the best performer across the group. Improvements in follow-up DNAs over the last quarter have been seen in MRI, RMCH and St Mary's. All hospitals are focusing on reducing waiting times and clinic utilisation. The MFT overall position year to date for **new DNA rate is 10.9%** which has deteriorated by 0.9% from last year and for **follow up is 9.3%** which has improved from 9.6% last year.



MFT Operational Excellence Standards

Manchester University NHS Foundation Trust

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Hospital/MCS	Pre-procedure Elective Bed Days	Pre-procedure Non-Elective Bed Days	Did Not Attend Rate (New)	Readmissions: emergency readmissions within 30 days
Peer Average	0.12	0.71	7.09%	8.57%
MFT	**0.38**	**0.99**	**10.88%**	**7.38%**

Use of Resources Clinical Services Metrics MFT Performance

PROGRESS DURING QUARTER 2:

Following ratification of the revised **MFT Elective Standards** in June Hospitals have undertaken a **baseline assessment** by way of a table top exercise against the updated standards. This demonstrated progress continues to be made across the standards but areas of focus for improvement is evident. These are with regards to consent in clinic, review and locking of lists 2 weeks in advance, theatre start times, on the day processes and flow to theatre . A fuller assessment is to be undertaken in Q4 and will enhance the theatre accreditation programme.

During Q2 we have been preparing for the NHSI Use of Resources assessment that is expected in Q4. The assessment is based on a number of Key Lines of Enquiry (KLOEs) which are the lens through which trust performance should be seen . The KLOEs correspond to a number of areas of productivity, one of which is how well the trust is using its resources to provide clinical services effectively and thereby maximise patient benefits. There are **4 key metrics** which are being used as the basis to understand the drivers for performance. These are pre-operative non-elective and elective LoS, readmissions and did not attends. Apart from readmissions MFT is **behind benchmark peers on 3 of the metrics with the MRI and WTWA having the greatest opportunities.**

Improvement plans are in place to deliver against the standards with the metrics being monitored through the Accountability Oversight Framework. A **portfolio of evidence** has been collated to demonstrate the plans and improvements made to date. Using GIRFT national recommendation in specialties such as cardiac surgery a focus is on admitting on the day of surgery to bring the metric in line with peers. We are rolling out **Enhanced Recovery After Surgery plus (ERAS+)** focusing on training patients to be in the best shape possible for surgery. Plans are in place for **improving emergency theatre access** in order to reduce the non-elective pre-operative bed days by end of Q4.

Our **approach to embracing Get it Right First Time (GIRFT)** across MFT has been developed with the Group Medical Director. Its approach is flexible in order to accommodate the different hospital sizes, and delivery of benefits is supported by the **Clinical Standards Groups** (CSG's), whose primary role is to work across services to remove unwarranted clinical variation. The approach we are taking has been described as an exemplar by the GIRFT North West Hub Director.

MFT Operational Excellence Standards

Manchester University NHS Foundation Trust

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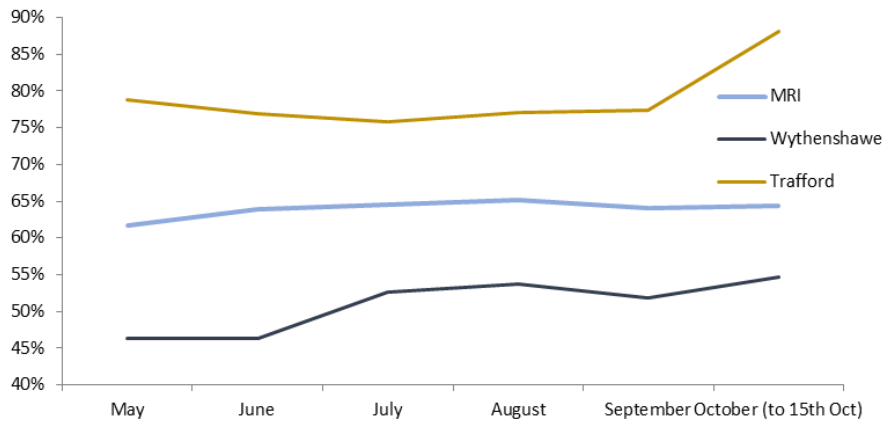

Percentage of stranded patients MFT and Hospitals (May to October)

PROGRESS DURING QUARTER 2:

Following the success of the **Urgent Care Review undertaken** at Wythenshawe Hospital in June the same exercise was completed across the MRI during July. The reviews undertook an assessment of

- factors contributing to the **deterioration in performance in Q1**
- the impact of the **additional measures/interventions** implemented short term to improve performance for Q1
- the financial impact of these additional measures/interventions
- the **sustainability and cost of these measures**/ interventions for the remainder of the year
- the potential impact/unintended consequences of any proposed changes
- the **effectiveness of current monitoring** of delivery of the Sustainability Transformation Fund (STF) trajectory and recommendations regarding any improvements
- clarity regarding **Group 'intervention regime'** for ED performance for the remainder of the year, to include the trigger points for daily escalation meetings

A **lessons learnt from both reviews was undertaken** to understand the variations evident across sites and share the good practice. It was clear there were very different areas for focus across both sites. At **Wythenshawe the main challenge is with regards to ED staffing and medical recruitment**, in which a consultant attraction strategy has been put in place and a successful ED open day held in September. Across the **MRI the issue is the volume of stranded and super stranded patients** (patients with a length of stay greater than 7 and over 21 days) which are **12% higher** than Wythenshawe, and impeding patient flow. During Q2 **Wythenshawe and Trafford has started to see an increase in stranded patients.** Immediate actions were put in place throughout August and patient flow transformation plans as a result of the urgent care reviews are in place. Length of stay is tracked via the Accountability Oversight Framework and MRI has seen a marginal reduction in length of stay and working closely with the LCO the volume of stranded patients although high has stabilised. Equally across Wythenshawe length of stay has improved which has contributed to **bed efficiencies equivalent to 22 beds** at the end of Q2 and a lower bed occupancy than the MRI. A **weekly urgent care assurance meeting** has been put in place chaired by the Chief Operating Officer to oversee delivery at a Group level.

Across the MRI a campaign has been launched to refocus wards on the **principles of SAFER** which is being led by the Clinical Head of Division for Specialised Medicine. This will result in supporting improved flow through earlier in the day discharges. At Wythenshawe a focused month is underway during October that will introduce **heading home discharge principles** and provide consistency to daily ward rounds.

Integrated Care and Pathways to deliver Clinical Benefits

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OUR COMMITMENTS FROM JULY – SEPTEMBER 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 2:

October 2018 has seen the one year anniversary of the creation of MFT. In the past year the Transformation team has continued to support the major inter-hospital integration projects. Programme boards are well established for Trauma & Orthopaedics, Cardiac, Urology and General Surgery specialties with other multidisciplinary groups in place to support integration in Stroke, Vascular, Head and Neck, Respiratory and Frailty services.

The Chief Transformation Officer and Single Hospital Programme Director **presented to the Manchester Health & Care Commissioners and Greater Manchester Health Partnership on the progress made against the Manchester agreement metrics, one year on from the merger**. This was well received and provided commissioners an insight into the amount of effort that is required to implement changes that initially were seen as quick wins but to make the required changes were complex, eg weekly additional emergency gynaecology lists being offered at Wythenshawe.

Orthopaedics

Orthopaedic surgeons from across the trust have been collaborating on **procurement of equipment** and rationalising usage. This will save in excess of **£180K** for MFT.

Daily **virtual fracture clinic** implemented at the MRI site to review sub-speciality patients attending ED. This was an example of implementing good practice from Wythenshawe.

A business case for **increasing consultant and middle grade ortho-geriatrician** posts across MFT has been approved and recruitment is now underway.

Integrated Care and Pathways to deliver Clinical Benefits

Manchester University NHS Foundation Trust

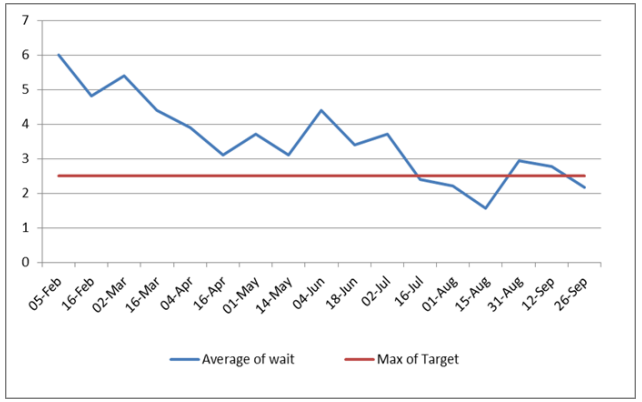
General Surgery

The **new Surgical Assessment Unit at the MRI has opened**. This unit will bring together the existing surgical hot clinic and the new consultant-led General Surgery ambulatory care service. The hot clinic will be expanded to 7 days per week.

New Surgical Ambulatory Assessment Unit, MRI

Gynaecology

Following the successful implementation of an **additional urgent surgery list** the average waiting time for patients requiring that service has **reduced from over 4.5 to under 2.5 days**. This represents a significant improvement and a reduction in waiting time for patients at what is an anxious time.



Waiting times for Urgent Surgery Feb – Sep 18

Vascular

Working with the team **reviewing GIRFT** data for MRI & Wythenshawe Hospitals and **mapping key pathways particularly Aortic Aneurysm**. In November there will be a session for all of the MFT vascular surgeons to begin planning the future service.

MRI Vascular Centre

Cardiac

A plan has been developed that will see the **implementation of a new weekend service for patients with emergency heart rhythm problems** in Manchester. This new service will see the MRI and Wythenshawe hospitals collaborating to ensure that there is **robust provision for these patients every weekend.**

Cardiac Diagnostic Team

Integrated Care Pathways to deliver Clinical Benefits

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Frailty

Work continues on **harmonising frailty pathways**. Plans have been developed for the implementation of a dedicated **multidisciplinary frailty assessment unit** at the MRI hospital from December to improve the response and experience for patients.

Head & Neck

The head and neck teams from MRI and Wythenshawe supported by the Transformation team are working together to think about how patients can benefit from increased collaboration and integration. The initial focus is on **procurement savings and the pooling of waiting lists**.

Urology

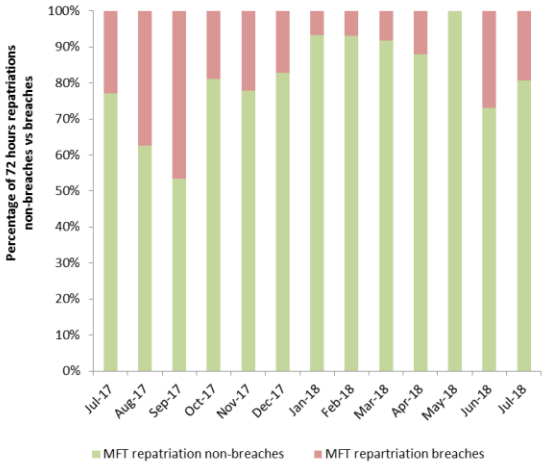
A new pathway has been agreed that would offer MRI patients the option of l**ithotripsy** for treatment of kidney stones during an **emergency admission**.

Elective lithotripsy is being phased out at MRI with the vast majority of patients now booked at **Wythenshawe providing additional choice and a reduced waiting time**.

The urology teams from Wythenshawe and MRI have been developing future plans for the delivery of urology services across MFT which will feed into the trust's clinical strategy

Stroke

The **single point of access for the repatriation of stroke** patients into MFT has gone live 1st October 2018. Coupled with improvements to the bed management for the stroke wards it is anticipated that this will **reduce the amount of time patients spend away from their families** in a regional stroke centre



Stroke 72 hours Admission Performance
Jul 17 – Jul 18

Lithotripter at Wythenshawe

Creating the Culture and build capability for continuous improvement for Change

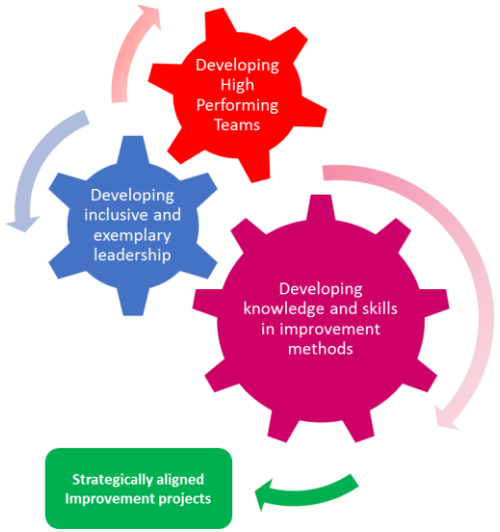
Manchester University NHS Foundation Trust

OUR OBJECTIVES FROM JULY – SEPTEMBER 2018, 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 Leadership & Improvement Framework

PROGRESS DURING QUARTER 2:

Working with OD&T a **Leadership and Improvement Framework** has been developed which sets out the approach to align strategies, our improvement framework and methodologies, capability and capacity building plans, leadership, support and shared learning and how we measure for improvement.

- **Blended approach** using Institute of Health Improvement, Model of Improvement, MFT IQP and Lean
- Equal focus on building a **readiness for change, shared vision and purpose** and spread and scaling up
- Developing the use of a range of **improvement and OD tools**
- Underpinned by strong leadership, engagement and co-design with staff, patients and wider community and high performing team work
- **Collaboration and shared learning**
- Working towards **measurement for improvement**

The **MFT values and behaviours framework** launched in September have been shared throughout all of the integration Programme Boards.

High Performing Team approach, as identified in the Leadership and Culture strategy is continuing to be shared across the Group. The Trust is working with Affina OD (AOD) to help build our capacity for developing effective team based working to deliver high quality care, operational performance, and staff and patient satisfaction. **63 multidisciplinary staff ranging** from middle managers to senior leaders and service improvement, OD and Transformation specialists are now underway with the Affina Team Coach training programme, supporting team leaders to access the AOD Connect on line platform and apply the ten-staged Affina Team Journey programme. The Team Journey approach will be used for strategic teams as part of integration and transformation. The portfolio of support being offered to Team Coaches and Team Leaders is increasing and the programme is being **promoted to clinical areas** following their IQP accreditation and those self selecting in order to **build capability and confidence** across team leader populations and the coaching network, and the creation of a case study portfolio aims to share the benefit and learning from the teams who have implemented the Team Journey successfully.

Creating the Culture and build capability for continuous improvement for Change

Manchester University NHS Foundation Trust

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CAPACITY

"Dosing Formula"	WTE dedicated Improvement
0.05% 11 Staff	>50% WTE
0.05% 92 Staff	10-50% WTE
5% 930 Staff	5-10% WTE
50% 9307 Staff	1-5% WTE

CAPABILITY

Level	Training
Strategic/ Expert	+ 1 year
Practitioner	Months - Year
Champion	Weeks-Month
Foundation	Hours - Days

What does this mean for MFT?

To train	10341
Trained	1922
Percentage Trained	19%

Dosing	Numbers
0.05% Expert	11 staff
0.5% Practitioner	92 staff
5% Champion	931 staff
50% Foundation	9307 staff

Keiser Permanente Dosing Formula

PROGRESS DURING QUARTER 2:

Work has continued to develop the **capability and capacity building plans**, with a review of the baseline Kaiser Permanente dosing formula in light of new reporting functionality being applied and organisational structures being updated on the electronic staff record.

The e-learning module for foundation levels has been further developed which contains knowledge tests and skills assessment tools, built in conjunction with AQuA.

An application day at Champion level is being developed to follow the Foundation e-learning to support staff to apply the knowledge they have gained to a change project. In the interim while both Foundation and Champion levels are being finalised a two day, **'Introduction to Improvement Lite'** is being run onsite by AQuA looking at Foundation level knowledge and Champion application. The Improvement Practitioner level programme has concluded with positive feedback from the 23 participants. The Change curriculum is also being enhanced with a programme from **Health Innovation Manchester**.

To support the development of **Hospital Training plans**, further guidance is being developed to support HR and OD Directors and Transformation Leads to target and prioritise staff for development, looking at local change projects and also preparing for Trust wide change with the commissioning of a new **Electronic Patient Record and forthcoming preparations for implementation**. This will include offering training to those staff participating in the EPR Development Council and the Administration and Clerical and Operational Management workforce who will be contributing to, and effected by the new EPR.

A improvement hub is in the process of being developed as part of the new MFT intranet site. This will bring together a wealth of resources from transformation, IQP and OD&T together to make it easier for staff to navigate the information more easily. A collaboration hub will provide a platform for networking, sharing and generating ideas. It is expected this will be live in the new year.

Looking Ahead

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	Delivery of MFT Operational Excellence Standards	Integration	Culture Change & Capability Building
Quarter 1	• Ratification of Elective Standards • Launch Outpatient Standards across Wythenshawe & Withington • Improvement framework across MRI • Audit of Outpatients across MRI • Share Learning through Transform Together Event and publish case studies • Digitalising Outpatients Simulation Exercise	• Endoscopy due diligence • Ratification of Frailty Standards • Review of Cardiac Services • Development of ACS pathways protocol • Options paper developed for Head & Neck • Options appraisal for Orthopaedics elective activity at TGH • Evaluate progress against Manchester Agreement	• Launch new curriculum for building capability • Support Hospitals in developing training plans • High Performing Team Coaching and accreditation
Quarter 2	• Relaunch elective standards and support Hospitals in refresh of improvement plans against Standards • Share Learning through Transform Together Event and publish case studies • Wythenshawe & Withington Outpatient EBD Event • Review of Urgent Care flow across MRI	• Establish pathway for Fractured neck of femur patients from Wythenshawe to TGH • Evaluate frailty across the 3 sites against standards and develop improvement plans • Pooled daycases in Urology • Implementation of new pathways for Lithotripsy • Evaluate progress against Manchester Agreement	• Quarterly staff pulse check • Implement Single Improvement Hub • Communicate Transformation Strategy 'Rich Picture' • Shelford Network
Quarter 3	• Working with the nursing team on ensuring the theatre accreditation process embeds the elective standards • Share Learning through Transform Together Event and publish case studies • Support Wythenshawe & Withington in assessment against outpatient improvement plans • Re-focus on SAFER to embed standards across MRI & Wythenshawe	• Implement Single point of access for Stroke referrals • Establish a Trusted Assessor model • Implementation of ambulatory care for general surgery • Evaluate progress against Manchester Agreement • Review and support quick wins against Clinical Service Strategies	• Quarterly staff pulse check • Draft capacity training specification for 2019/20
Quarter 4	• Review standards against good practice • Evaluate progress against the work programme and agree 2019/20 plan • Hospital Capacity Plans • Share Learning through Transform Together Event and publish case studies • Elective standards assessment	• Develop 19/20 plans based on the opportunity pack data and accountability oversight framework • Evaluate progress against Manchester Agreement	• Evaluate 19/20 capability programme • Quarterly staff pulse check

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Julia Bridgewater, Chief Operating Officer
Paper prepared by:	David Furnival, Group Director of Estates & Facilities Claire Igoe, Head of Environmental Sustainability
Date of paper:	November 2018
Subject:	The MFT Sustainable Development Management Plan
Purpose of Report:	Indicate which by ✓ • Information to note • Support • Resolution • Approval ✓
Consideration of Risk against Key Priorities:	The ambitious SDMP sets out the Trust vision, strategy and objectives for delivering sustainable healthcare across the city of Manchester, Trafford and beyond. The SDMP for the Trust is underpinned by annual delivery plans and progress reported in the annual report.
Recommendations:	To **approve** the attached document.
Contact:	Name: David Furnival Tel: 0161 7015067

1. Executive Summary

The Sustainable Development Management Plan outlines the organisations vision, aims, objectives, plans and priorities for delivering sustainable healthcare. It sets out how the organisation will use its influence to drive improvements in the best interest of the public's health.

This paper requests approval for MFT's newly drafted Sustainable Development Management Plan (SDMP). The SDMP will help MFT to:

- Identify clear actions to drive forward sustainable healthcare
- Achieve cost savings in areas such as utilities, waste disposal and transport
- Improve the health of our local community
- Meet our legislative and policy requirements
- Provide the required evidence that we are effectively managing sustainability and enhancing social value when bidding for work

2. Why do we need a new SDMP?

The full length version of the NHS standard contract requires that all providers are required to have an SDMP in place. NHS Improvement and NHS England expect all NHS providers to have a Board approved SDMP as this is considered a measure of a well-led organisation. The Department of Health and Social Care, NHS England and all arm's length bodies produce their own Board approved SDMPs and lead by example. Information from the NHS Sustainable Development Unit (SDU) indicates that sustainability is a high priority in the new Long Term Plan.

Following the organisational merger and significant developments in associated national and regional policy, a new strategy is required. This strategy replaces the legacy CMFT's Sustainable Development Management Plan and the legacy UHSM's Carbon Management Plan.

Delivering sustainable healthcare will achieve the goals of reducing our environmental impact (and associated carbon footprint), reducing costs and enhancing our social value.

The SDMP has been assigned a maximum validity of 5 years and will be subject to regular reviews during the interim period, or in light of major national policy or organisational changes.

3. What's in the SDMP?

The strategy has been fully aligned with national guidance, best practice, Manchester specific policies and follows the structure set out in a guide recently published by NHSI in conjunction with the national Sustainable Development Unit.

The content is based on the latest organisational assessment, undertaken against the national Sustainable Development Assessment Tool (SDAT), a qualitative assessment of sustainable development for healthcare providers. The results from this assessment were used in conjunction with a series of stakeholder workshops to further refine the content, and a consultation with both key stakeholders and wider staff has been undertaken to ensure that the plan meets the needs of the organisation.

Objectives have been set against each of the ten areas within the SDAT;

- Corporate Approach
- Asset Management and Utilities
- Travel and Logistics
- Climate Change Adaptation
- Capital Projects
- Green Space and Biodiversity
- Sustainable Care Models
- Our People
- Sustainable Use of Resources
- Carbon and Greenhouse Gases (GHGs)

4. How will the SDMP be delivered?

Delivery of the strategy will be through a combination of an ongoing programme of work that is being undertaken by the Energy & Sustainability Team and collation and reporting of other relevant work programmes that the organisation is undertaking.

The Head of Environmental Sustainability will be responsible for monitoring, tracking and reporting performance against the SDMP through internal and external channels as required.

The Group Director of Estates and Facilities will be responsible for providing the resources required to deliver the plan and has senior ownership of the Sustainability portfolio.

5. Recommendation

The Board of Directors are requested to approve the attached SDMP, continue to provide active support, champion the associated work programmes and receive an update on progress against the SDMP at least annually.

Agenda Item 8.4(ii)

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The Masterplan

Making Sense of Sustainable Healthcare

2018–2023

Sustainable Development Management Plan (SDMP)

Version 1.0

A bit about us

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

We are now one of the largest Acute Trusts in the UK, employing over 20,000 staff and treating more than two million patients every year across nine Hospitals.

Our family of Hospitals incorporates Altrincham Hospital, Manchester Royal Eye Hospital, Manchester Royal Infirmary, Royal Manchester Children's Hospital, Saint Mary's Hospital, Trafford General Hospital, University Dental Hospital of Manchester, Wythenshawe Hospital and Withington Community Hospital.

We are the main provider of Hospital care to around 750,000 people in Manchester and Trafford, and the single biggest provider of specialised services in the North West of England, which include Breast Care, Vascular, Cardiac, Respiratory, Urology Cancer, Paediatrics, Women's Services, Ophthalmology and Genomic Medicine.

Contents

Chairman’s foreword

I very much welcome and support this **Sustainable Development Management Plan (SDMP)***. We have undergone significant organisational changes since our last SDMP was released in 2014 and we've made great progress on the delivery of our previous commitments. Since the last plan, healthcare budgets have devolved, two Trusts have merged to form Manchester University NHS Foundation Trust (MFT) and the production of this plan is very timely.

As a large, multi-site organisation we have a significant environmental impact. We generate substantial waste and carbon as a result of our clinical activities, and the travel and transport needed to deliver goods and services and move staff, patients and visitors impacts on local air quality. Without a firm strategy and plans to manage and reduce our environmental impact and improve efficiency and resilience, the cost of delivering our services will rise and become more challenging in a changing climate.

As an **Anchor Institution** we are committed to embedding sustainability across our own organisation, leading by example in our sector and improving the health and wellbeing of the communities we serve. We will collaborate with our healthcare partners and key stakeholders to ensure that our work is aligned to deliver a shared set of goals.

Everyone has a part to play in delivering this plan, and by working together we can achieve more and deliver sustainable healthcare.

Kathy Cowell OBE DL
Group Chairman

***All terms in bold are explained in the Glossary which can be found in Appendix 1**

This plan will contribute to the great sustainability work being undertaken right across Greater Manchester.

The Greater Manchester Combined Authority (GMCA) has formed the Green City Region, tasked with helping businesses, residents and the public sector to improve energy efficiency, address **climate change** and **air quality** as well as invest in the natural environment. This requires bringing together stakeholders from across the city to make Greater Manchester carbon neutral.

A message from the Mayor of Greater Manchester

I have an ambition to make Greater Manchester one of the leading green cities in Europe. To achieve this, we need to accelerate our ambitious plans to reduce waste, protect and enhance our natural resources, decarbonise our energy and tackle air pollution.

I welcome and endorse MFT's commitment to the green agenda. This plan sets out a clear path and firm actions, and aligns with my goal to bring Greater Manchester's date for achieving carbon neutrality forward by at least a decade to 2040.

Andy Burnham
Mayor of Greater Manchester

Introduction

This ambitious SDMP sets out our vision, strategy and objectives for delivering sustainable healthcare across the city of Manchester, Trafford and beyond. Our SDMP is underpinned by annual delivery plans and progress reported in the annual report.

A sustainable health and care system delivers high quality healthcare within the available social, economic and environmental resources. It provides added value for taxpayers and improves public health within the context of diminishing financial and natural resources. We cannot change the past, but we have a moral and ethical responsibility to leave behind a world that is not polluted or depleted of essential resources for future generations.

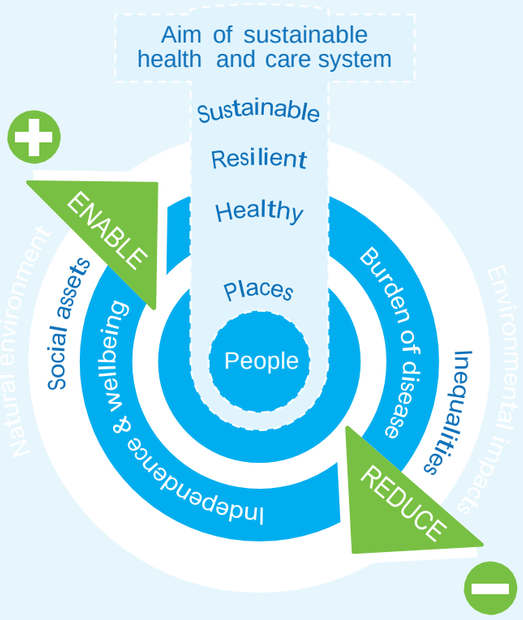
What is Sustainable Healthcare?

Enable the positives

By valuing our physical and social environment, we can restore our natural environment and strengthen our social assets, while enhancing our independence and wellbeing at both a personal and community level. By doing so we improve the quality of care, build strong communities and generate conditions where life is valued in ways that current generations can be proud to pass on.

Reduce the negatives

By radically reducing the harmful impact of how we currently live we can stop wasting finite resources, reduce the burdens of preventable mental and physical ill health, reduce social inequalities and reduce risks from a changing climate. In addition, many interventions that reduce harmful impacts also promote positive **co-benefits** and reduce the burden of disease.



Why do we need this strategy?

All NHS organisations are required to have a Board-approved SDMP that is monitored, evaluated and informed by engagement with staff, service users and the public.

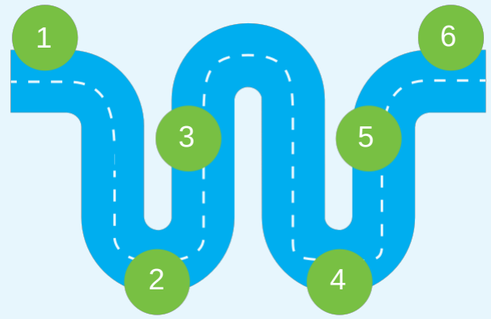
We are legally obliged to address climate change, with an 80% reduction in carbon emissions required by 2050 as set out in the UK's Climate Change Act (CCA). This strategy responds to this and other requirements placed on the Trust to manage and reduce our environmental impact.

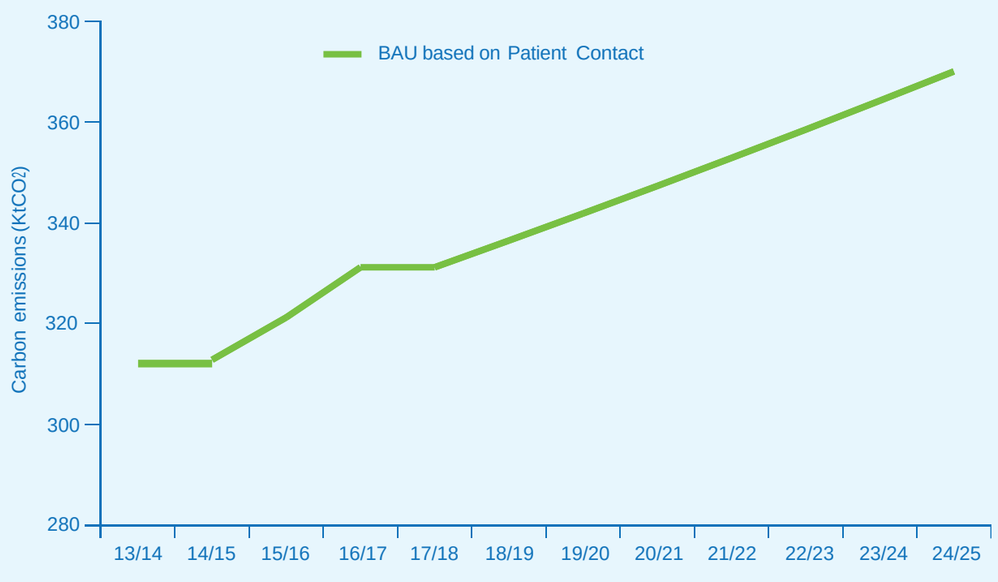
As a leading local Anchor Institution, we play an important role beyond the boundaries of our Estate, in contributing to a greener, healthier and more prosperous Greater Manchester. Manchester is one of the 20% most deprived unitary authorities in England. Life expectancy is 8.1 years lower for men and 7.0 years lower for women in the most deprived areas and alcohol-related hospital stays are worse than the average for England. The dominant causes of morbidity and mortality are now chronic and preventable long-term conditions, which are exacerbated by poverty, stress, air quality and dietary and lifestyle factors such as obesity and inactivity. The population is ageing, and by supporting people to live well for longer, and addressing health and social inequalities present in our local communities, we can help to reverse this trend and improve health outcomes.

We've developed our SDMP to be inclusive and representative whilst responding to a rapidly changing world. Sustainable healthcare will help our budgets stretch further; it contributes towards the green ambitions of Greater Manchester and it will reduce pressure on health services.

Business-as-usual is simply not an option any longer. We are facing an increasingly complex series of interconnected challenges. Patient numbers will continue to increase and, without a plan, our **carbon footprint** will not reduce in line with legal obligations, and we would not hit local and national targets. Collective action delivered by multi-stakeholder partnerships is essential if we are to deliver sustainable healthcare.

Navigating this strategy





Based on projected future patient activity, our carbon footprint will continue to grow and we would not meet our mandatory obligations.

Vision for sustainable healthcare

Fundamental and innovative long-term transformations are needed if we are to respond to an emerging future and protect the environmental, financial and social sustainability of the Trust.

We are committed to being a leader in sustainable healthcare, by reducing environmental impact, protecting our natural environment, empowering staff and operating responsibly, enhancing social value and collaborating with our stakeholders across the system to generate the best health and quality of life for all who live and work within the communities we serve. This will be achieved by embedding sustainability into workplace practices and across our supply chain, applying our Trust's vision of 'Together Care Matters', and recognising that we can achieve more by working in partnership.

Some of the targets set in our SDMP are not a quick fix and may exceed the lifetime of this strategy, but it is our duty to be open and honest about the successes and challenges we face. We are ready to be bold in order to become a leading provider of sustainable healthcare.

What's in the strategy?

Previous strategy focused on Estates efficiencies around energy, water, waste and travel. The scope of our new strategy has been expanded to encompass wider issues of health, wellbeing and social value, whilst moving us closer to achieving long term carbon reduction targets.

To help inform the content of this strategy, and ensure that we covered all aspects of sustainability, we identified Four Core Themes.

Environment
Realising environmental gain

Improving environmental efficiency across our estate and using resources more efficiently.

Health
Enhancing health and wellbeing

Supporting the health and wellbeing of patients and staff by providing healthy spaces and empowering healthy choices.

Future
Being future ready

Increasing the resilience of our organisation and assets to future demands and pressures.

Community
Delivering social value

Enhancing our role and impact in the community by thinking and working beyond the boundaries of our nine hospitals in Greater Manchester.

The Four Core Themes have been applied across the 10 modules of the healthcare sector tool for measuring and improving qualitative sustainability performance. This tool is known as the Sustainable Development Assessment Tool, or **SDAT**. The ten modules have been used as a basis for defining this strategy.

Corporate Approach	Asset Management & Utilities	Travel & Logistics	Adaptation	Capital Projects
Greenspace & **Biodiversity**	Sustainable Care Models	Our People	Sustainable Use of Resources	Carbon / **GHGs**

Sustainable Development Goals (SDGs)

Our strategy is aligned with the UN's 17 Sustainable Development Goals (2015-2030), an ambitious collection of global aims intended to encourage countries to end all forms of poverty, fight inequalities and climate change, whilst ensuring that no one is left behind. We have considered how MFT can contribute to the SDGs as a whole, as well as how planned activity across the ten SDAT modules contributes towards the delivery of this strategy.

Developing the SDMP

The process of developing this strategy involved staff as well as wider stakeholders. This was important to ensure that it reflected the needs and ambitions of our organisation, and empowered staff to contribute and embed sustainable healthcare within their roles and departments.

1 →

We reviewed legacy plans and performance to date.

2 ↓

Baseline assessment
Our latest SDAT score and action plan identified areas for improvement and best practice.

3 ←

Stakeholder engagement
We held workshops with key stakeholders to understand priorities, consider future trends and inform the content of the strategy.

4 ↓

A **materiality assessment** was undertaken to gather insights on the relative importance of specific sustainability issues and inform our strategy. We considered the scale of impact and influence across all ten modules of the SDAT. Further detail is contained within Appendix 2.

5 →

Wider staff consultation
We shared our initial aims and objectives across the organisation and gathered feedback.

6 ✓

Finalising the strategy
Feedback and staff input was taken on board in the development of the full strategy.

Drivers for change

Drivers provide legal and policy context for improving sustainability and can be categorised into five key groups, as outlined below. These drivers are correct at the time of publication but are subject to regular review and updates across the lifetime of this strategy.

1. Legislative

Civil Contingencies Act Climate Change Act Environmental Protection Act Public Services (Social Value) Act
European Emissions Trading Scheme
The Waste Regulations

2. Healthcare specific guidance, strategies and policies

Standard Form Contract Sustainable Development 2017-19
HM Treasury's Sustainability Reporting Framework
Public Health Outcomes Framework
Fair Society, Healthy Lives (The Marmot Review)
NHS Long-Term Plan
Sustainable Development Strategy for the Health and Social Care System 2014-20
Adaptation Report for the Healthcare System
The Carter Review
NICE guidance – physical activity, walking and cycling
Health Technical Memoranda and Health Building Notes
Sustainable Transformation Partnerships Plan
The Naylor Review

3. International and European Guidance

EU Waste Directive
Intergovernmental Panel on Climate Change Global Warming of 1.5ºC Report
United Nations Sustainable Development Goals
World Health Organisation: Environmentally Sustainable Health Systems in Europe
World Health Organisation: European Policy for Health and Wellbeing
The Global Climate and Health Alliance:
Mitigation and Co-benefits of Climate Change

4. UK Strategy and Guidance

National Policy and Planning Framework 2012
DEFRA The Economics of Climate Resilience
The Stern Review 2006: The Economics of Climate Change
HPA Health Effects of Climate Change
National Adaptation Programme:
Making The Country Resilient To The Changing Climate
DEFRA 25 Year Plan
UK Air Quality Strategy
Building Regulations
Government Buying Standards

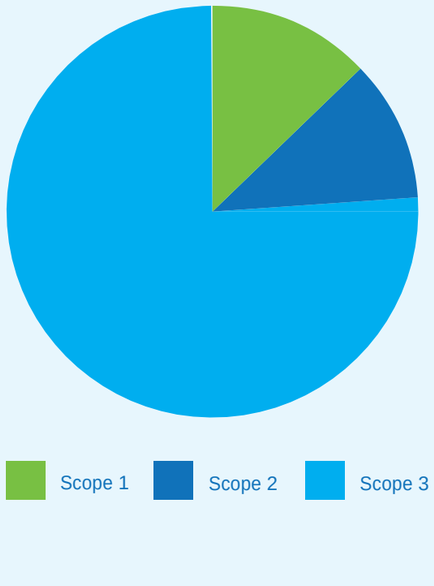
5. Manchester; local strategies and plans

Greater Manchester Climate Change and Low Emission Implementation Plan
Greater Manchester Transport Strategy 2040
Greater Manchester Air Quality Action Plan
Green and Blue Strategy and Action Plan
Springboard – A New Environmental Vision For Greater Manchester
Manchester Joint Health and Wellbeing Strategy
Made to Move
Manchester Population Health Plan
Our Manchester – The MCR strategy
Plastic Free GM campaign

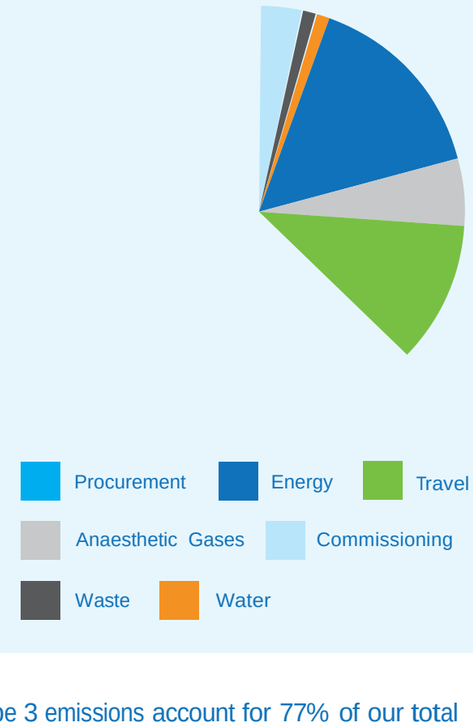
Progress to date

All our activities have a carbon footprint and this is categorised into three scopes. Scope 1 covers **direct** emissions from our activities (use of anaesthetic gases and burning of gas to produce heat), Scope 2 covers **indirect** emissions from the generation of purchased energy and Scope 3 covers all other indirect emissions in the value chain; including procurement, transport related activities not under our direct control and outsourced activities such as waste disposal and leased assets.

2017/18 Carbon footprint by Scope



2017/18 Carbon footprint by activity



Scope 1 and 2 emissions account for 23% and Scope 3 emissions account for 77% of our total carbon footprint. We have less control over our Scope 3 carbon footprint which includes vital services such as catering, cleaning and waste which are managed by our facilities management provider, Sodexo at some sites.

The accuracy of measuring Scope 3 emissions is lower due to a reliance on third party data, however, despite these challenges we are fully committed to including Scope 3 within our strategy and reporting processes. When reporting on our carbon footprint, we will report on areas where we have made tangible reductions, as well as any increases and we'll explain the reasons why.

Our carbon footprint is also influenced by various unavoidable and external factors. These include but are not limited to;

Factors	MFT changes 2013 - 2018
Carbon conversion factors (Set by the UK Government)	Change annually, electricity generation has significantly decarbonised due to the rise of renewables and nuclear
Patient contact	10.1% increase
Opening hours	Increase in evening and weekend clinics
Weather	6% increase in **heating degree days**
Changes to our Estate	21% increase in the size of our Estate

There are methodologies that we use within our reporting to account for these factors, in order to clearly assess our performance.

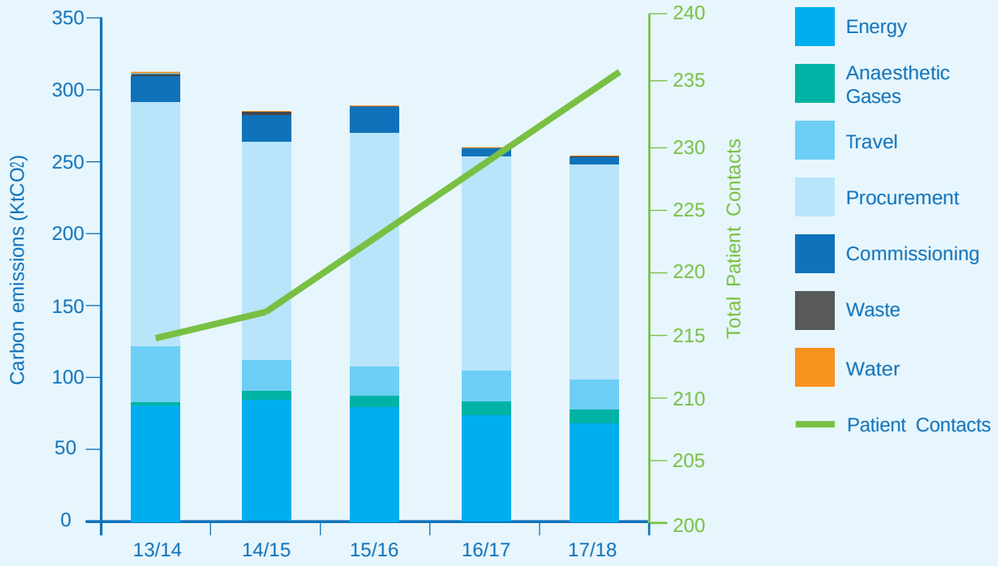
Performance since the last strategy

In 2014, the legacy Trust sustainability strategies both set a target of a 2% reduction in total (or absolute) Scope 1 and Scope 2 carbon emissions per year, against a 2013 baseline.

Despite facing various challenges as indicated in the table above, we have reduced our absolute Scope 1 and Scope 2 emissions by 3% against a 2013 baseline.

Although a separate target was not defined in our previous strategies, Scope 3 emissions have also decreased by 7.3% in this time.

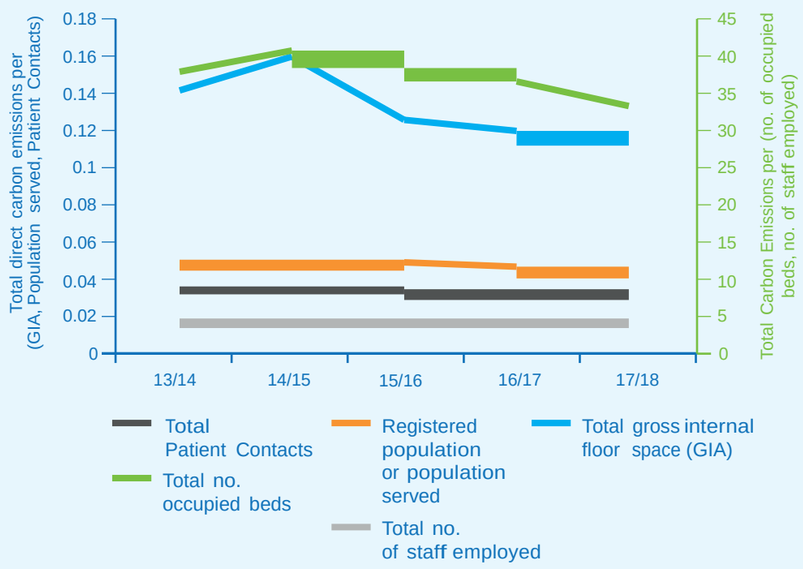
Five year carbon footprint



It is important to note that although some of our activities such as water use and waste disposal are minimal when presented in terms of their carbon footprint, they still account for a key part of the Trusts resources footprint and are therefore accounted for within this strategy.

Using recognised sustainability reporting metrics for the healthcare sector, we have measured a 12% reduction in Scope 1 and 2 emissions per patient contact and 20% reduction per gross internal floor space (m^2). Performance against other metrics is highlighted below.

Benchmarked carbon footprint using key reporting metrics

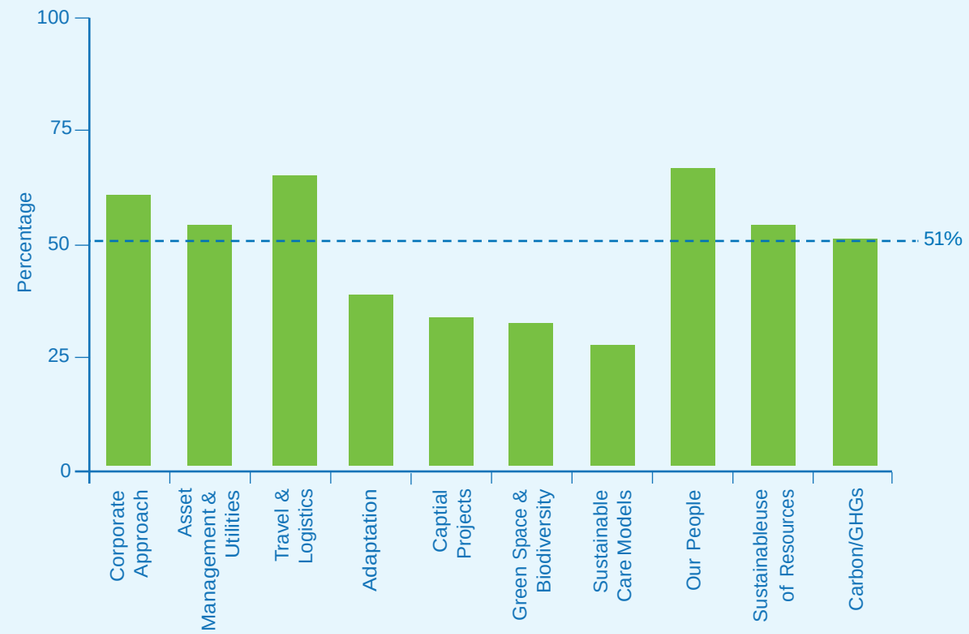


You can find more information on major schemes and deliverables within our Annual Reports.

In addition to reductions in our total carbon footprint, we have also made progress against qualitative reporting metrics, such as the SDAT tool. This tool was released in late 2017 to replace the previous Good Corporate Citizen assessment and the scores are not easily comparable.

The overall score for our latest assessment was 51%, slightly above the average for similar Acute Trusts. We have made good progress in areas including our people, travel and logistics and corporate approach. As the SDAT is a self-assessment tool, we maintain a robust audit trail and evidence file to justify our scoring.

SDAT Assessment score 2018



How we currently contribute to the UN SDGs

	GOAL	CONTRIBUTION
1	No Poverty End poverty in all its forms everywhere	Stakeholder in the **Manchester Local Care Organisation** (MCLO), which runs statutory community health and social care services. MFT provides work experience placements and internships.
2	Zero Hunger End hunger, achieve food security and improved nutrition and promote sustainable agriculture	**PFI** facilities management provider supports a 'Stop Hunger' campaign and has a payroll giving scheme. Dedicated Patient Dining Group, which looks at ways to improve food quality, choice and overall dining experience.
3	Good Health and Well-being Ensure healthy lives and promote well-being for all at all ages	Sit on Trafford and Manchester Health and Wellbeing Board. We have rolled out Chathelp at our partnership schools. We are a key stakeholder in the Manchester Population Health Plan 2018 – 2027, the city's overarching plan for reducing health inequalities.
4	Quality Education Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all	MFT actively supports Apprenticeships. Two Supported Internship Programmes support young people with learning disabilities to access employment opportunities and gain qualifications, helping to obtain and retain paid employment.
5	Gender Equality Achieve gender equality and empower all women and girls	Our Equality and Diversity Policy was released in 2017. 80% of our workforce is female and 62% of senior staff (directors and above) are female. As part of our policy, there are no gender specific roles.
6	Clean Water and Sanitation Ensure availability and sustainable management of water and sanitation for all	Water use and efficiency is closely managed and we report usage and emissions annually. All procedures and responsibilities are found in our Water Safety Policy.
7	Affordable and Clean Energy Ensure access to affordable, reliable, sustainable and modern energy for all	We deliver an ongoing programme of energy efficiency measures, including installing the planning of **combined heat and power** (**CHP**) networks and upgrades to LED lighting across all sites.
8	Decent Work and Economic Growth Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all	We offer a Pre-Employment programme providing opportunity for local unemployed people. Since 2009, the Trust has worked with partners to offer a vocational programme for people interested in working at the Trust, either in a clinical or non-clinical capacity. Since 2016; the Trust has supported an additional 15% more apprenticeships. We measure and set targets for SME spend.
9	Industry, Innovation and Build Infrastructure resilient infrastructure, promote inclusive and sustainable industrialisation and foster innovation	Software applications are in place to bring together clinical and administrative date as part of our Electronic Patient Records (EPR) rollout. Energy efficiency and resilience is a key priority within our sustainability programmes.
10	Reduced Inequalities Reduce inequality within and among countries	We have a number of programmes to recruit overseas health professionals.
11	Sustainable Cities and Communities Make cities and human settlements inclusive, safe, resilient and sustainable	Make the most of assets so that the local community can benefit and MFT sponsorship of the Manchester Health Academy.
12	Responsible Consumption and Production Ensure sustainable consumption and production patterns	We work across our supply chain to realise opportunities for wider benefits and embed sustainability principles into all of our contracts and throughout the lifetime of our goods and services.
13	Climate Action Take urgent action to combat climate change and its impacts	We recently developed our first **Climate Change Adaptation** Plan (CCAP) and will be forming a working group to oversee this delivery area.
14	Life below Water Conserve and sustainably use the oceans, seas and marine resources for sustainable development	Facilities management contractor, Sodexo have a strategy on sustainable seafood and maintain a wide variety of sustainable species in catalogues and menus.
15	Life on Land Protect, restore and promote sustainable use of terrestrial ecosystems, sustainable manage forests, combat desertification and halt and reverse land degradation and halt biodiversity loss	We have implemented various schemes to improve greenspace provision and in August 2018 commissioned ecological and **natural capital** surveys of all main sites.
16	Peace, Justice and Strong Institutions Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels	We have a **modern slavery** statement and transparent reporting on organisational performance.
17	Partnership for the Goals Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development	We've included the SDGs within our strategy to ensure that we can work together with stakeholders towards sustainable development and to help understand where activities can contribute.

Highlights to date

Awards and accolades

Excellence
in sustainability reporting for 2015/16 and 2016/17

2018
Gold Travel Choices Award from Transport for Greater Manchester

2017
Overall winners at the NHS Sustainability Day Awards

Winners in the Environmental Improvement Category at the Health Business Awards

NHS and Public Service silver Green Apple Award

Travel

8%
reduction in **single occupancy car journeys** against our 2015 baseline and a 5% increase in active travel

Energy

£400,000
invested in energy efficiency schemes since 2017

Waste

80 tonnes
of CO_2 and over £166,000 saved through our reuse network Warp it since 2016

Biodiversity

8
is the average number of honeybee hives that have been kept on the roof of the Trust headquarters since spring 2017, supported by trained staff beekeepers. Excess honey is sold and profits donated to sustainability projects

Staff engagement

5,000
sustainability actions have been completed through our staff engagement programme, **Green Impact**. We are the largest and most successful NHS Trust to take part

What we want to achieve

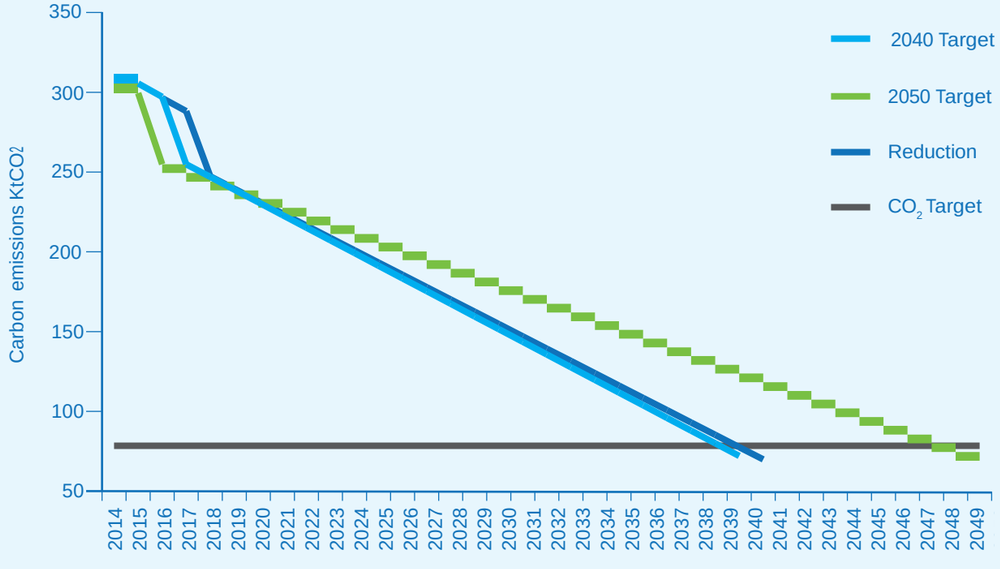
To become a leader in sustainable healthcare, we need to set ambitious goals and carbon reduction targets. We are in a unique situation as, whilst we are legally obligated to meet the Climate Change Act target of an 80% reduction by 2050, we have ten years less than the rest of the NHS to do this if we align our targets with the 2040 deadline set by the Mayor of Manchester. This will require a significant upshift in the pace and scale of our delivery programmes.

We've set three overarching goals for this strategy which are underpinned by the specific objectives in the Areas of Focus section.

GOAL 1

To reduce absolute Scope 1 and 2 emissions by 1% each year and reduce our total carbon footprint (Scopes 1,2 and 3) by 3% each year benchmarked against gross internal floor space and patient contact.

Our long-term carbon reduction goals



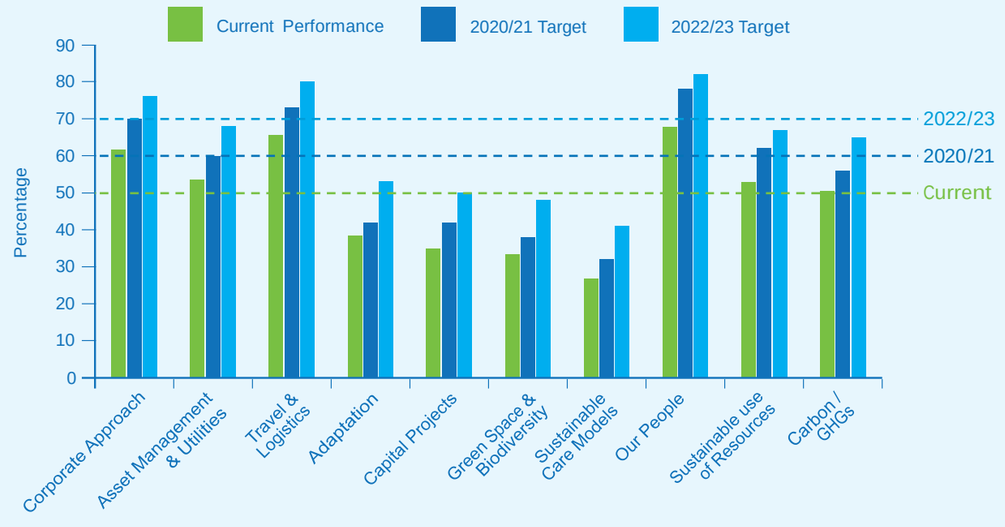
Setting this goal means that we can deliver the Mayor's 2040 target, but as this date is not legally binding, we have a further 10 years to make up any difference if required, particularly in light of further major organisational changes.

In terms of our qualitative performance, we will use the SDAT to measure progress. While we aim to increase our score across all areas, we will be focusing on those identified as high influence and high impact within the materiality assessment, including greenhouse gases, asset management and utilities and climate change adaptation.

GOAL 2

To achieve an overall score of at least 70% in the SDAT within the lifetime of this strategy.

SDAT Goals



We are relatively early on in the process of addressing the sustainable development goals, and we must embrace these if we are to deliver sustainable healthcare. We can achieve this by embedding the SDGs into the core of the organisation, corporate strategy and across our activities.

GOAL 3

To embed the UN SDGs across all of our sustainability activities, including all related strategies, plans and policies.

Areas of focus

We've considered each of the 10 modules of the SDAT and set out our overall aim, specific objectives and considered how we will measure and evidence progress. Our current performance, in conjunction with the materiality assessment and the staff consultation has informed this section. We've also indicated which of the SDGs we will be contributing to within each section.

Corporate Approach

It is essential that senior staff, stakeholders and governors are engaged in, and accountable for, delivering our SDMP, and that policies, procedures, business cases and processes reflect this.

Aim: To ensure that sustainability is embedded within organisational strategy and processes, and that we deliver, monitor and report on progress supported by a nominated board level sustainability lead.

Realising environmental gain

- Maintain an ambitious and up to date strategy and report performance quarterly to senior management and annually to the Board.
- Establish a sustainability leadership and training programme for staff and governors.
- Enable staff, patients and visitors to provide regular feedback and suggestions to improve sustainability performance.

Enhancing health and wellbeing

- Support the Manchester Local Care Organisation (MLCO) to deliver community services focused on the prevention of ill health, achieving co-benefits and a shared responsibility for health and wellbeing.
- Establish a Healthy Estate with a greater focus on improving the environmental determinants of health such as food, active travel, green space, air quality and biodiversity.

Being future ready

- Develop and deliver a sustainable procurement strategy, led by a nominated Sustainable Procurement Lead.
- Develop a Sustainability Impact Assessment for Business Cases.

Delivering social value

- Contribute to and deliver against key local environmental strategies.
- Inform sector sustainability guidance and policy, learn from best practice and share progress within the healthcare sector and beyond.
- Play an active role as an Anchor Institution, creating opportunities for local communities such as work experience and access to employment, thus contributing to the local economy and improving local population health.

Measuring progress

- Assess SDAT score in line with targets.
- Carry out annual sustainability surveys to measure staff awareness levels.
- Include a comprehensive sustainability section in the annual report.

Capital Projects

Refurbishing and developing the Estate allows us to embed sustainability and efficiency using smart design and emerging technologies across our improvement works.

This requires taking a whole life costing approach to projects by considering sustainability in design, construction, commissioning, operation and decommissioning, helping to future-proof our organisation.

Aim: To reduce the environmental impact of building works during design, refurbishment, construction, operation and decommissioning stages.

Realising environmental gain

- Develop sustainability guidelines for all Capital Projects including major refurbishments, driving resource efficiency through the Estates Strategy.
- Take a design for performance approach to Capital Projects, including application of the **BSRIA Soft Landings Framework**.
- Nominate a sustainability lead for large scale projects to work alongside the capital team appyling recognised methodologies such as **BREEAM** to guide selection of appropriate measures and maximise benefits.
- Inform staff how the heating, cooling, lighting and ventilation of their building operates, and how they can report any performance issues.

Enhancing health and wellbeing

- Prioritise access to natural light, ventilation, greenspace, and active travel infrastructure in the development and refurbishment of Trust Estate.

Being future ready

- Work with contractors to take a whole life costing approach to new building design and refurbishment and maximise in-use energy and water efficiency.
- Incorporate sustainability into the refurbishment and decommissioning process.

Delivering social value

- Weight social value outcomes when procuring new services in the design and building of a new space, for example, use of local suppliers and SMEs.

Measuring progress

- Energy and water consumption, including design and in-use performance.
- BREEAM score or **WELL Building Standard**.

9 INDUSTRY, INNOVATION AND INFRASTRUCTURE

12 RESPONSIBLE CONSUMPTION AND PRODUCTION

Asset Management & Utilities

Our activities are intensive and constant, with utilities representing a substantial cost and environmental impact to the organisation. It's essential that we accurately measure and reduce consumption to make sure we're getting the best value for money and minimising environmental impact.

Embedding more efficient practices, new technologies and improving staff awareness will help to improve utility efficiency across everyday activities and as part of longer-term plans.

Aim: To embed energy and water efficient technologies and practices throughout our Estate and services and deliver year-on-year reductions in consumption.

Realising environmental gain

- Monitor utility consumption across our Estate and deliver a programme of targeted energy and water efficiency schemes to manage and drive down use.
- Specify renewable energy when we enter into new purchasing arrangements for electricity.
- Inform and educate staff, patients and visitors about how their actions affect energy and water consumption.

Enhancing health and wellbeing

- Respond quickly to any issues such as overheating or leaks through effective monitoring and leak detection systems.
- Educate staff about how to improve home energy efficiency.

Being future ready

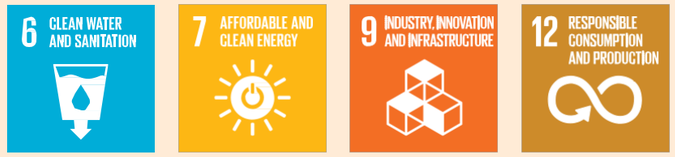
- Increase on-site energy generation capacity from renewable resources.
- Assess lifecycle costs of energy and water when purchasing new equipment and use this as a criteria in decision-making.
- Include energy and water efficiency criteria when leasing buildings and define minimum standards for sustainability.
- Identify any inefficient buildings that we lease and request improvements or identify alternatives if they don't meet minimum standards for sustainability.

Delivering social value

- Work collaboratively with community partners to maximise the use of built assets and grounds.
- Monitor the air quality impacts of on-site combustion activities such as biomass.

Measuring progress

- Annual **ERIC** returns.
- Utilities consumption and cost, broken down by individual buildings where data is available.
- Percentage of energy from renewable sources.



Sustainable Use of Resources

We generate large volumes of waste and have legal responsibilities to make sure that it is properly segregated, handled and disposed of. Procurement constitutes the largest proportion of our carbon footprint and we must reduce unnecessary use of resources across all of our organisational activities.

By applying the waste hierarchy, rethinking traditional waste models and working closely with our staff and supply chain, we can move towards a **circular economy** approach and away from a throwaway culture.

Aim: To take an innovative approach to driving out waste, delivering year-on-year reductions in cost and volumes.

Realising environmental gain

- Replace **single use products** with reusable alternatives where there is a viable and lower carbon option, and be transparent when this is not feasible.
- Deliver initiatives to reduce food waste and ensure that it is treated in the most sustainable way.
- Segregate more waste streams at source to improve recycling rates and upgrade recycling facilities at all sites.
- Reduce materials for final disposal to landfill and increase material and energy recovery.

Enhancing health and wellbeing

- Provide healthy, informed and sustainable catering choices that meet and exceed national guidelines.
- Implement concessions and vending solutions to make it easier for people to make healthy choices.

Being future ready

- Use our purchasing power wisely, by working with suppliers to procure products that minimise packaging use and offer innovative solutions to waste reduction, including take back schemes.
- Move away from a 'purchase – use – dispose' approach to waste and towards a circular economy approach (e.g. buying a service rather than a product, use of leasing arrangements).

Delivering social value

- Develop a sustainable catering policy and only work with suppliers that can deliver our requirements.
- Promote a culture of reuse and refurbishment of items if it's cost effective, rather than buying new.
- Adopt a whole life cycle approach to purchasing.
- Apply a higher weighting for social value in the procurement of products and services.
- Work with major suppliers on sustainability.

Measuring progress

- Procurement carbon footprint
- Waste streams and volumes
- Number of suppliers engaged with sustainability

Carbon/GHGs

Everything we do generates a carbon footprint. By measuring and monitoring emissions, we can focus on reducing this.

Setting targets, making use of new technologies and engaging staff, suppliers and contractors with our SDMP will help to reduce our carbon footprint.

Aim: To measure our carbon emissions, identify hotspots and take targeted action to reduce this year-on-year.

Realising environmental gain

- Calculate and report carbon emissions, continually improve methodology calculations for Scope 3 and align targets with the Greater Manchester Climate Change Strategy.
- Deliver an ambitious annual programme of carbon reduction projects targeting areas in which we can make material progress including pharmaceuticals.
- Develop a sustainable anaesthesia programme, raising awareness of the impact of anaesthetic gases on the environment and taking actions to reduce this.

Enhancing health and wellbeing

- Work with stakeholders to reduce carbon emissions associated with patient travel and supply chain.

Being future ready

- Contribute to the Manchester Climate Change Strategy and other city-wide sustainability initiatives.

Delivering social value

- Calculate and report carbon emissions from procurement activities.
- Engage with suppliers on sustainability and carbon reduction.

Measuring progress

- Carbon footprint as published in our annual report.
- Carbon footprint from anaesthetic gases per patient.

Climate Change Adaptation

Climate change is one of the biggest public health threats and challenges that we face.

Extreme weather conditions, such as flooding and heat waves, are increasing in severity and frequency and are now a visible reality. We must act now to adapt to a changing climate and mitigate the negative effects of past and future climate-altering actions.

We're embedding climate change awareness and action across MFT and considering how our infrastructure, services, procurement, local communities and colleagues are prepared for the impacts.

Aim: To ensure that our whole organisation is prepared to deal with the effects of climate change, particularly extreme weather events, and continue to invest in adaptation and mitigation measures.

Realising environmental gain

- Nominate an Adaptation Lead and incorporate adaptation into our sustainability governance structure, corporate risk register and reporting processes.
- Invest in mitigation and adaptation technologies.

Enhancing health and wellbeing

- Maximise the quality and resilience of our greenspace to help mitigate the effects of climate change.

Being future ready

- Work with key internal and external stakeholders and partners to deliver and update our Board-approved Climate Change Adaptation Plan (CCAP) and align our approach with Manchester's Climate Change Strategy and national healthcare guidance.

Delivering social value

- Ensure that our emergency plans consider that vulnerable communities are supported during any extreme weather events.

Measuring progress

- BREEAM/WELL Building Standard or other sustainable buildings methodology scores.
- Monitor and report the progress of our Climate Change Adaptation Plan (CCAP).

Green Space and Biodiversity

Nurturing and improving green space has benefits for mental and physical wellbeing. It also leads to improved air quality, noise reduction, supports biodiversity and helps combat climate change.

By collaborating with partners and local communities we will implement a clear strategy that helps us contribute to local biodiversity and make the best use of available green space.

Aim: To maximise the quality and benefits from our green spaces and reduce biodiversity loss by protecting and enhancing natural assets.

Realising environmental gain

- Develop a biodiversity and green space strategy and policies that encompass the challenges and opportunities across our Estate.
- Incorporate biodiversity and green space into our sustainability governance structure and work closely with our contractors to maximise the benefits.

Enhancing health and wellbeing

- Raise awareness of the benefits of natural capital for physical and mental health and wellbeing by providing opportunities for staff to get involved in Trust-wide initiatives such as beekeeping and gardening schemes.
- Explore food growing schemes and incorporation of products into Trust catering services.

Being future ready

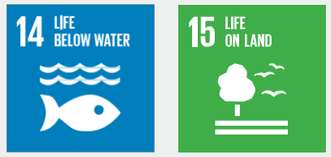
- Repurpose unused areas, such as roofspace and walls with a focus on improving green space and biodiversity and create wildflower areas.

Delivering social value

- Work with staff and local community organisations to provide quality accessible urban green spaces and encourage their use.

Measuring progress

- Production of a green infrastructure and biodiversity strategy and delivery of associated action plan.
- Value of natural capital.



Sustainable Care Models

We need to improve the environmental sustainability of care pathways, and better integrate healthcare services to improve efficiency.

Delivering the best quality of care within the available environmental, social and economic resources is a growing challenge. Ensuring we have a healthcare system that is fit for the future is increasingly important as we are starting to face the effects of climate change. This will directly impact the way we care for patients and how diseases are spread.

Aim: To deliver the best quality of care while being mindful of its social, environmental and financial impact and take a whole systems approach to the way it is delivered.

Realising environmental gain

- Identify carbon hotspots such as medical equipment and pharmaceuticals and ensure that action plans identify and mitigate environmental impacts.
- Embrace new and existing digital technologies to reduce the environmental impact of care, prevent ill health and manage long-term health conditions.
- Apply sustainability principles to new build and refurbished Estate to create a healing environment and support improved quality of care.
- Enable patient and clinician led service redesign.

Enhancing health and wellbeing

- Collaborate with stakeholders to create a healthy environment for patients, including temperature, light and food choices.
- Take a proactive approach to identify the leading causes of staff sickness and implement a package of measures to address this.

Being future ready

- Reduce carbon emissions associated with areas of high impact such as pharmaceuticals and anaesthetic gases by educating staff and encouraging lower impact alternatives.
- Work with partners and stakeholders to identify and deliver solutions that reduce the number of hospital visits, such as the provision of treatment closer to home (e.g. macular treatment centres and home dialysis).
- Pilot the redesign of selected care pathways to drive out any unnecessary stages.

Delivering social value

- Work with partner organisations to identify support schemes that support vulnerable patients upon discharge such as improving home energy efficiency. This will regulate temperatures and reduce likelihood of hospital readmission.

Measuring progress

- Patient feedback and scores (e.g. PLACE).
- Feedback relating to the care environment (e.g. temperature, light).
- Financial and social co-benefits from sustainable models of care initiatives delivered.
- Staff sickness rates.
- Emergency hospital admissions.

Travel and Logistics

The transport of goods, services, staff, patients and visitors has a significant impact on local air quality, congestion and health.

Delivering a robust **Travel Plan** and supporting staff, patients and visitors to use more active and sustainable travel methods will reduce the impact of these activities, leading to cost savings and health benefits.

Aim: To encourage sustainable and active travel wherever possible and reduce the carbon and air quality impacts of our organisation and supply chain.

Realising environmental gain

- Develop and deliver a new Healthy Travel Strategy for MFT with ambitious plans to reduce single occupancy car journeys and the travel impact of our supply chain.
- Ensure all new Trust vehicles are low carbon and reduce the environmental impact of our fleet.
- Ensure staff have access to facilities for video/teleconferencing to reduce business miles between sites and from attending external meetings.
- Monitor indoor and outdoor local air quality around our sites; identify pollution hotspots and deliver mitigation activities.
- Increase the number of electric charging points available to staff and visitors and increase the proportion of **Electric Vehicles (EV)** within our vehicle fleet.

Enhancing health and wellbeing

- Review active travel infrastructure across all sites and develop plans to improve it.
- Deliver a programme of sustainable and active travel events across all main sites and clearly communicate any changes to local transport services.

Being future ready

- Optimise logistic operations and travel between sites to reduce emissions.
- Actively monitor and seek opportunities for improving the efficiency of delivery and travel and design these into new developments and Estate improvements.

Delivering social value

- Develop high quality travel infrastructure that can also be accessed by the local community.
- Include travel and transport sustainability criteria within key contracts.

Measuring progress

- Annual staff travel survey.
- Carbon emissions from travel.
- Air quality on site.
- Proportion of Trust fleet that is EV and provision of EV infrastructure.
- **Health Outcomes Travel Tool (HOTT)**.

Our People

Making sure that staff are engaged with the sustainability agenda is essential for the delivery of sustainable healthcare. Every single member of staff has a role to play in delivering this strategy. Engaging staff to adopt sustainable practices will enable them to take ownership within their own areas of influence.

Sustainability principles do not just apply at work; they apply at home, across our supply chain and beyond.

Aim: To support staff to improve sustainability at work and home and empower them to make sustainable choices in their everyday lives.

Realising environmental gain

- Deliver programmes to raise sustainability awareness and provide staff with opportunities to contribute.
- Identify an HR lead for sustainability and collaborate to include sustainability in job descriptions and performance reviews.
- Raise the Trust's sustainability profile locally, regionally and nationally.

Enhancing health and wellbeing

- Work with staff groups to enhance and align our approach to sustainability with other Trust initiatives.
- Provide opportunities for staff to boost their own health and wellbeing through work-based activities such as Bicycle User Groups.

Being future ready

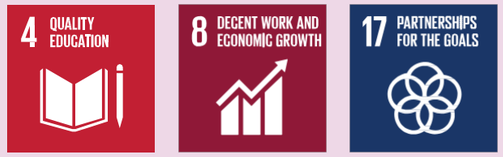
- Actively seek opportunities to gamify sustainable behaviours and reward staff for participation.

Delivering social value

- Provide staff with a variety of development and training opportunities that support our SDMP.

Measuring progress

- Number of environmentally-focused **staff benefits**.
- Staff participation in sustainability programmes.
- **Social Value Calculator**.
- **CQUIN** performance.



Communications

To help drive change across the whole organisation, we take a considered, structured and engaging approach to sustainability communications. By communicating what we are doing both within and outside of the organisation, we can engage staff, highlight key priorities and position ourselves as an exemplar organisation for sustainable healthcare.

We produce an annual communications calendar, encompassing regional and national activities such as the Sustainable Health and Care Campaign and Clean Air Day. This helps us structure and plan each month's communication activities in line with designated themes. We support our communications strategy with a monthly Trust-wide sustainability newsletter, staff interest groups and an active events programme. Information on the main areas of activity is shared on the Trust intranet, and we also share information via the internet pages.

As well as informing and engaging departments to drive organisational progress on sustainability, we use various channels as an educational resource to drive change in the workplace as well as at home. We have a dedicated email address for staff queries, and an active Twitter account (@mftgreen). We provide staff with a wealth of materials they can use within their own areas, including posters and stickers, which are refreshed periodically.

We periodically produce case studies for external bodies, such as the **Sustainable Development Unit** and NHS Improvement, as well as presenting work at conferences and events.

All our communications use simple and meaningful language, to make our work authentic, and where appropriate, fun.

There is 'no one size fits all' approach to communicating sustainability, and we have a large, geographically spread and diverse body of staff to engage. Our approach involves maintaining high quality and regular communications across a variety of channels, and to continually review and learn from what we do. We will maintain a communications plan for all of the requirements that fall under this strategy.

Tracking progress

We will be measuring the progress of this strategy using both qualitative and quantitative methods. The main way in which we'll measure the qualitative progress is by carrying out an annual assessment using the SDAT. We have set a goal of achieving an overall score of 70% within the five year lifetime of this plan, which corresponds to a 19% increase on our current position.

We have a number of quantitative reporting processes in place for other areas, examples of which are outlined below. The Governance section outlines where we will be reporting progress to, both within and outside our organisation.

Sustainable travel

An annual travel survey is undertaken to determine changes in how staff travel to work and collate feedback. Data is analysed using the HOTT (Health Outcomes Travel Tool) to see which interventions will have the best effect in making progress.

Energy and utilities

We monitor consumption of energy and water on a monthly basis, across each site as well as for individual buildings, and carry out a more in-depth analysis every quarter. This helps us see where our interventions are having the desired effect and quickly identify any issues. We are working towards a greater level of automation with this process.

Waste

We monitor waste volumes every month for each waste stream and site.

Carbon footprint

Organisational carbon footprint is measured and reported annually using sector guidance. This includes all scopes of emissions, and helps us to focus interventions on carbon hotspots.

Social Value

We'll identify and track social value metrics such as SME spend and weighting within tenders.

Governance

Clear leadership is vital if we are to successfully deliver the commitments outlined in this strategy. As this strategy is broad and encompasses a wide range of work areas, there are other detailed documents that underpin our approach. Some of these have already been developed, such as our Climate Change Adaptation Plan, and some of these will be developed in the future, such as a Green Space and Biodiversity strategy.

Our governance structure is outlined below.

Group Board – Kathy Cowell, Chairman, Board Sustainability Lead

The Group Board offers senior level leadership, supports implementation and ensures alignment with the organisation's value, culture, strategy and operations. Progress is communicated quarterly to the Board Sustainability Lead in the form of a written report and meeting with the Head of Environmental Sustainability.

Group Estates and Facilities Management Board – chaired by the Group Director of Estates and Facilities

This committee meets on a monthly basis and has strategic oversight across the entirety of the Estates and Facilities portfolio across all sites. A sustainability update is reported formally on a quarterly basis. The group is responsible for approving all plans, strategies and policies that don't require Group Board approval.

Sustainability Steering Group (SSG)

This group meets on a quarterly basis and is responsible for ensuring that the SDMP is maintained, implemented and reported against and that all projects are on track. It includes representatives from a range of stakeholder areas.

Sustainability subgroups

Various sub committees at both site and organisational level feed into the SSG. This also includes task and finish groups.

Staff led user groups

These groups represent staff interests in relation to specific work areas and have no formal reporting lines, for example the Bicycle User Group (BUG).

Energy and Sustainability team

This team sits within the Estates and Facilities Department and provides project delivery and expertise across all MFT sites. Annual work programmes and budgets are agreed at the start of each financial year and progress is reported quarterly via the SSG and annually via a report.

Reporting

It is key that we use robust systems when reporting on sustainability activities. We have numerous commitments and reporting obligations and we also maintain an environmental management system called Investors in the Environment. To meet our obligations, we have established a clear process as outlined below.

Annual

Complete SDAT
This will measure our qualitative progress on sustainability for the previous year, inform plans for the coming year, and will enable comparative performance against similar Trusts.

Complete **SDU** Sustainability Reporting Portal
This informs the sustainability section of the Trust's Annual Report and calculates the Trust's carbon emissions (Scope 1, 2 and 3).

Sustainability report
This reports progress against the SDMP and provides highlights of the main activities delivered throughout the year.

ERIC (Estates Return Information Collection)
A mandatory data collection for all NHS Trusts required by the Department of Health.

Quarterly

Progress reports
Internal progress reports are produced for the Sustainability Steering Group, Estates and Facilities Group Management Board and Board Sustainability Lead.

Monthly

Data collation
Collation of utilities, waste data and other data required for **KPIs**.

SDMP tracking tool
Internal system used to identify and track projects for each financial year and monitor performance against investment budgets.

Risk

Identifying potential risks relating to delivery of this strategy and working to reduce their likelihood and severity is an essential requirement to effectively deliver our sustainability agenda. Where we identify significant risks, they are logged and monitored through our internal risk and governance system. We've identified the following risks associated with the delivery of our strategy.

Finance

To deliver the commitments in this strategy we will need finance in place. Increasing energy prices and waste disposal costs may mask some of the efficiency savings we make from delivering the strategy, so we will mitigate this risk by maintaining senior support and transparent reporting.

Not meeting carbon reduction targets

Due to the nature of the Trust's services, as the intensity of our activities increases and the Estate grows, our absolute carbon emissions may also increase. Because of this we will always measure and report on normalised (e.g. per patient contact, bed day or per m^2) emissions, as well as absolute consumption.

Non-compliance with legislation

Due to the size, scale and complex nature of our organisation, there is a risk we won't comply with legislation and could be faced with a financial penalty as well as damage to reputation. We mitigate this risk through systems, training and auditing of activities against the relevant requirements.

Climate change

The risks to the organisation from climate change are outlined in our Climate Change Adaptation Plan (CCAP). These include risks to buildings, staff, health and wellbeing. Maintaining and delivering our plan is vital to address these risks.

Reputation

Our reputation for sustainability is paramount to our performance. As one of the largest Acute Trusts in the UK, it's important we take a leading approach and have a robust strategy and reporting structure. We are required to provide assurance when bidding to deliver services.

Finance

Effective management of environmental performance brings significant financial benefits. Energy, carbon and transport costs are rising and there are a number of ways we can manage the impact of this, such as:

- Making sure our utility supplies and waste disposal arrangements are competitively priced.
- Managing the way we use energy and water on site – educating staff on best practice and quickly responding to issues such as leaks and overheating.
- Driving down utilities and wastes costs by procuring more efficiently and investing in schemes to reduce consumption.

We will apply this approach to financing our SDMP:

1

An annual budget will be allocated to deliver plans and ensure compliance against all requirements. This will vary but will encompass a fully resourced Sustainability Team as well as a budget to deliver sustainability programmes and small to medium sized invest-to-save schemes.

2

Where there is a direct financial payback, we will typically consider schemes with a **payback period** of less than five years for a viable investment. However, this will not exclude investing in schemes with a longer payback period (e.g. battery storage and on-site energy generation), particularly where there are wider benefits such as improved resilience.

3

Where schemes are already planned, such as new build, **life-cycling** and refurbishment of our Estate, we will provide top-up funding from our core budget to ensure that longer-term energy or water savings are realised. An example of this would be replacement of lighting with a more energy efficient option than what is costed for within our **PFI** contract terms.

4

We will actively pursue external financing for larger investments in energy and water reduction schemes. This will include Carbon Energy Fund (CEF), Salix and NHS funding. We will seek joint ventures with partners and innovative opportunities, considering these on an invest-to-save basis.

5

We will explore any local grant sources that may become available, for example investment in sustainable or active travel infrastructure.

Be part of the Masterplan
Get involved and have your say!

Make sense

Review the actions within this SDMP and think about how you can contribute within your own role.

Find out more

Sign up to the sustainability newsletter and check the intranet and internet pages for more information on our programmes. If you work at the Trust, contact ECOteam@mft.nhs.uk for advice and support. No matter what your role is at the Trust, there will be something for you!

Talk

Say it loud! Talk to your colleagues, line manager and embed sustainability practices within your area of work. Whether it's a small or large project, it all adds up to make a difference.

Appendix 1 – Glossary

Air quality

The quality of the air and how polluted it is, measured using the Air Quality Index. Numbers from 1 to 10 indicate air pollution levels and accompanying health messages.

Anchor Institution

Large, typically non-profit organisations whose long-term sustainability is tied to the wellbeing of the communities they serve.

Biodiversity

The complete variety of animals, plants, environments and ecosystems that exist on Earth.

BSRIA Soft Landings Framework

Six phase approach to help the project team focus on clients needs throughout the project, from construction/refurbishment/alteration into use, allowing for post-occupancy evaluation.

Building Research Establishment Environmental Assessment Method (BREEAM)

A method of assessing, rating and certifying the environmental, social and economic sustainability of buildings.

Carbon Footprint

The total amount of greenhouse gases produced to directly and indirectly support human activities, usually expressed in equivalent tonnes of carbon dioxide (CO_2e).

Scope 1 – direct greenhouse gases

Emissions from sources that are owned or controlled by the organisation.

Scope 2 – indirect greenhouse gases

Emissions from the consumption of purchased electricity, steam, or other sources of energy generated upstream from the organisation.

Scope 3 – other indirect greenhouse gases

Emissions that are a consequence of the operations of an organisation, but are not directly owned or controlled by the organisation.

Circular Economy

A regenerative system in which resource inputs and waste, emissions, and energy leakage are minimised by slowing, closing, and narrowing energy and material loops.

Climate change adaptation and mitigation

Adaptation is adjustments in human and natural infrastructure, to lower the risk of expected or actual consequences of climate change, for example, improving the quality of road surfaces to withstand hotter temperatures. Mitigation consists of activities to reduce, prevent or remove greenhouse gases from the atmosphere. Mitigation includes new technologies, low carbon energy sources, behaviour change and improving energy efficiency.

Climate change

A large-scale, long-term shift in the planets weather patterns and average temperatures due to the production and use of finite fossil fuels. Includes the side effects of warming such as melting ice caps, rising sea levels and extreme weather patterns.

CO_2e – Carbon Dioxide Equivalent

A standard unit for measuring carbon footprints. For any quantity and type of greenhouse gas, CO_2e signifies the amount of CO_2 which would have the equivalent global warming impact. For example, one tonne of methane is equivalent to 25 tonnes CO_2 and some fluorinated gases have global warming effects up to 23,000 times greater than CO_2.

Co-benefits

In the context of climate change, this means the benefits beyond the direct benefits of a more stable climate. For example, by increasing energy diversity, energy security is improved and by reducing CO_2 other air pollutants are reduced because they are emitted from the same sources.

Combined Heat and Power (CHP)

Generation of electricity whilst also capturing usable heat.

Commissioning for Quality and Innovation (CQUIN)

A scheme intended to deliver clinical quality improvements and better outcomes for patients by making a proportion of healthcare providers' income conditional on demonstrating improvements in specified areas of patient care.

Electric Vehicle (EV)

A vehicle that is driven by an electric motor which draws its current either from storage batteries or from overhead cables.

Estates Return Information Collection (ERIC)

Requirement of NHS Trusts to report annually on the costs of maintaining and servicing their Estates and Facilities.

Global Warming

The Earths rising surface temperature, one effect of human-induced climate change.

Greenhouse Gases (GHGs)

Gases that can absorb infrared radiation emitted from the earths surface and re-radiate it back. Carbon dioxide, water vapour and methane are the most predominant greenhouse gases. In the healthcare sector, anaesthetic gases are also a significant contributor.

Green Impact

Behaviour change programme developed by the National Union of Students (NUS).

Health Outcomes Travel Tool (HOTT)

SDU's tool to help NHS organisations measure the impact their travel and transport has in environmental, financial and health terms.

Heating Degree Days and Cooling Degree Days

Variables derived from outside air temperature to account for the effect of weather on energy consumption. Below set temperatures buildings need to be heated and above set temperatures buildings will require cooling.

KPI Dashboard

Measurable value that demonstrates how effectively we are achieving our key objectives. A KPI dashboard organises and visualises these metrics.

Lifecycle

In the context of a PFI hospital this is the replacement of assets as required over the duration of the project agreement.

Manchester Local Care Organisation (MLCO)

A partnership organisation bringing together NHS community health and mental health services, primary care and social care services in the city. MFT is one of the partners in this organisation.

Materiality Assessment

Allows an organisation to prioritise its environmental efforts and budgets accordingly. Considers organisation impacts in terms of scale of influence and scale of impact.

Modern Slavery

The recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation.

Natural Capital

Stocks of natural assets which include geology, soil, water, air and all living things. It is from natural capital than humans derive a wider range of services, often called ecosystem services, which make life possible. Placing an economic value on natural capital enables the deployment of resources required to maintain and enhance it.

Patient-Led Assessments of the Care Environment (PLACE)

A system for assessing the quality of the hospital environment. It puts patients' views at the centre of the process, focusing entirely on the care environment (privacy and dignity, cleanliness, food and general building maintenance).

Payback Period

The length of time required to recover the cost of an investment. For example, investing £100,000 in energy efficient lighting that saves £25,000 per year in electricity and maintenance costs means that the payback period is 4 years.

Private Finance Initiative (PFI)

A method of providing funds for major capital investments, where private firms are contracted to complete and manage public projects.

Sustainable Development Assessment Tool (SDAT)

An online qualitative tool designed to help healthcare organisations understand their sustainable development work, measure progress and create an action plan.

Sustainable Development Unit (SDU)

A national unit working on behalf of the health and care system. It supports the NHS, public health and social care to embed the three elements of sustainable development – environmental, social and financial.

Sustainable Development Management Plan (SDMP)

A Board-approved document that assists organisations to clarify their objectives on sustainable development and sets out a plan of action.

Single Occupancy Car Journeys

Journeys (either business, commuting or social) that are made where the only occupant is the driver.

Single Use Product/Item

Used on a single patient during a single procedure, or used only once before being discarded. Examples include disposal drinking cups, single use sterile instruments and disposable water bottles.

Social Value Calculator

Social value refers to impacts of programmes, organisations and interventions, including the wellbeing of individuals and communities, social capital and the environment. A social value calculator helps us quantify measures.

Travel Plan

A package of actions put in place by an employer to encourage staff to use alternatives to travelling alone in their cars. This can save time and money as well as reducing environmental impact.

WELL Building Standard

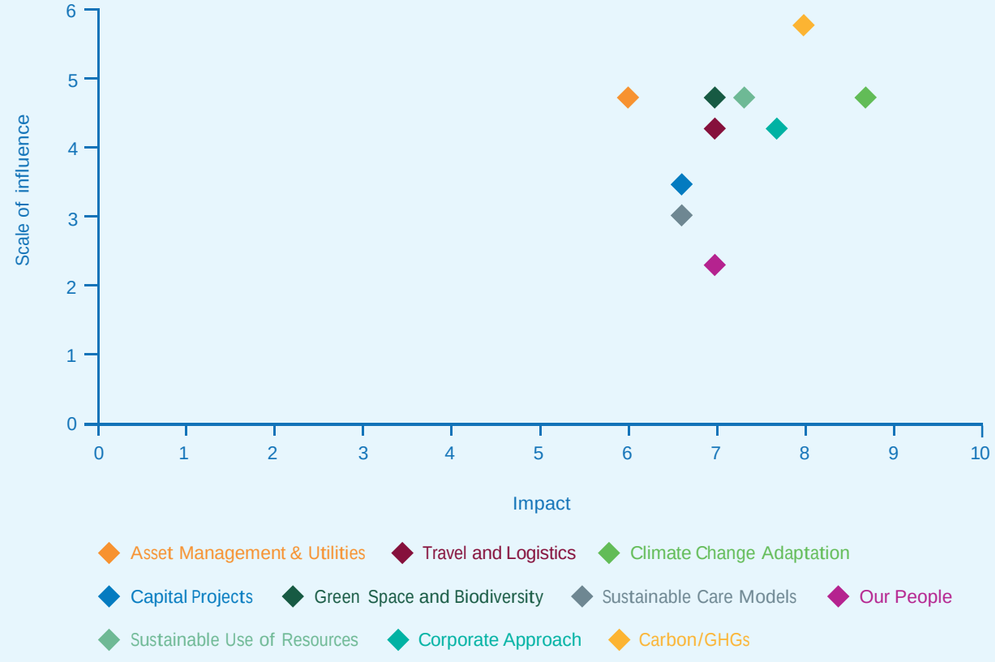
Best practice design and construction of buildings to support human health and wellbeing.

Whole-life Costing

Sometimes called 'life-cycle cost', this approach assesses the absolute cost of a product or service over the course of its lifetime, from its conception through to its end of life, taking into account purchase, maintenance and repair, training, utilities and disposal.

Appendix 2 – Materiality assessment

A materiality assessment was carried out to prioritise the areas that form the most material issues. The exercise was completed with input from stakeholders and informs our SDMP as well as annual reporting. The assessment was carried out on the 10 modules of the SDAT, using guidance published by the Sustainable Development Unit, and the results are presented in the matrix below.



MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Peter Blythin, Director Single Hospital Service
Paper prepared by:	Peter Blythin, Director, Single Hospital Service
Date of paper:	12th November 2018
Subject:	Progress report on the Manchester Single Hospital Service.
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Resolution • Approval
Consideration of Risk against Key Priorities:	Failure to deliver the Manchester Single Hospital Service Programme effectively will present risks to all of the Trust's Key Priorities, but particularly Priority 1: - to deliver the merger of the two organisations with minimal disruption whilst ensuring that the planned benefits are realised in a timely manner.
Recommendations:	The Board of Directors is asked to receive the report and note the progress made and on-going actions.
Contact:	Name: Peter Blythin Director Single Hospital Service Tel: 0161 701 8573

1.0 Introduction

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

2.0 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.

3.0 Progress to Date

3.1 Integration

3.1.1 Integration plans have been progressively and comprehensively updated to ensure that they continue to support the establishment of the new organisation. The work has been overseen by the Integration Steering Group chaired by the Director for the Single Hospital Service supported by a number of Group Executive Directors.

3.1.2 As part of this, a number of corporate programmes have successfully concluded their integration projects, with many continuing as part of the post-merger "business as usual" work.

3.1.3 One such deliverable involved the provision of a Group wide Employee Health and Wellbeing Service to provide comprehensive support for all MFT staff. Feedback from staff has been immensely positive indicating that the pre-merger decision to increase support for staff during a major period of change has proved worthwhile. Moreover, a staff opinion 'pulse check survey' taken six months into the merger showed an improvement in staff advocacy as compared to the 2017 staff survey results.

3.1.4 In addition, the Informatics Team has been able to implement a number of systems and tools to assist colleagues in working and communicating across sites. These systems can also support clinical decision-making and improve operational efficiencies as colleagues are able to collaborate regardless of where they are located across MFT. An example of such systems is The Hive, which provides Group wide operational performance reports. Instant messaging and video conferencing software has also been implemented to reduce the need for staff to travel between sites during working hours.

3.1.5 Furthermore MFT has developed a Leadership and Culture Strategy with a significant focus on organisational development including major work streams focussed on vision and values, team development and leadership and improvement capability

building. This is linked to the integration work required to embed the new leadership structures across Hospitals and Managed Clinical Services.

3.1.6 A number of clinical services have also achieved impressive patient benefits through the delivery of specific integration programmes. In this context, colleagues from across MFT hospitals and the community are continuing to collaborate and harmonise patient pathways and services to provide improved patient experience and better clinical outcomes. Examples of clinical integration benefits include the following:

- **Urology:**

Teams from Wythenshawe Hospital and Manchester Royal Infirmary (MRI) have continued to work on improving services for patients with kidney stones through increased utilisation of the Lithotripter at Wythenshawe Hospital. The objective is to ensure that this service is available to MRI and Wythenshawe patients throughout the week, and that no patient waits more than a maximum of four weeks. In March 2018, on average, 60 patients were waiting longer than four weeks for their procedure. However, in July 2018, this was significantly reduced and no patients waited longer than four weeks for their treatment.

In September 2018, a non-elective pathway was implemented as well as increased elective throughput at Wythenshawe Hospital. Through September, there were 53 lithotripter treatments that took place at Wythenshawe Hospital.

There has been significant increase in patient choice for Lithotripsy as sessions have increased from once a fortnight to 3 days per week thereby providing a much improved service for patients as a direct consequence of the merger.

- **Orthopaedic services:**

Orthopaedic services are now running joint Multidisciplinary Teams (MDTs) across all MFT sites for key clinical groups including hip/knee, and shoulder/elbow. This work stream is currently exploring 'virtual MDTs' for shoulder/elbow and foot/ankle patients, where pooled waiting lists are operating across MFT. This has led to improved patient choice and access to services.

- **Urgent Gynaecology Surgery:**

Additional urgent gynaecology surgery lists across Wythenshawe and St Mary's Hospitals are in place which offer patients better choice for their procedures in terms of both time and location as well as a reduced time to treatment overall. The baseline figure for this metric was 4.1 days, and the objective is to get this down to 2.5 days. In September 2018, the average wait for urgent gynaecology surgery was 2.31 days**,** indicating an improved service for women. This standard is now being maintained.

- **Imaging and Nuclear Medicine:**

  Imaging and Nuclear Medicine colleagues across sites are working together to combine protocols and procedures to ensure consistent standards are being met across all areas of work. An accountability and oversight framework has been introduced to manage turnaround times for scan reports across our hospitals, reducing the time that patients are waiting to receive their results. Plans are now being developed to offer patients' access to scans at a different site if one hospital has reached capacity or if this is closer to their home or workplace.

3.2 Development of Year Two Integration Plans and Continued Governance Arrangements

3.2.1 A small number of year one projects have been re-phased to deliver in year two. This has happened where clinical staff have identified that by increasing the project scope, there is greater potential to increase patient benefits. For example, the Dental Laboratory consolidation project will seek to develop a wider project scope that considers the anticipated transfer of NMGH to MFT, and how the most efficient Dental Laboratory service can be introduced across whole of Manchester.

3.2.2 Year two integration plans are also being further developed with corporate, operational and clinical leads as teams work towards the implementation of complex programmes of work which will see harmonised care pathways and application of MFT-wide resources to reduce variability of treatment i.e. the same standard of care wherever a patient is treated in MFT.

3.3 Integration Steering Group

3.3.1 The Integration Steering Group (ISG) continues to oversee the delivery of the integration work streams, providing resource and support to help work stream leads deliver their programmes of work. The ISG recently refreshed its Terms of Reference following the organisation's Year One landmark to ensure that the forum remains relevant and vigilant to the ongoing needs of work streams and their integration programmes.

3.3.2 Furthermore, the ISG has recently commissioned a review of the Equality Impact Assessments (EQIAs) that have been completed as part of the SHS Programme. ISG sought assurances on the quantity and quality of the EQIAs to ensure that any integration plans did not inadvertently discriminate against any patient and promoted equality, diversity and inclusion wherever possible.

3.3.3 The review concluded that 48 EQIAs had been completed as part of the SHS Programme. These EQIAs were reviewed and scrutinised by the Equality and Diversity Team as part of their approvals process. MFT remains dedicated to continuing the EQIA process for each integration project as part of the Trust's commitment to champion equality and diversity.

3.3.4 Part of the post-merger integration plan includes tracking and monitoring delivery of all merger related benefits. To help ensure this activity continues to receive the attention it warrants, a further iteration of the Post-Transaction Integration Plan (PTIP) is being developed. The development of the PTIP will outline integration plans for the following year and will continue to ensure that MFT realises and tracks merger benefits wherever possible.

3.3.5 In conjunction with the development of the PTIP, a Year One Report is being produced and is in the final stages of development. The Year One Report outlines case studies of patient and organisational benefits that have been delivered as a result of the merger. Additionally, the Year One Report also details some of the lessons learned that MFT has collated throughout its first year in operation. These include areas such as:

- Programme Management
- Working with external agencies
- Operating in a novel transaction environment
- Describing merger benefits

3.3.6 All of the above-mentioned integration work remains closely connected to the development of the MFT clinical service strategy. This includes a focus on implementation plans for improvements to clinical services. The work is clinically led and is generating a huge amount of clinical engagement across MFT.

4.0 The Manchester Investment Agreement Metrics

4.1 The delivery of the Manchester Investment Agreement patient benefits is reported to Manchester Health and Care Commissioners (MHCC) on a quarterly basis. MFT is held to account by MHCC on the delivery of specific, measurable patient benefits such as shorter wait times to surgery and improved clinical outcomes. It is anticipated that a further cohort of metrics will be included in the agreement as part of a process to review and re-baseline deliverables that MFT will seek to realise over the coming two years.

4.2 MFT colleagues attended a meeting with MHCC and Greater Manchester Health and Social Care Partnership (GMH&SCP) in October 2018 to update on the delivery of the Manchester Investment Agreement metrics. Clinicians from Urology, Gynaecology and Orthopaedic services attended to present updates on the improvements they have been able to realise as a result of the merger (see point 3.1.6 above). Colleagues from MHCC and GMHSCP acknowledged the achievements MFT had been able to make since the merger took place.

5.0 Proposed Transfer of North Manchester General Hospital (NMGH) – Project 2 of the Single Hospital Programme

5.1 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.

5.2 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 is chaired by Jon Rouse, Chief Officer GMH&SCP.

5.3. One of the challenges in completing this work is the need to ensure that the strategic cases submitted by SRFT and MFT are complementary i.e. not contradictory or in any way inconsistent with the two-lot proposal. In this context, MFT continues to work collaboratively with MHCC, PAHT, SRFT, NHS I and colleagues at GMH&SCP to ensure the two transactions associated with the dissolution of PAHT remain on track.

5.4. In anticipation of the proposed transaction, MFT and MHCC continue to engage with colleagues at NMGH through a staff engagement programme. Colleagues are able to attend and provide updates to staff working on the NMGH site and answer any queries they may have with regards to the transaction. Additionally, MFT and NMGH have also undertaken a joint Consultant recruitment programme in the interest of addressing some of the medical staffing challenges across the City of Manchester.

5.5. As part of the development of a credible strategic case, MFT is working with MHCC to explore the role of NMGH as part of the local health and social care economy. This work is being progressed by the North Manchester Strategy Board, led by MHCC.

6.0 Conclusions

6.1. Integration work within MFT is progressing well and the primary focus continues to be realising patient benefits and creating new efficiencies through the application of robust leadership and governance arrangements. This approach will help ensure MFT plays its full part in realising the Manchester Locality Plan.

6.2 As part of the effort being made to deliver the Manchester Locality Plan MFT remains committed to implementing the Single Hospital Service for Manchester 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 GM H&SCP in its role in overseeing the dissolution of PAHT.

7.0 Recommendation

7.1 The Board of Directors is asked to note the content of the report.

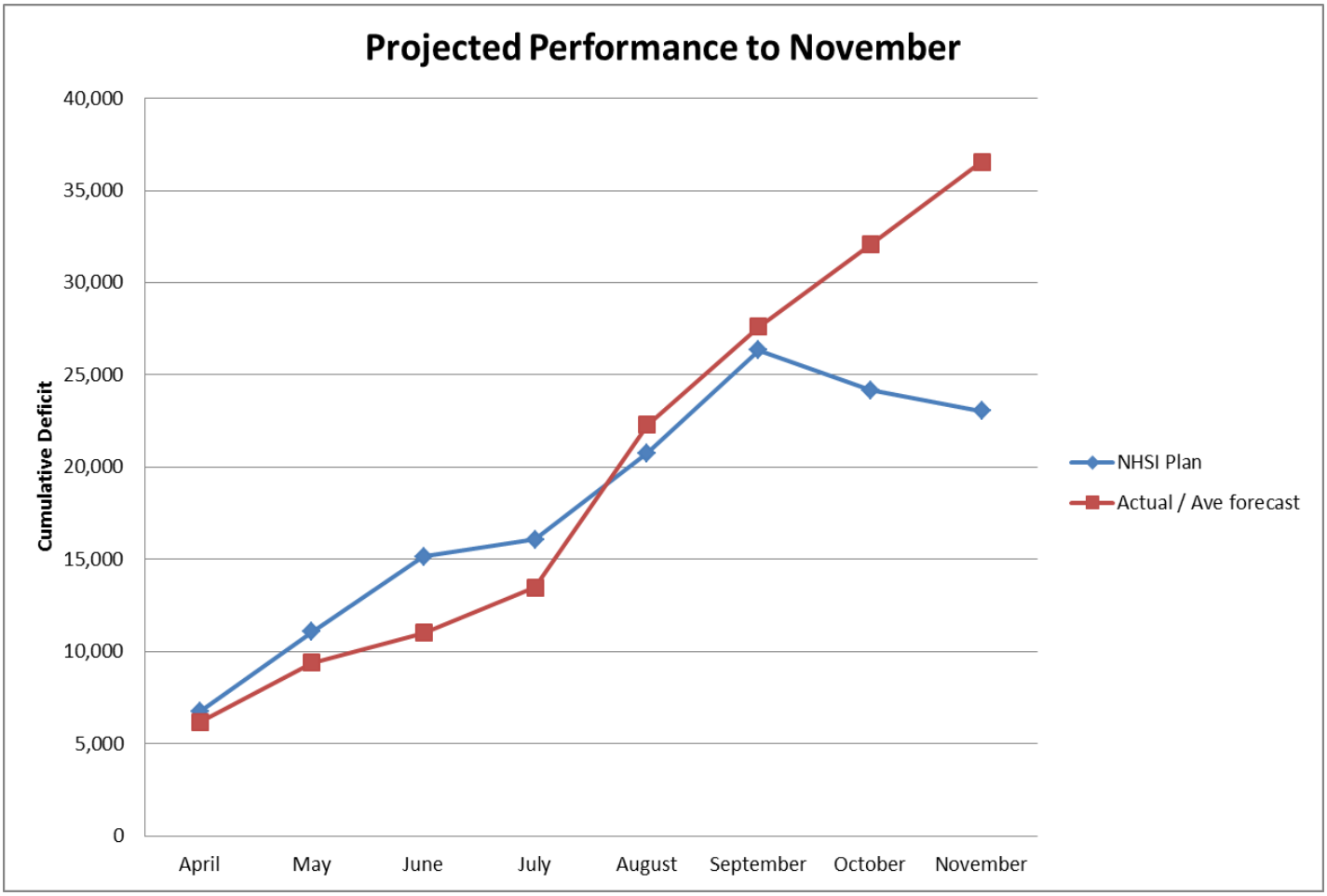
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Adrian Roberts – Chief Finance Officer
Paper prepared by:	Ursula Denton – Director of Finance
Date of paper:	12th October 2018
Subject:	Financial Performance for 2018/19
Purpose of Report:	• Approval ✓
Consideration of Risk against Key Priorities:	Maintaining financial stability for both the short and medium term
Recommendations:	Working within a Group Financial Recovery framework and timeline, Hospital leadership teams have each identified further targeted interventions which will accelerate delivery of existing plans and ensure adequate grip and control over their run-rate performance over the third quarter. In each case, accountability, timescales and quantified impacts are now set out for these further steps, which will: • Drive agency costs reductions • Accelerate delivery of identified savings plans • Sustain income delivery • Further strengthen accountability for control of expenditure
Contact:	Adrian Roberts Tel: 0161 276 6692

Executive Summary

1.1	**Delivery of financial Control Total**	The financial performance for the first half of the year was **a bottom line deficit** (on a control total basis excluding Provider Sustainability Fund) **of £13.8m** (**1.7%** of operating income). Trusts' financial performance is assessed with PSF excluded. The Trust is very narrowly within the delivery plan profile submitted to NHS Improvement.
1.2	**Run Rate**	This underlying deficit of £13.8m over 6 months represents **a run rate deficit of £2.3m per month,** which is not compatible with delivery of a £12m deficit excluding PSF over the year as a whole. See projected performance to November charted below, if no action were taken. **Actual agency spending has increased by 11% over the first 6 months, compared to 2017/18.** The agency spend ceiling set nationally by NHS Improvement requires a ***reduction*** in spending this year of ***17.5%***, in line with improvements in control over agency costs achieved across the hospital sector generally over the last 18 months. Table 2 on page 5 provides the Hospital/MCS performance against agency ceilings. Hospitals/MCS' have aggregate Trading Gap targets of £66.5m. To date, delivery plans amounting to £43.4m have been put into place.
1.3	**Remedial action to manage risk**	Working within a Group Financial Recovery framework and timeline, Hospital leadership teams have each identified further targeted interventions which will accelerate delivery of existing plans and ensure adequate grip and control over their run-rate performance over the third quarter. In each case, accountability, timescales and quantified impacts are now set out for these further steps, which will: • Drive agency costs reductions • Accelerate delivery of identified savings plans • Sustain income delivery • Further strengthen accountability for control of expenditure The impact of these actions collectively, is expected to significantly mitigate the run-rate trend - with around £7m of delivered improvements in financial performance (including one-off savings) against that trend, over the third quarter.
1.4	**Cash & Liquidity**	As at 30th September 2018 the Trust had a cash balance of £129.2m.
1.5	**Capital Expenditure**	The Capital Plan for 2018/19 is £74.0m. Capital expenditure in the year to date was £24.8m against a plan of £35.8m. In light of the factors causing slippage over the early months, forecast spending to March 2019 has been reviewed.


Projected Performance to November
Cumulative Deficit
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
April
May
June
July
August
September
October
November
NHSI Plan
Actual / Ave forecast

Financial Performance

Income & Expenditure Account for the period ended 30th September 2018

		Year to date - Month 6				
	Annual Plan	Year to date budget	Variance from budget	Variance as % of budget	Variance to Month 5	Year to date Actual
INCOME	£'000	£'000	£'000	%	£'000	£'000
Income from Patient Care Activities						
A and E	45,379	22,662	81		129	22,743
Non-Elective (includes XBD's)	263,388	130,784	1,055		1,243	131,839
Elective (includes Day Case & XBD's)	213,805	104,520	-1,356		-976	103,164
Out-Patients (includes First & Follow up)	173,805	85,161	140		512	85,301
Other NHS Clinical Income	474,771	237,752	1,263		-2,558	239,015
Community Services (includes LCO)	103,421	51,711	37		-18	51,748
Drugs (excludes Blood Products - HAEM)	105,319	52,662	-599		281	52,063
Sub -total Income from Patient Care Activities	**1,379,888**	**685,252**	621	0.1%	-1,387	**685,873**
Private Patients/RTA/Overseas(NCP)	8,135	4,030	637		287	4,667
Total Income from Patient Care Activities	**1,388,023**	**689,282**	1,258	0.2%	-1,100	**690,540**
Training & Education	61,163	30,585	71		7	30,656
Research & Development	55,629	27,817	-301		-2,391	27,516
Misc. Other Operating Income	109,714	60,623	-9,109		-6,682	51,514
Other Income	**226,506**	**119,025**	-9,339	-7.8%	-9,066	**109,686**
Total Income	**1,614,529**	**808,307**	-8,081	-1.0%	-10,166	**800,226**
EXPENDITURE						
Pay	-917,483	-464,670	-4,970	-1.1%	-3,868	-469,640
Non pay	-634,454	-320,412	11,036	3.4%	12,510	-309,376
Total Expenditure	**-1,551,937**	**-785,082**	6,066	0.8%	8,643	**-779,016**
EBITDA Margin (excluding PSF)	**62,592**	**23,225**	-2,015	-8.7%	-1,523	**21,210**
Interest, Dividends and Depreciation						
Depreciation	-30,226	-15,162	1,796		1,461	-13,366
Interest Receivable	443	221	108		60	329
Interest Payable	-41,138	-20,632	56		46	-20,576
Dividend	-3,755	-1,500	80		0	-1,420
Surplus/(Deficit) on a control total basis	**-12,084**	**-13,848**	24	0.2%	44	**-13,824**
Surplus/(Deficit) as % of turnover						**-1.7%**
PSF Income	**44,931**					**11,008**
Non operating Income						**53**
Depreciation - donated / granted assets						**-394**
Impairment						**-1,333**
	32,847					**-4,490**

Operating Unit Performance against breakeven measure

Income	Pay	Non Pay	Trading Gap	Hospital	Variance to breakeven budgets - (adverse) / positive			Variance to Control Total		I&E Annual Turnover
Year to date variance					Year to date (to month 6)		Comparative position as at month 5	Indicative control total (YTD)	Variance to control total	
£000s					£000s	%	£000s	£000s	£000s	£000s
1,479	-1,367	-1,567	0	Clinical & Scientific Support	-1,454	-1.3%	-1,448	203	-1,657	220,726
46	3,702	-2,261	-1,931	Facilities, Research & Corporate	-445	-0.3%	664	0	-445	255,119
455	863	-407	535	Manchester LCO	1,445	3.0%	1,283	1,250	195	96,964
1,334	-4,993	-1,268	-12,323	MRI	-17,250	-9.5%	-14,224	-11,833	-5,417	361,948
209	598	298	-2,758	REH / UDH	-1,653	-4.2%	-1,146	-1,500	-153	77,789
125	-243	124	0	RMCH	6	0.0%	102	750	-744	223,746
455	-53	-85	-1,726	Saint Mary's Hospital	-1,409	-1.7%	-1,338	-900	-509	161,675
-1,233	-1,586	349	-10,534	WTWA	-13,004	-6.5%	-11,022	-9,957	-3,047	399,253
2,870	**-3,079**	**-4,818**	**-28,737**	**Trust position**	**-33,763**	**-3.8%**	**-27,128**	**-21,987**	**-11,776**	**1,797,220**

Key Run Rate Areas

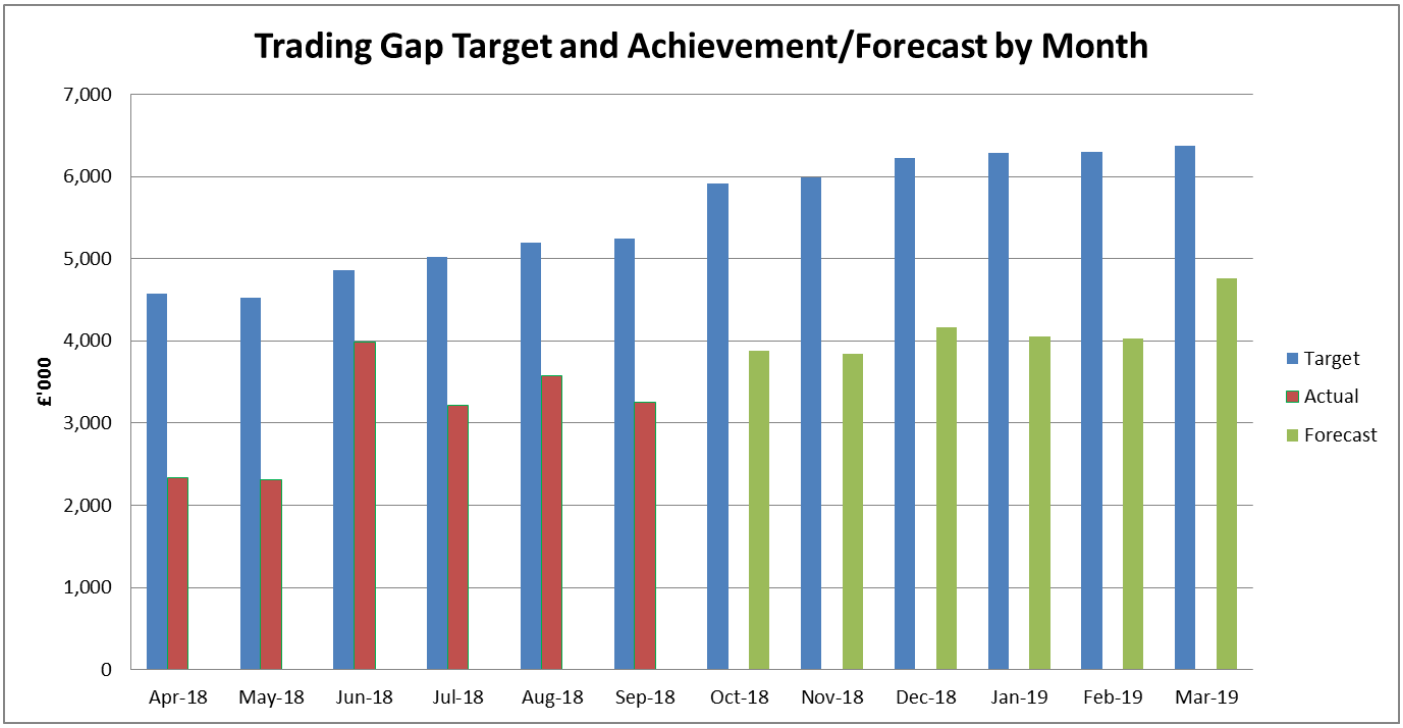
1. 2018/19 Trading Gap challenge

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	1,072	612	(460)	57%	2,231	1,346	(886)	60%
Blood Management	6	1	(5)	14%	14	6	(8)	41%
Contracting & income	3,552	3,726	174	105%	7,791	7,565	(226)	97%
Hospital Initiatives	1,786	2,316	530	130%	6,375	7,349	975	115%
Length of stay	0	0	0	0%	50	50	(0)	100%
Outpatients	913	604	(309)	66%	1,793	1,479	(313)	83%
Pharmacy and medicines management	709	718	9	101%	1,876	1,827	(48)	97%
Procurement	1,998	1,555	(443)	78%	5,262	4,805	(457)	91%
Theatres	868	925	57	107%	2,742	2,034	(709)	74%
Workforce - medical	2,137	1,782	(355)	83%	5,689	4,670	(1,019)	82%
Workforce - nursing	653	665	12	102%	1,623	1,635	12	101%
Workforce - other	541	1,031	490	191%	684	1,174	490	98%
Full year effect of prior year schemes	4,738	4,738	(0)	100%	9,476	9,476	(0)	100%
Unidentified	10,460	0	(10,460)	0%	20,920	0	(20,920)	0%
Grand Total	**29,433**	**18,672**	**(10,761)**	**63%**	**66,525**	**43,416**	**(23,109)**	**65%**

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%

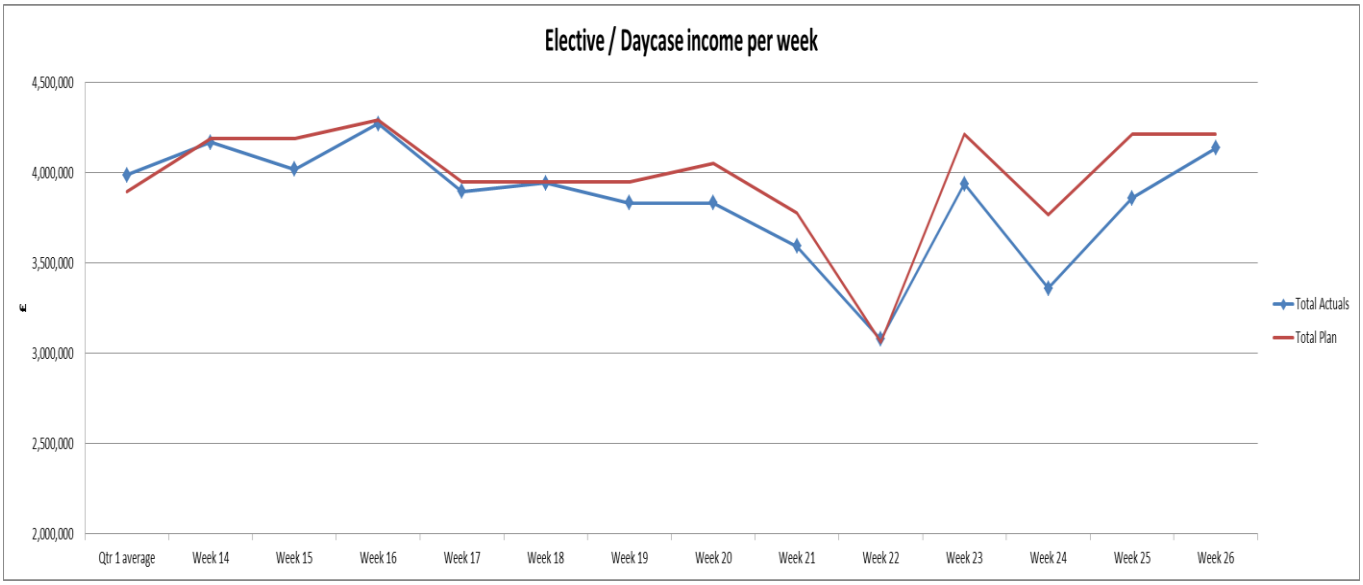


2. Agency spend by Hospital / MCS

	Agency spend M1-6 (£000)	Agency ceiling M1-6 (£000)	Difference (£000)
Clinical & Scientific Support	2,669	2,284	385
Manchester LCO	405	27	378
MRI	5,557	4,251	1,306
REH / UDH	668	534	134
RMCH	865	733	132
Saint Mary's Hospital	218	176	42
WTWA	5,394	3,740	1,654
Total	**15,776**	**11,745**	**4,031**

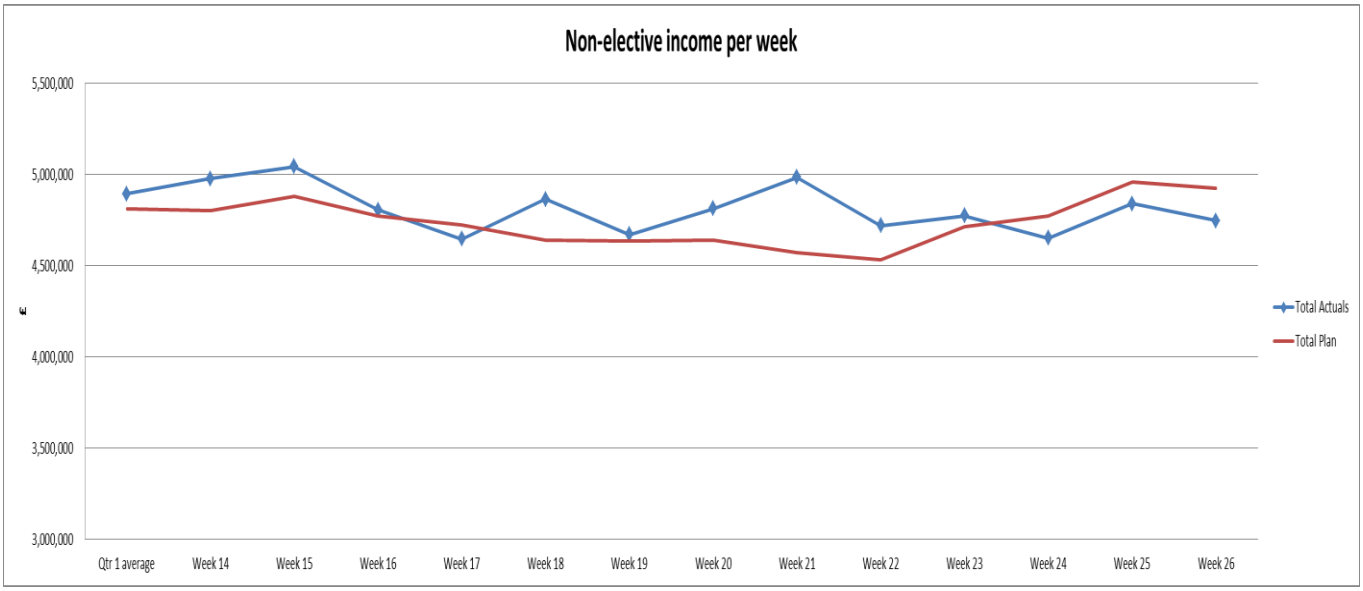
3. Elective / Daycase income: September 2018

Graph 2



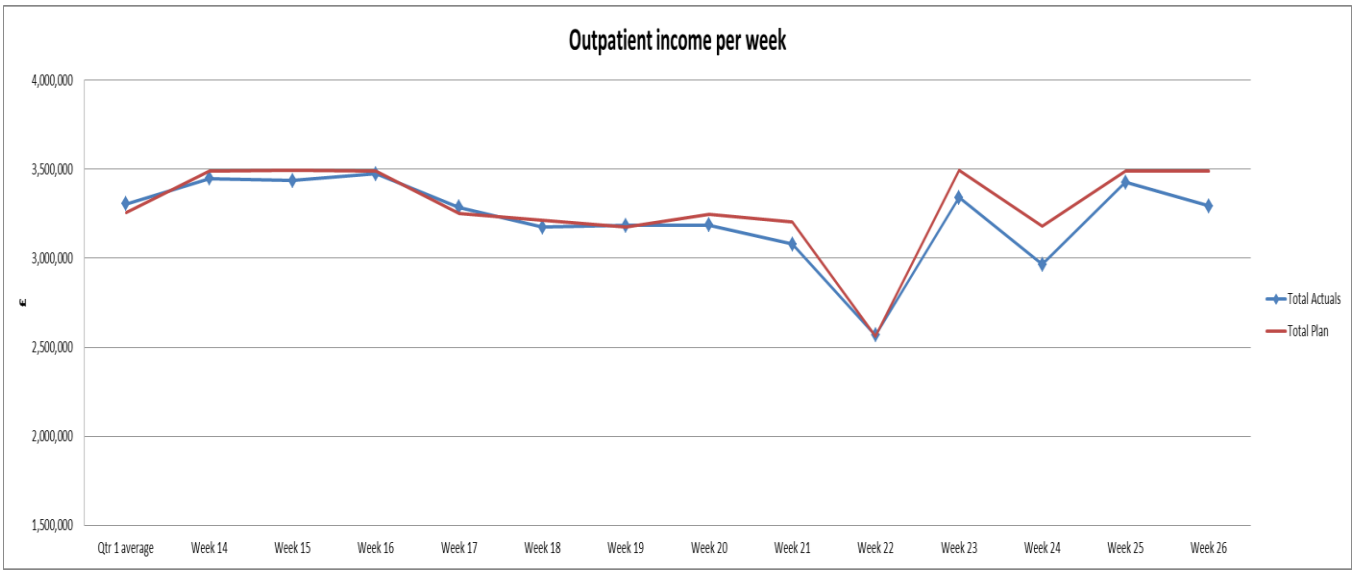
4. Non-Elective income: September 2018

Graph 3



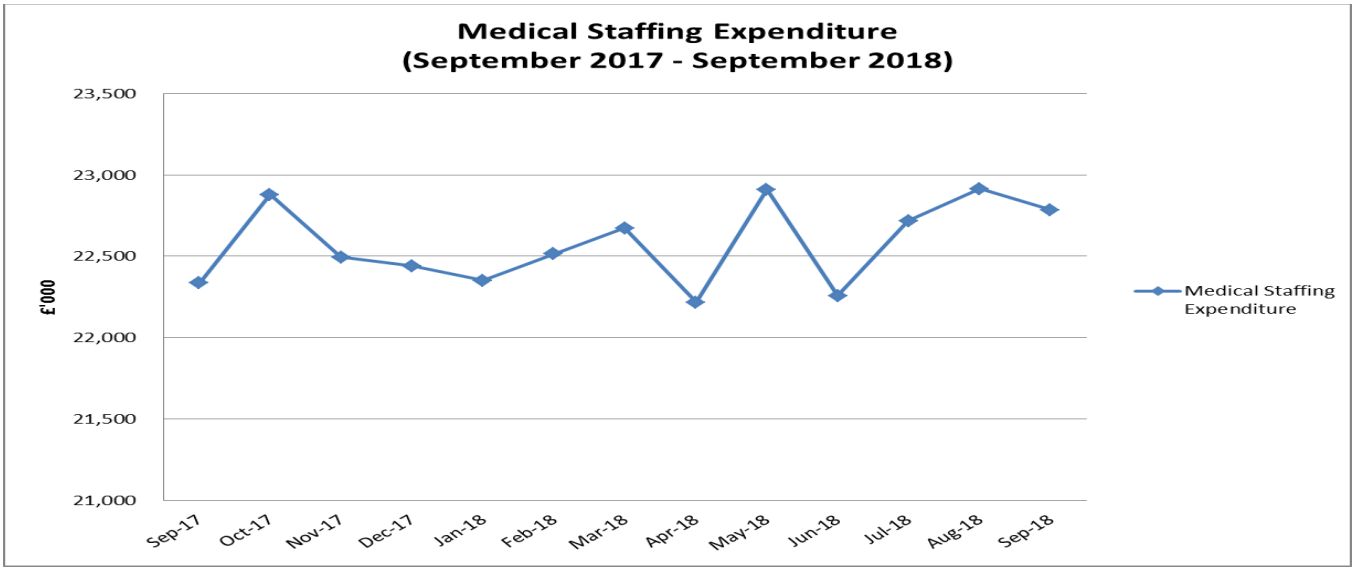
5. Outpatient income: September 2018

Graph 4



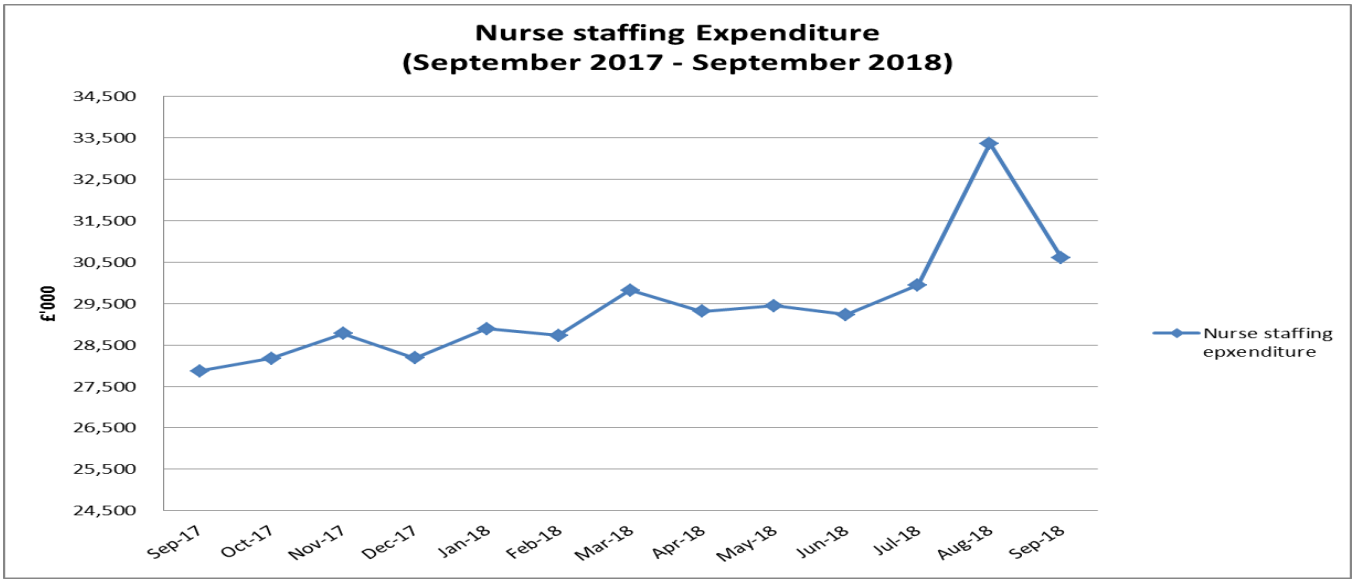
6. Medical Staffing: September 2018

Graph 5



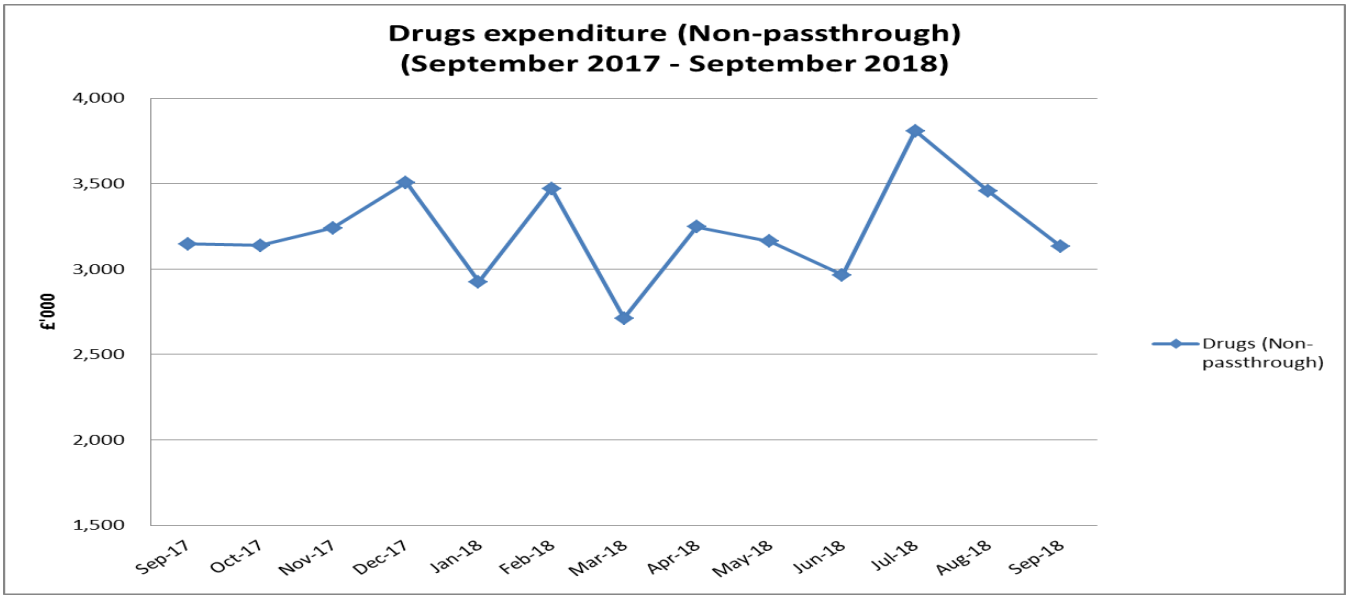
7. Nurse staffing: September 2018

Graph 6



8. Prescribing Drugs: September 2018

Graph 7



NHS Improvement's KPIs

	Plan YTD		*Actual YTD*	
	Metric	***Level***	***Metric***	***Level***
Liquidity ratio	0.0	1	(1.1)	2
Capital servicing capacity	1.2	4	1.0	4
I&E Margin	0.2%	2	(0.3%)	3
I&E margin: Distance to financial plan	0.0%	1	(0.5%)	2
Agency spend Metric - above / (below) the agency ceiling	9.6%	2	26.1%	3
Use of Resource (UOR) metrics - Level 1 being highest		**2**		**3**

	Annual Plan (full year)		*Forecast 18/19*	
	Metric	***Level***	***Metric***	***Level***
Liquidity ratio	0.2	1	(0.1)	2
Capital Servicing Capacity	1.6	3	1.5	3
I&E Margin	2.0%	1	1.7%	1
I&E margin: Distance to financial plan	0.0%	1	(0.3%)	2
Agency spend Metric - above / (below) the agency ceiling	8.1%	2	16.4%	2
Use of Resource (UOR) metrics - Level 1 being highest		**2**		**2**

Narrative:

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

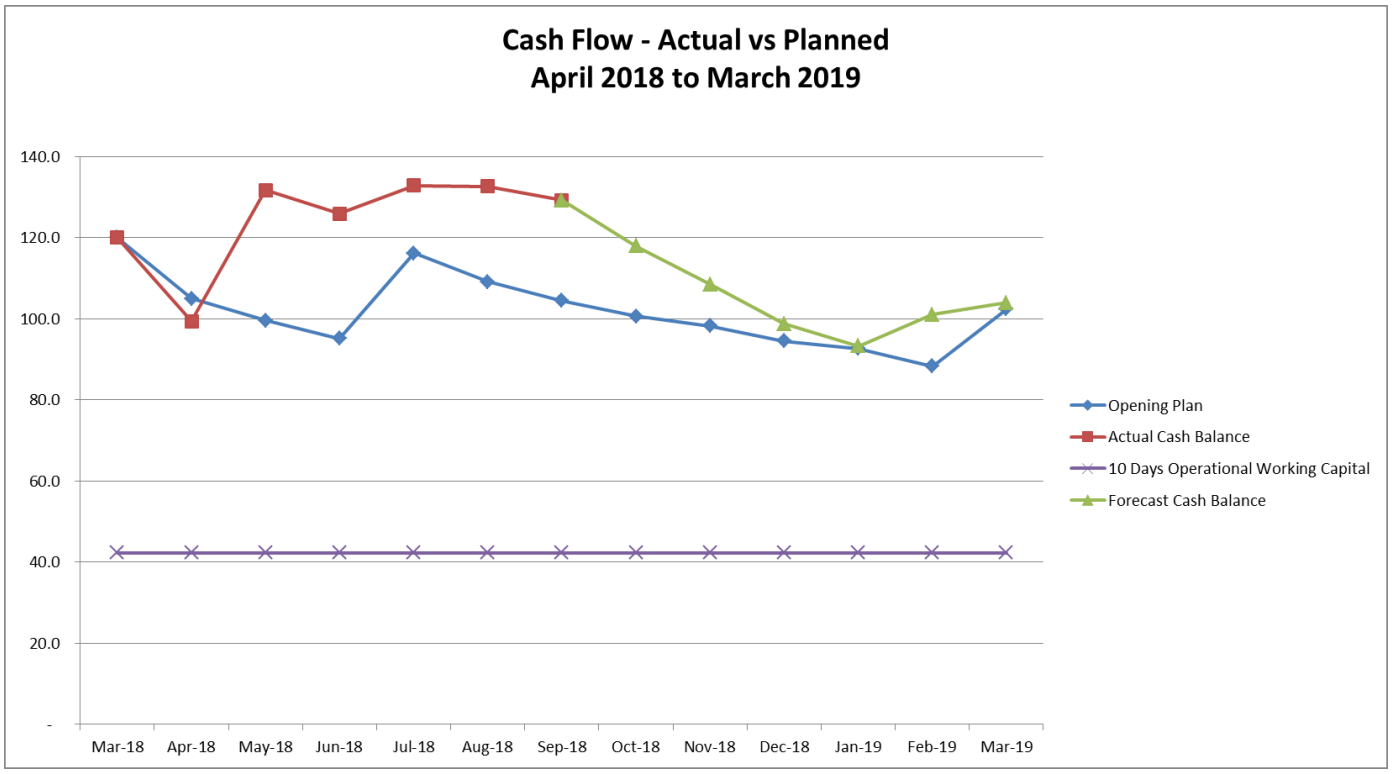
Two elements are driving adverse variances to the plan submitted to NHSI:

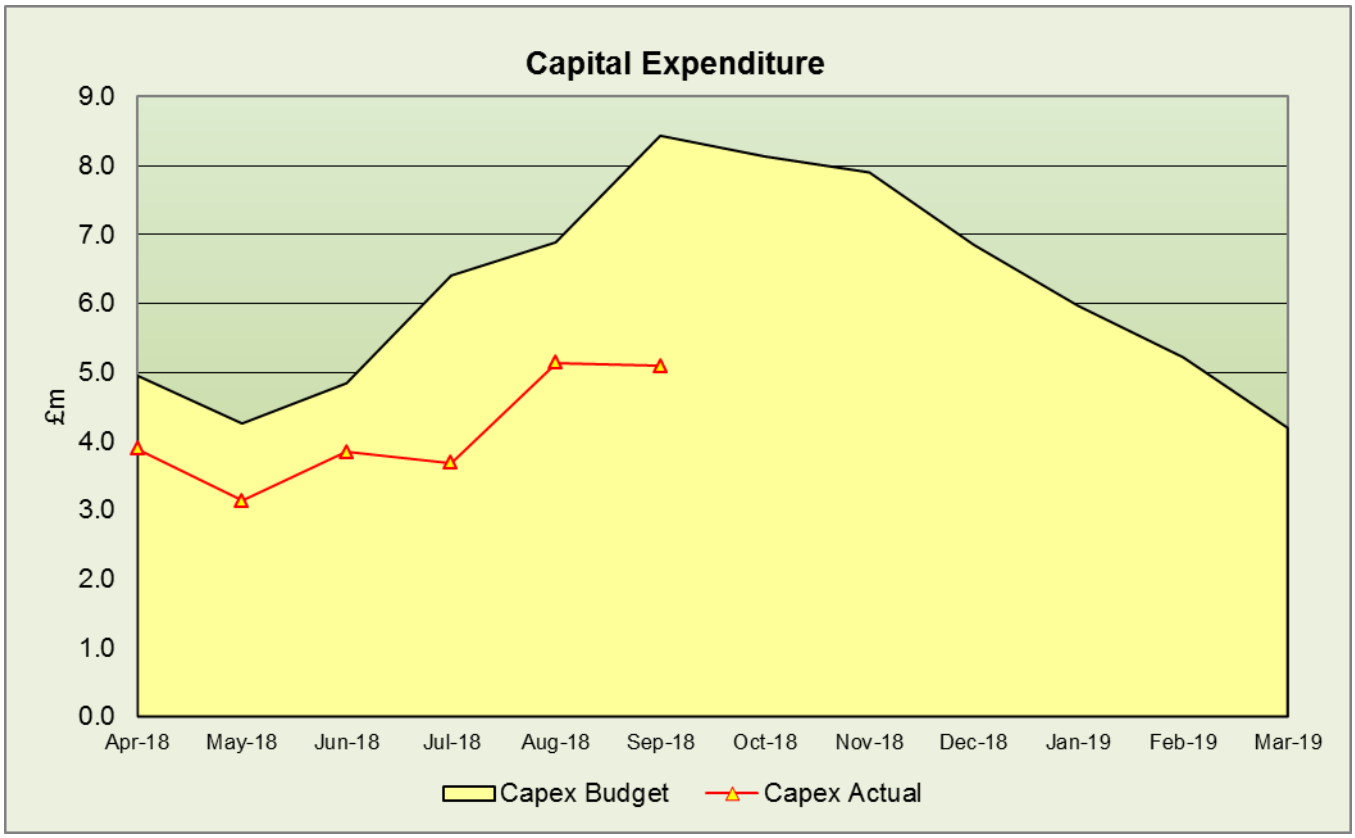
- An adverse variance on the agency spend, which now exceeds the agency ceiling by 27% in-year.
- The loss of the Provider Sustainability Fund associated with A&E performance is driving a deteroration in the I&E margin scores.

Balance Sheet

	Actual Opening Bals 01/04/2018 £000	Actual Year to Date 30/09/2018 £000	Movement in Year to Date £000
Non-Current Assets			
Intangible Assets	4,397	3,471	(926)
Property, Plant and Equipment	617,672	628,275	10,603
Investments	866	866	0
Trade and Other Receivables	5,591	6,876	1,285
Total Non-Current Assets	**628,526**	**639,488**	**10,962**
Current Assets			
Inventories	17,026	17,189	163
NHS Trade and Other Receivables	90,505	80,918	(9,587)
Non-NHS Trade and Other Receivables	41,863	39,889	(1,974)
Other Current Assets	0	0	0
Non-Current Assets Held for Sale	210	210	0
Cash and Cash Equivalents	119,896	129,220	9,324
Total Current Assets	**269,500**	**267,426**	**(2,074)**
Current Liabilities			
Trade and Other Payables: Capital	(9,497)	(8,698)	799
Trade and Other Payables: Non-capital	(154,265)	(176,985)	(22,720)
Borrowings	(22,286)	(22,923)	(637)
Provisions	(23,052)	(20,173)	2,879
Other liabilities: Deferred Income	(22,635)	(25,794)	(3,159)
Other Liabilities: Other	0	0	0
Total Current Liabilities	**(231,735)**	**(254,573)**	**(22,838)**
Net Current Assets	**37,765**	**12,853**	**(24,912)**
Total Assets Less Current Liabilities	**666,291**	**652,341**	**(13,950)**
Non-Current Liabilities			
Trade and Other Payables	(2,601)	(2,600)	1
Borrowings	(423,858)	(415,599)	8,259
Provisions	(7,251)	(9,235)	(1,984)
Other Liabilities: Deferred Income	(5,252)	(2,068)	3,184
Total Non-Current Liabilities	**(438,963)**	**(429,502)**	**9,460**
Total Assets Employed	**227,328**	**222,839**	**(4,490)**
Taxpayers' Equity			
Public Dividend Capital	203,291	203,291	0
Revaluation Reserve	45,408	45,408	0
Income and Expenditure Reserve	(21,371)	(25,861)	(4,490)
Total Taxpayers' Equity	**227,328**	**222,839**	**(4,490)**
Total Funds Employed	**227,328**	**222,839**	**(4,490)**

Cash flow and Capital Expenditure





Scheme	Plan £'000	Plan YTD at 30th Sep 2018 £'000	Spend YTD at 30th Sep 2018 £'000	Spend in future months £'000	Forecast Year End £'000
Property and Estates schemes					
Helipad	5,246	2,825	46	3,192	3,238
Diabetes Centre	1,849	1,144	10	345	355
Emergency Department - Wythenshawe	5,548	2,772	3,451	2,907	6,358
MRI ED redevelopment	3,992	1,036	301	2,291	2,592
RMCH ED redevelopment	1,000	498	0	150	150
Property & Estates Schemes - Compliance Work	18,534	9,731	5,206	9,483	14,689
Property & Estates Schemes - Development	11,862	7,016	2,528	5,416	7,944
Property & Estates - sub-total	**48,031**	**25,022**	**11,542**	**23,784**	**35,326**
IM&T schemes					
Electronic Patient Records (EPR)	2,100	654	0	2,100	2,100
IM&T Rollng Programme	1,555	780	867	688	1555
IM&T Strategy	7,949	2,785	5,875	3,791	9,666
IM&T - sub-total	**11,604**	**4,219**	**6,742**	**6,579**	**13,321**
Equipment rolling replacement programme	**6,904**	**2,786**	**2,667**	**4,617**	**7,284**
PFI Lifecycle	**7,500**	**3,750**	**3,827**	**3,673**	**7,500**
Total expenditure	**74,039**	**35,777**	**24,778**	**38,653**	**63,431**

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Strategy
Paper prepared by:	Group Executive Director of Strategy
Date of paper:	30 October 2018
Subject:	Strategic Development Update
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Resolution • Approval
Consideration of Risk against Key Priorities:	All individual strategic developments are risk assessed and monitored through the Board Assurance and Risk Management processes.
Recommendations:	The Board of Directors is asked to note the report and in particular: - Announcement of the successful bid to host the North West Genomics Laboratory Hub. - Updates on the GM Theme 3 transformation programme and constituent projects. - Progress on the development of an overarching group service strategy and the clinical service strategies.
Contact:	Name: Darren Banks, Group Executive Director of Strategy Tel: 0161 276 5676

1. Introduction

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

2. National Issues

The North West Genomics Partnership, hosted by Manchester University NHS Foundation Trust, has been chosen as one of the seven Genomics Laboratory Hubs across the country. In addition, the North West Genomics Partnership has been successful in bidding to provide eight specialist testing categories which are:

- Cardiology
- Haematology
- Hearing
- Immunology
- Metabolic
- Neurology
- Ophthalmology
- Inherited cancer (awarded in conjunction with the North East GLH)

3. Greater Manchester Issues

Theme 3 transformation

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

Theme 3 transformation projects									
Provider lead	**MFT**				**MFT & Wigan**	**MFT & ODN**	**SRFT**	**SFT**	**WWL**
	Vascular	Breast cancer	Paediatric surgery	Respiratory	Cardiology	Critical care	Neuro Rehab	Benign urology	Ortho MSK
Case for change	✓	✓	✓	✓	✓	✓	✓	✓	✓
Co-dependencies and clinical standards	✓	✓	✓				✓	✓	✓
Model of care	✓	✓	✓	✓	✓		✓	✓	✓
ECAP submission	✓	✓	✓	✓	✓		✓	✓	✓
CRG approval	✓	✓	✓	✓	✓		✓	✓	✓
Theme 3 Exec approval	✓	✓	✓	✓	✓		✓	✓	✓
Theme 3 Board approval	✓	✓	✓	✓	✓		✓	✓	✓
JCB endorsement*									
Modelling complete									

Green indicates an update from the last BoD meeting

* We are currently taking all models of care through the newly established Joint Commissioning Board for endorsement

Updates on MFT-led transformation projects:

- All models of care where MFT is the provider transformation lead have now been approved to go through the modelling stage with McKinsey. This includes:
    - Vascular
    - Breast cancer
    - Paediatric surgery
    - Respiratory
    - Cardiology

- Critical care
    - The project is being supported by the Operational Delivery Network and the case for change has now been approved.

4. MFT Issues

Service strategy development

Overarching group service strategy

Following engagement with a wide range of internal and external stakeholders, the Group Service Strategy is nearing completion. The next step is approval by the Board of Directors. Once approved it will continue to be iterated over the next 6 months:

- Some areas of the strategy will require iteration once all of the individual Clinical Services Strategies are complete (waves 2, 3 and MCSs)
- Summaries of each clinical strategy will be added as they are developed
- Any site-specific or proposals for major service change are at a formative stage. We will not decide to make or implement any material service changes until after we and/or our commissioners have taken appropriate steps that may (as required) include public involvement, consultation with the relevant Health Overview Scrutiny Committee(s) and the completion of an equality impact assessment.

Clinical service strategies

All workshops as part of wave one have now been completed with development of the draft clinical strategy documents ongoing.

Wave two and three clinical leads have been appointed with wave two scheduled to launch at the start of November 2018.

Engagement sessions with colleagues from North Manchester General Hospital representing each wave one service have been well attended. These have involved MHCC and the Single Hospital Service team to ensure that we are all aligned in relation to planning for NMGH.

The communications and engagement strategy for both the over-arching Group Service Strategy and the Clinical Service Strategies is being revised now that we are entering a new phase in the work and need to engage more widely.

5. Actions / Recommendations

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

- Announcement of the successful bid to host the North West Genomics Laboratory Hub.
- Updates on the GM Theme 3 transformation programme and constituent projects.
- Progress on the development of an overarching group service strategy and the clinical service strategies.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Strategy
Paper prepared by:	Group Executive Director of Strategy
Date of paper:	29 October 2018
Subject:	Annual Planning 2019/20
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Resolution • Approval
Consideration of Risk against Key Priorities:	All individual strategic developments are risk assessed and monitored through the Board Assurance and Risk Management processes.
Recommendations:	The Board of Directors is asked to note the proposed annual planning process
Contact:	Name: Darren Banks, Group Executive Director of Strategy Tel: 0161 276 5676

Annual Planning 2019/20

1. Introduction

The purpose of this paper is to set out the annual planning process for 2019/20 and in particular to seek agreement to the proposed vision and key priorities that the whole of the organisation will work towards. As last year, these will be set at group level, with key priorities set by Hospitals / Managed Clinical Services (MCS).

2. Vision and Strategic Aims

The starting point for the planning cycle is to review the Trust vision and strategic aims. The existing Trust vision and strategic aims were established as part of the Single Service Hospital Programme. As we are still part way through this programme, it is proposed that they are retained for 2019/20. This gives some stability and continuity for the Hospitals and MCSs. The obvious time to renew the vision is once the acquisition of NMGH has been achieved.

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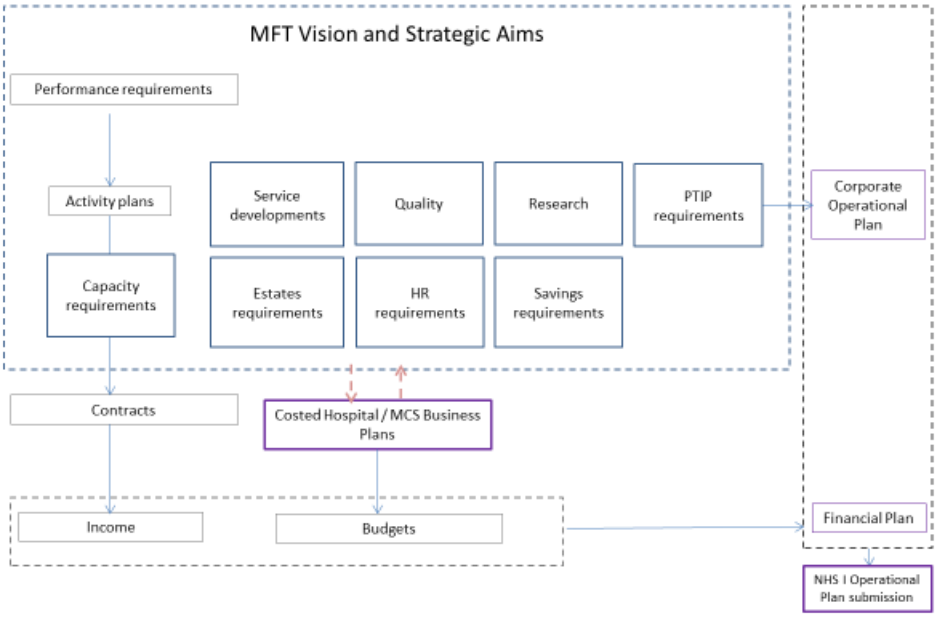
3. Planning Process for 2019/20

The schematic below shows how the various planning processes fit together, ultimately leading to the production of the Hospital Business Plans and the Trust Operational Plan required by NMH I.



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The Hospital / MCS Business Plan (HBP) sets out for the coming year how Hospitals / Managed Clinical Services (MCS) plan to deliver: all of their targets and aspirations in relation to activity, quality, safety and performance, the SHS benefits and any service developments, all within budget, including consideration of the workforce requirements and plans for how these will be fulfilled.

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3.2 MFT Operational Plan

NHS I require a Group level annual plan that shows for the organisation, how we plan to deliver the NHS 'must-dos' for the coming year. The exact requirements change each year. We know now the timeline that NHS I expect us to work to, but not the content and format of the submission.

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3.3 Timeline

The timeline below shows how we intend to dovetail the requirements of our internal planning with the NHS I requirements.

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Final submission to NHS I	4 April 19
EDT sign-off	8th April 19
Group Management Board sign-off	29th April 19

3.4 Council of Governors

It is proposed that there is an initial event with the Council of Governors in December which will be to review performance against the 2018/19 key priorities and to introduce the 2019/20 planning round. A further session will be held in January when Governors will have an opportunity to comment on and input to the proposed Hospital / MCS plans. Given the new organisational arrangements with Hospitals and Managed Clinical Services the format of this session will need to change from previous years. Subject to discussion with the Governors in December this will probably be held as a market-place type event.

3.5 Service Strategy

The Service Strategy programme, through which we are developing our longer-term plans, will conclude in early 2019/20. Plans approved through the process will be fed to the Hospitals / MCS as they become available for incorporation into their HBPs. For 2019/20 this is likely to include the over-arching Trust Service Strategy and the wave 1 Clinical Service Strategies. However it is not envisaged that the all of the strategic plans will be fully incorporated into annual plans until 2020/21.

4. Actions / recommendations

The Board of Directors is asked to note the proposed 2019/20 annual planning process.

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:	12th November 2018
Subject:	**Manchester Local Care Organisation Update**
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Resolution • Approval
Consideration of Risk against Key Priorities:	Leading on the development and implementation of integrated care.
Recommendations:	The BoD are asked to note the contents of this paper.
Contact:	Name: Elliot Shuttleworth Tel: 07779981115 Name: Tim Griffiths Tel: 07985448165

1. Introduction

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

- Regulatory Assessment;
- MLCO System Escalation;
- New Care Models;
- VCSE Memorandum of Understanding;
- Integrated Care Provider contract national public consultation;
- MLCO Freedom to Lead event;
- MLCO Operational Structures and Leadership Arrangements;
- Bringing Services Together; and
- MFT Scrutiny Committee

2. Regulatory Assessment

2.1 In October, MLCO led community health services for children's and adult's community health services across North, Central and South Manchester, as with the rest of the Group, has been subject to regulatory assessment by the Care Quality Commission (CQC).

2.2 Despite MLCO being an integrated care provider, it is important to acknowledge that the MLCO was established through the signing of a Partnering Agreement, which did not alter the statutory and contractual accountabilities of the services that are provided by it. As such the assessment was not extended to a broader range of services such as Adult Social Care.

2.3 As previously advised, MLCO mobilised dedicated programme management capacity to support the delivery of a CQC programme, and put in place governance arrangements to ensure that there is effective oversight of the programme. This included monthly SHINE meetings chaired by the Chief Executive, which fed directly into arrangements put in place by MFT.

2.4 Subsequent to the CQC visit, the MLCO Executive Team will continue to undertake service visits that had been mobilised at the inception of MLCO. The purpose of these visits has been to support the integration of staff into a new organisation under new leadership arrangements. Feedback from teams in regards to these visits has been positive and an ongoing programme has now been developed to ensure that the senior leadership team within MLCO have a visible and recognisable presence within our community services.

2.5 Although the MLCO, as with the broader Group, await the outcome of the assessment, it would be remiss not to acknowledge the significant and positive contribution of our community based staff to the process. It is these staff that are the bedrock of the MLCO, and they continue to provide a valued service to some of Manchester's most vulnerable residents on a daily basis.

3. MLCO System Escalation

3.1 Alongside leading the programmes of work bringing together health and social care services and delivering transformation activity, the MLCO is working with MFT to support local people by working to prevent the need for admission to hospital wherever possible, and getting people home from hospital in a timely and safe manner when they do need hospital care. With support from partners including Manchester City Council and Greater Manchester Mental Health NHS Foundation Trust, there has been an initial period of focussed activity to support people who have faced a long length of stay in hospital.

3.2 To date this work has overseen the discharge of 58 complex patients with a cumulative length of almost 6,000 days. Alongside this, plans have been developed around medium to long term improvements to support system-flow between the community and acute hospitals and to develop sustainability plans. Both of these are summarised below.

3.3 MLCO is now working with the Manchester Royal Infirmary (MRI) and developing plans to redesign organisational processes and develop new system-wide processes between the hospital and community. The aim is to sustain improvement in patient flow in the medium to long term. As part of this the MRI Complex Discharge Team was deployed into the MLCO from 1st October 2018, and steps are underway to establish an Integrated Discharge Team based on the models in place in North and South Manchester. System-wide processes and an integrated team will assist in ensuring that people are not only prevented from becoming stranded, but more importantly, that they are better supported in the community to avoid admission wherever possible in the first place. The MLCO is also working with Manchester Health and Care Commissioning (MHCC) to review resource allocation to ensure that this work can be sustained as a key priority.

3.4 The MLCO is also part of the MRI's Patient Flow Improvement Board, supporting work programmes and bringing a system and partnership viewpoint where appropriate. An example of the MLCO's involvement is the development of a frailty unit on the MRI site and linking in Primary Care and NWAS colleagues to help develop and resource a solution where suitable patients can be conveyed directly to a multi-disciplinary frailty unit bypassing and relieving pressure on the Emergency Department.

3.5 Further to the focused work programmes in development at the MRI, MLCO is also working collaboratively with colleagues at the Wythenshawe and North Manchester hospital sites. It is expected that a number of the programmes of work will be scaled up to ensure that there is a consistent offer for people across the City of Manchester.

3.6 In addition to the work identified above, MLCO continue to identify and develop programmes, that will look to make both an immediate and medium term impact on patient flow across Manchester. This is in conjunction with the development of new models of care identified in Section 4 and includes a range of schemes such as: development of a control centre to co-ordinate out of hospital care across the City of Manchester and review of the current urgent primary care

model with all providers. The MLCO is in discussion with MHCC and Partners regarding resourcing solutions to support this.

4. New Care Models

4.1 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 are:

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

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

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

- **Integrated Neighbourhood Teams** are the building blocks of the MLCO target operating model. Each of the 12 neighbourhoods will have a senior manager overseeing a range of integrated services and recruitment to the 12 key roles (INT Lead) across the city is now underway which is expected to be completed in December 2018.

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

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

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

4.3 The development and mobilisation of the other New Care Models (NCM) continues and Board are asked to note further updates in respect of the programmes:

- The Health Development Coordinator roles for Central and South are being recruited to and the services will go live as the Coordinators commence in post.
- Following the full mobilisation of the High Impact Primary Care pilot across the City (in three neighbourhoods), the service is going through its planned evaluation and investment review. Proposals are in development for the next phase of the service delivery.
- The Enhanced Home from Hospital service is currently being re-procured as part of the Citywide Support Services procurement led by MHCC.
- Crisis Response, Discharge to Assess and Reablement, which form three core aspects of the Manchester Community Response (MCR) service model, continue with their implementation as follows:
    - Crisis Response for Central Manchester went live in November for North West Ambulance Service (NWAS) referrals. South will follow once remaining staffing roles have been filled which is likely to before the end of the financial year. Crisis Response already operates in North Manchester.
    - The roll out of Discharge to Assess has started in North and South with re-planning in Central underway. Staff continue to be recruited into the teams to increase service capacity and support rollout.
    - The expansion of the Reablement service continues with significant progress made against the recruitment target of 62 additional Reablement Support Worker staff. To date 61 posts have been appointed to, with 41 starting in role.
- All of the other mobilised models remain on track. There are system recruitment challenges relating to Advance Nurse Practitioners, Therapists and reablement workers. The MLCO team is actively reviewing recruitment approaches to address this.

5. MLCO Operational Structures and Leadership Arrangements

5.1 Throughout 2018, the MLCO has developed plans to create new structures for our public-facing services, including the creation of 12 Integrated Neighbourhood Teams and 3 new Manchester Community Response Teams. This resulted in the consultation on the new integrated structures which ran between 20th August and 17th September 2018.

5.2 It is through this process that four of the twelve neighbourhood lead posts have been filled as have two of the three Manchester Community Response Lead posts. As a result, eight Neighbourhood Lead roles and one Manchester Community Response Lead currently remain unfilled. External recruitment is taking place to fill these positions. It is expected that the recruitment process will be complete by December 2018, with people in post in early 2019.

6. VCSE Memorandum of Understanding

6.1 As per previous updates to Board, MLCO continue to work with the VCSE to develop an MOU to define their future working arrangements.

6.2 As further background to this, in November 2017 it was agreed that MLCO would secure the seconded support of a senior officer from with the VCSE to lead and develop the work to establish the sector as a core partner of MLCO. The entailed hardwiring of the VCSE as a partner of the MLCO and embedding genuine engagement and participation approaches that ensure residents and communities are at the heart of MLCO.

6.3 In order to achieve this, it was agreed that the work and future relationship should be underpinned by a Memorandum of Understanding through the utilization of process designed by the sector. A substantive draft of this is scheduled to be produced in November 2018, and subject to agreement through the MLCO Partnership Board.

7. Integrated Care Provider Contract National Public Consultation

7.1 Further to the successful outcome of the judicial review process, NHS England began a public consultation in regards to the draft Integrated Care Provider (ICP) contract, with responses due by 26th October 2018. Should the contract be approved on a national basis, it would be subject to implementation at a local level from MHCC.

7.2 The draft ICP contract was reviewed by the MLCO and Partner organisations in line with the review into the future organisational form arrangements of the MLCO and Phase 2 contractual discussions. Following this review, the Partners submitted a joint Manchester system wide response to the consultation process, outlining feedback as to how the contract could be amended. It is expected at this stage a further iteration of the ICP contract will be released in early 2019.

8. MLCO Freedom to Lead Event

8.1 Over 200 MLCO staff and partners joined colleagues from across the city at our first leadership event, Freedom to Lead, at the Central Methodist Rooms in September 2018. Team and service leaders from community health and social care, frontline staff, partners, voluntary and community representatives all took part.

8.2 It gave the MLCO a chance to update staff on where the organisation is six months in and to discuss the benefits of working together as one team across the city, discussing ideas around moving forward in neighbourhood and city wide teams.

8.3 Freedom to Lead was all about connecting people across the city together. Twelve teams showcased the work that they have been doing at storytelling sessions and a series of workshops allowed people to collaborate on ideas.

8.4 There was initial positive feedback about the event and a full evaluation is currently being undertaken to provide more feedback and assist with planning for future leadership events.

9. Bringing Services Together

9.1 The MLCO continue to work closely with colleagues at MCC and MHCC to ensure that services across the public service spectrum are more effectively aligned. Bringing Services Together for People in Places (BST) is a joint delivery plan across MCC, MHCC and the MLCO and wider partners to improve system and citywide collaboration. The aim is to reduce complexity for residents and our collective workforce by reducing duplication and strengthening relationships in places.

9.2 This work will support the working of the Integrated Neighbourhood Teams and associated Neighbourhood Partnership Approach by:

- Developing a plan to agree the relationship between Neighbourhood Partnerships, Ward Coordination, Place Groups and Locality Provider Partnerships;
- Helping to align the flow of plans and priorities across the system so that Neighbourhood plans add value to Ward plans and Place plans;
- Creating more informal networking spaces to help build relationships before Neighbourhood Partnerships are established. Working through system challenges in a bottom up approach with frontline and operational managers;
- Working collectively with VCSE and universal services to address ‘system’ challenges that could impact Neighbourhood Approach e.g. capacity of organisations; and,
- Joining up resident engagement activities to ensure insight and stories are shared.

9.3 The MLCO Executive Team have met with colleagues from MCC, and continue to work collaboratively to ensure that the work streams set out within the overarching programme are delivered, recognising that moving forward BST will support the Integrated Neighbourhood Teams to develop and embed a different way of working at neighbourhood level.

10. MFT Scrutiny Committee

10.1 The inaugural MFT Scrutiny Committee met 12th September 2018. The Committee will review the delivery of MFT's community services (the MLCO Services), through the MLCO Executive, including:

- Performance against the MLCO Accountability Oversight Framework;
- Exploration of emerging or identified financial risks;
- Monitoring of clinical core priorities and performance;
- Monitoring of quality and governance;
- Progress in delivery of revised models of care and improved outcomes; and
- Monitoring of MLCO risk register.

10.2 Areas which require more detailed scrutiny arising from Board reports or emerging or identified significant risks will be addressed by the Committee as deemed necessary. The next meeting of the committee is scheduled for 12th November 2018.

11. Recommendations

11.1 The Board are asked to note the contents of the report.

MANCHESTER HOSPITALS NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

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

1. Introduction

1.1. The Board of Directors received a briefing paper in August 2018 detailing the arrangements for the CQC comprehensive inspection of the Manchester University NHS Foundation Trust.

1.2. This paper sets out the progress of the inspection.

2. Regulatory Inspection

Care Quality Commission

2.1. The CQC has completed the on-site component of the Hospital and MLCO Services inspection.

2.2. The visits took place on:

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

2.3. Daily feedback was given throughout the inspection and any issues raised were addressed and responded to immediately. At the time of writing no serious unknown risks were escalated during the inspection process.

2.4. The CQC Team are reviewing a large amount of documentary evidence submitted alongside their visit findings, and corroborating their findings. These findings will be detailed in a final report with ratings applied.

2.5. The ratings will be applied as per CQC guidance, across the core services for Safe, Caring, Effective, Responsive and Well-led for each location. They will be aggregated up to give an overall rating on quality of care. The four ratings which can be applied are inadequate, requires improvement, good or outstanding.

2.6. The Well-led assessment rating will be presented separately.

2.7. The report and the Trust ratings will be published approximately 3 months after the well-led assessment has been completed. This is therefore anticipated to be towards the end of January, early February.

3. Recommendations

3.1. The Board of Directors are asked to note the contents of the paper.

[1] At the time of writing the report the Well-Led review was outstanding

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Strategy
Paper prepared by:	Group Executive Director of Strategy
Date of paper:	29 October 2018
Subject:	Annual Planning 2019/20
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Resolution • Approval
Consideration of Risk against Key Priorities:	All individual strategic developments are risk assessed and monitored through the Board Assurance and Risk Management processes.
Recommendations:	The Board of Directors is asked to note the proposed annual planning process
Contact:	Name: Darren Banks, Group Executive Director of Strategy Tel: 0161 276 5676

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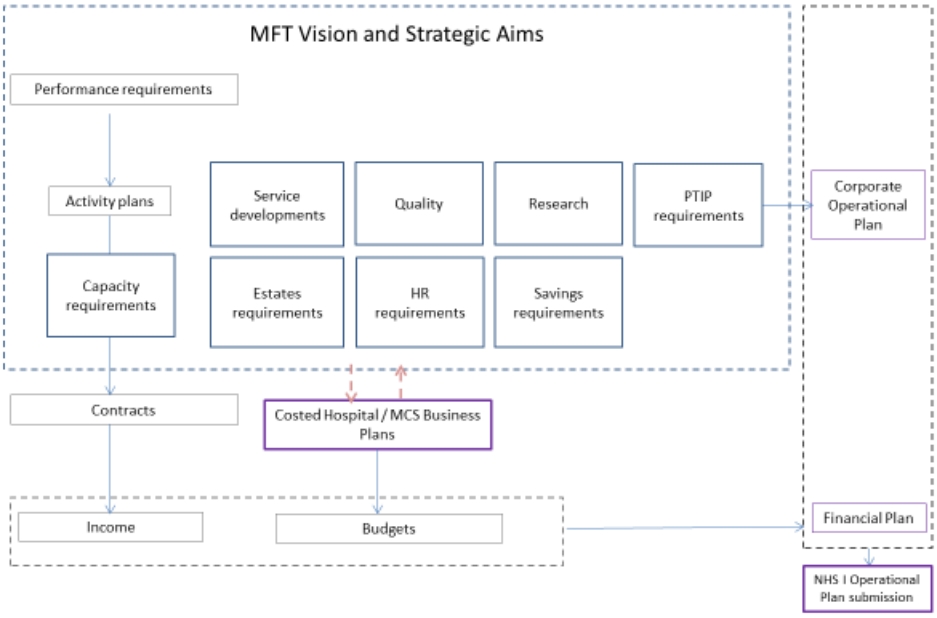

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Amendments following EDs review	18 March 19
Group COO sign-off	25 March 19
Final submission to NHS I	4 April 19
EDT sign-off	8th April 19
Group Management Board sign-off	29th April 19

3.4 Council of Governors

It is proposed that there is an initial event with the Council of Governors in December which will be to review performance against the 2018/19 key priorities and to introduce the 2019/20 planning round. A further session will be held in January when Governors will have an opportunity to comment on and input to the proposed Hospital / MCS plans. Given the new organisational arrangements with Hospitals and Managed Clinical Services the format of this session will need to change from previous years. Subject to discussion with the Governors in December this will probably be held as a market-place type event.

3.5 Service Strategy

The Service Strategy programme, through which we are developing our longer-term plans, will conclude in early 2019/20. Plans approved through the process will be fed to the Hospitals / MCS as they become available for incorporation into their HBPs. For 2019/20 this is likely to include the over-arching Trust Service Strategy and the wave 1 Clinical Service Strategies. However it is not envisaged that the all of the strategic plans will be fully incorporated into annual plans until 2020/21.

4. Actions / recommendations

The Board of Directors is asked to note the proposed 2019/20 annual planning process.

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:	12th November 2018
Subject:	**Manchester Local Care Organisation Update**
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Resolution • Approval
Consideration of Risk against Key Priorities:	Leading on the development and implementation of integrated care.
Recommendations:	The BoD are asked to note the contents of this paper.
Contact:	Name: Elliot Shuttleworth Tel: 07779981115 Name: Tim Griffiths Tel: 07985448165

1. Introduction

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

- Regulatory Assessment;
- MLCO System Escalation;
- New Care Models;
- VCSE Memorandum of Understanding;
- Integrated Care Provider contract national public consultation;
- MLCO Freedom to Lead event;
- MLCO Operational Structures and Leadership Arrangements;
- Bringing Services Together; and
- MFT Scrutiny Committee

2. Regulatory Assessment

2.1 In October, MLCO led community health services for children's and adult's community health services across North, Central and South Manchester, as with the rest of the Group, has been subject to regulatory assessment by the Care Quality Commission (CQC).

2.2 Despite MLCO being an integrated care provider, it is important to acknowledge that the MLCO was established through the signing of a Partnering Agreement, which did not alter the statutory and contractual accountabilities of the services that are provided by it. As such the assessment was not extended to a broader range of services such as Adult Social Care.

2.3 As previously advised, MLCO mobilised dedicated programme management capacity to support the delivery of a CQC programme, and put in place governance arrangements to ensure that there is effective oversight of the programme. This included monthly SHINE meetings chaired by the Chief Executive, which fed directly into arrangements put in place by MFT.

2.4 Subsequent to the CQC visit, the MLCO Executive Team will continue to undertake service visits that had been mobilised at the inception of MLCO. The purpose of these visits has been to support the integration of staff into a new organisation under new leadership arrangements. Feedback from teams in regards to these visits has been positive and an ongoing programme has now been developed to ensure that the senior leadership team within MLCO have a visible and recognisable presence within our community services.

2.5 Although the MLCO, as with the broader Group, await the outcome of the assessment, it would be remiss not to acknowledge the significant and positive contribution of our community based staff to the process. It is these staff that are the bedrock of the MLCO, and they continue to provide a valued service to some of Manchester's most vulnerable residents on a daily basis.

3. MLCO System Escalation

3.1 Alongside leading the programmes of work bringing together health and social care services and delivering transformation activity, the MLCO is working with MFT to support local people by working to prevent the need for admission to hospital wherever possible, and getting people home from hospital in a timely and safe manner when they do need hospital care. With support from partners including Manchester City Council and Greater Manchester Mental Health NHS Foundation Trust, there has been an initial period of focussed activity to support people who have faced a long length of stay in hospital.

3.2 To date this work has overseen the discharge of 58 complex patients with a cumulative length of almost 6,000 days. Alongside this, plans have been developed around medium to long term improvements to support system-flow between the community and acute hospitals and to develop sustainability plans. Both of these are summarised below.

3.3 MLCO is now working with the Manchester Royal Infirmary (MRI) and developing plans to redesign organisational processes and develop new system-wide processes between the hospital and community. The aim is to sustain improvement in patient flow in the medium to long term. As part of this the MRI Complex Discharge Team was deployed into the MLCO from 1st October 2018, and steps are underway to establish an Integrated Discharge Team based on the models in place in North and South Manchester. System-wide processes and an integrated team will assist in ensuring that people are not only prevented from becoming stranded, but more importantly, that they are better supported in the community to avoid admission wherever possible in the first place. The MLCO is also working with Manchester Health and Care Commissioning (MHCC) to review resource allocation to ensure that this work can be sustained as a key priority.

3.4 The MLCO is also part of the MRI's Patient Flow Improvement Board, supporting work programmes and bringing a system and partnership viewpoint where appropriate. An example of the MLCO's involvement is the development of a frailty unit on the MRI site and linking in Primary Care and NWAS colleagues to help develop and resource a solution where suitable patients can be conveyed directly to a multi-disciplinary frailty unit bypassing and relieving pressure on the Emergency Department.

3.5 Further to the focused work programmes in development at the MRI, MLCO is also working collaboratively with colleagues at the Wythenshawe and North Manchester hospital sites. It is expected that a number of the programmes of work will be scaled up to ensure that there is a consistent offer for people across the City of Manchester.

3.6 In addition to the work identified above, MLCO continue to identify and develop programmes, that will look to make both an immediate and medium term impact on patient flow across Manchester. This is in conjunction with the development of new models of care identified in Section 4 and includes a range of schemes such as: development of a control centre to co-ordinate out of hospital care across the City of Manchester and review of the current urgent primary care

model with all providers. The MLCO is in discussion with MHCC and Partners regarding resourcing solutions to support this.

4. New Care Models

4.1 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 are:

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

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

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

- **Integrated Neighbourhood Teams** are the building blocks of the MLCO target operating model. Each of the 12 neighbourhoods will have a senior manager overseeing a range of integrated services and recruitment to the 12 key roles (INT Lead) across the city is now underway which is expected to be completed in December 2018.

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

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

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

4.3 The development and mobilisation of the other New Care Models (NCM) continues and Board are asked to note further updates in respect of the programmes:

- The Health Development Coordinator roles for Central and South are being recruited to and the services will go live as the Coordinators commence in post.
- Following the full mobilisation of the High Impact Primary Care pilot across the City (in three neighbourhoods), the service is going through its planned evaluation and investment review. Proposals are in development for the next phase of the service delivery.
- The Enhanced Home from Hospital service is currently being re-procured as part of the Citywide Support Services procurement led by MHCC.
- Crisis Response, Discharge to Assess and Reablement, which form three core aspects of the Manchester Community Response (MCR) service model, continue with their implementation as follows:
    - Crisis Response for Central Manchester went live in November for North West Ambulance Service (NWAS) referrals. South will follow once remaining staffing roles have been filled which is likely to before the end of the financial year. Crisis Response already operates in North Manchester.
    - The roll out of Discharge to Assess has started in North and South with re-planning in Central underway. Staff continue to be recruited into the teams to increase service capacity and support rollout.
    - The expansion of the Reablement service continues with significant progress made against the recruitment target of 62 additional Reablement Support Worker staff. To date 61 posts have been appointed to, with 41 starting in role.
- All of the other mobilised models remain on track. There are system recruitment challenges relating to Advance Nurse Practitioners, Therapists and reablement workers. The MLCO team is actively reviewing recruitment approaches to address this.

5. MLCO Operational Structures and Leadership Arrangements

5.1 Throughout 2018, the MLCO has developed plans to create new structures for our public-facing services, including the creation of 12 Integrated Neighbourhood Teams and 3 new Manchester Community Response Teams. This resulted in the consultation on the new integrated structures which ran between 20th August and 17th September 2018.

5.2 It is through this process that four of the twelve neighbourhood lead posts have been filled as have two of the three Manchester Community Response Lead posts. As a result, eight Neighbourhood Lead roles and one Manchester Community Response Lead currently remain unfilled. External recruitment is taking place to fill these positions. It is expected that the recruitment process will be complete by December 2018, with people in post in early 2019.

6. VCSE Memorandum of Understanding

6.1 As per previous updates to Board, MLCO continue to work with the VCSE to develop an MOU to define their future working arrangements.

6.2 As further background to this, in November 2017 it was agreed that MLCO would secure the seconded support of a senior officer from with the VCSE to lead and develop the work to establish the sector as a core partner of MLCO. The entailed hardwiring of the VCSE as a partner of the MLCO and embedding genuine engagement and participation approaches that ensure residents and communities are at the heart of MLCO.

6.3 In order to achieve this, it was agreed that the work and future relationship should be underpinned by a Memorandum of Understanding through the utilization of process designed by the sector. A substantive draft of this is scheduled to be produced in November 2018, and subject to agreement through the MLCO Partnership Board.

7. Integrated Care Provider Contract National Public Consultation

7.1 Further to the successful outcome of the judicial review process, NHS England began a public consultation in regards to the draft Integrated Care Provider (ICP) contract, with responses due by 26th October 2018. Should the contract be approved on a national basis, it would be subject to implementation at a local level from MHCC.

7.2 The draft ICP contract was reviewed by the MLCO and Partner organisations in line with the review into the future organisational form arrangements of the MLCO and Phase 2 contractual discussions. Following this review, the Partners submitted a joint Manchester system wide response to the consultation process, outlining feedback as to how the contract could be amended. It is expected at this stage a further iteration of the ICP contract will be released in early 2019.

8. MLCO Freedom to Lead Event

8.1 Over 200 MLCO staff and partners joined colleagues from across the city at our first leadership event, Freedom to Lead, at the Central Methodist Rooms in September 2018. Team and service leaders from community health and social care, frontline staff, partners, voluntary and community representatives all took part.

8.2 It gave the MLCO a chance to update staff on where the organisation is six months in and to discuss the benefits of working together as one team across the city, discussing ideas around moving forward in neighbourhood and city wide teams.

8.3 Freedom to Lead was all about connecting people across the city together. Twelve teams showcased the work that they have been doing at storytelling sessions and a series of workshops allowed people to collaborate on ideas.

8.4 There was initial positive feedback about the event and a full evaluation is currently being undertaken to provide more feedback and assist with planning for future leadership events.

9. Bringing Services Together

9.1 The MLCO continue to work closely with colleagues at MCC and MHCC to ensure that services across the public service spectrum are more effectively aligned. Bringing Services Together for People in Places (BST) is a joint delivery plan across MCC, MHCC and the MLCO and wider partners to improve system and citywide collaboration. The aim is to reduce complexity for residents and our collective workforce by reducing duplication and strengthening relationships in places.

9.2 This work will support the working of the Integrated Neighbourhood Teams and associated Neighbourhood Partnership Approach by:

- Developing a plan to agree the relationship between Neighbourhood Partnerships, Ward Coordination, Place Groups and Locality Provider Partnerships;
- Helping to align the flow of plans and priorities across the system so that Neighbourhood plans add value to Ward plans and Place plans;
- Creating more informal networking spaces to help build relationships before Neighbourhood Partnerships are established. Working through system challenges in a bottom up approach with frontline and operational managers;
- Working collectively with VCSE and universal services to address ‘system’ challenges that could impact Neighbourhood Approach e.g. capacity of organisations; and,
- Joining up resident engagement activities to ensure insight and stories are shared.

9.3 The MLCO Executive Team have met with colleagues from MCC, and continue to work collaboratively to ensure that the work streams set out within the overarching programme are delivered, recognising that moving forward BST will support the Integrated Neighbourhood Teams to develop and embed a different way of working at neighbourhood level.

10. MFT Scrutiny Committee

10.1 The inaugural MFT Scrutiny Committee met 12th September 2018. The Committee will review the delivery of MFT's community services (the MLCO Services), through the MLCO Executive, including:

- Performance against the MLCO Accountability Oversight Framework;
- Exploration of emerging or identified financial risks;
- Monitoring of clinical core priorities and performance;
- Monitoring of quality and governance;
- Progress in delivery of revised models of care and improved outcomes; and
- Monitoring of MLCO risk register.

10.2 Areas which require more detailed scrutiny arising from Board reports or emerging or identified significant risks will be addressed by the Committee as deemed necessary. The next meeting of the committee is scheduled for 12th November 2018.

11. Recommendations

11.1 The Board are asked to note the contents of the report.

MANCHESTER HOSPITALS NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

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

1. Introduction

1.1. The Board of Directors received a briefing paper in August 2018 detailing the arrangements for the CQC comprehensive inspection of the Manchester University NHS Foundation Trust.

1.2. This paper sets out the progress of the inspection.

2. Regulatory Inspection

Care Quality Commission

2.1. The CQC has completed the on-site component of the Hospital and MLCO Services inspection.

2.2. The visits took place on:

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

2.3. Daily feedback was given throughout the inspection and any issues raised were addressed and responded to immediately. At the time of writing no serious unknown risks were escalated during the inspection process.

2.4. The CQC Team are reviewing a large amount of documentary evidence submitted alongside their visit findings, and corroborating their findings. These findings will be detailed in a final report with ratings applied.

2.5. The ratings will be applied as per CQC guidance, across the core services for Safe, Caring, Effective, Responsive and Well-led for each location. They will be aggregated up to give an overall rating on quality of care. The four ratings which can be applied are inadequate, requires improvement, good or outstanding.

2.6. The Well-led assessment rating will be presented separately.

2.7. The report and the Trust ratings will be published approximately 3 months after the well-led assessment has been completed. This is therefore anticipated to be towards the end of January, early February.

3. Recommendations

3.1. The Board of Directors are asked to note the contents of the paper.

[1] At the time of writing the report the Well-Led review was outstanding

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Professor Cheryl Lenney, Chief Nurse
Paper prepared by:	Karen Meadowcroft, Corporate Director of Nursing & Anne-Marie Varney, Acting Group Assistant Chief Nurse (Workforce)
Date of paper:	September 2018
Subject:	**Safer Staffing** – To provide the Board of Directors with the bi annual Nursing and Midwifery Safer Staffing report
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Resolution • Approval
Consideration of Risk against Key Priorities	**(Impact of report on key priorities and risks to give assurance to the Board that its decisions are effectively delivering the Trust's strategy in a risk aware manner)** 1. Patient Safety 2. Patient Experience 3. Productivity and Efficiency
Recommendations	To receive and note the work that is being undertaken to ensure provision of a nursing and midwifery workforce to support evidence based nursing and midwifery establishments.
Contact:	Karen Meadowcroft, Corporate Director of Nursing & Anne-Marie Varney, Acting Group Assistant Chief Nurse (Workforce) 0161 276 8862

Executive Summary

1. Introduction

1.1 The bi-annual, comprehensive report is provided to the Board of Directors on Nursing and Midwifery staffing. The report sets out the MFT position against the context of the National Nursing and Midwifery workforce challenges. The current workforce position is described with the actions in place to improve the Nursing and Midwifery staffing position across the Trust. The paper covers the period from April 2018-August 2018.

1.2 August reflects the highest number of vacancies in the calendar year as newly qualified nurses graduate in September and take up post throughout September and October. The Trust position is predicted to improve in September with an overall improved position from last year of 100 nurses and midwives. This has been achieved as a result of a successful international recruitment programme.

1.3 In some clinical areas there has been an overall increase to the nursing & midwifery establishment which has in part added to the number of overall vacancies..

1.4 The data demonstrates that the Trust has effective attraction and recruitment schemes however, turnover is high and the main focus must be on retention if we are to make the most of the recruitment strategies in place. The investment in staff and their career development alongside developing new roles and ways of working will be key to the sustainability of the nursing and midwifery workforce at MFT.

1.4 Retention is a key element of the workforce plans for the Trust. Notwithstanding the increase in supply of Nurses and Midwives to the Trust, it is recognised that this alone will not achieve our aim of full establishments. At the end of August 2018 the Nursing and Midwifery retention rate was 87.0%. This indicator measures the percentage of staff still employed in the Trust 12 months after joining. The MFT retention rate is 87.93%. The 12 month rolling turnover rate for Nursing and Midwifery was 13.78%.

1.5 At the end of August 2018, there were a total of **990.7wte (13.7%)** qualified Nursing and Midwifery vacancies across the Group compared to **874.0wte (12.4%)** at the end of April 2018. This is an increase in overall Nursing and Midwifery vacancies of **116.7wte** since April 2018.

1.6 The Trust vacancy position is expected to improve in Q3 following the graduation of student nurses and midwives who will take up posts within the Trust. The overall number of nursing and midwifery vacancies will decrease by **2.5% (185wte**) by November 2018 resulting in an overall vacancy factor of **11.1% (805.3wte)**. Workforce modelling undertaken predicts that there will be **814.9wte (11.2%)** nurse and midwife vacancies at the end of March 2019.

1.7 The majority of vacancies are within the Staff Nurse (band 5) workforce. At the end of August 2018 there were **743.6wte (18.7%)** staff Nurse (band 5) vacancies across the Trust compared to **619.3wte (16.0%)** at the end of April 2018. This is an increase

of **124.3wte (2.7%)** nursing and midwifery band 5 vacancies. This position will improve in November 2018 following the graduation and appointment of newly qualified nurses and midwives in Q3 when the number of band 5 Nurses and midwives vacancies are predicted to reduce to **589.6wte (14.8%)** a reduction of **154wte (3.9%).**

1.8 The workforce modelling undertaken predicts that there will be a further improvement in the nursing and midwifery workforce position at the end of March 2019. It is estimated that there will be an increase of **100wte** band 5 nurses and Midwives in post across the Trust compared to the workforce position in April 2018. This increase is primarily due to the increase in International Nurses recruited to the Trust.

1.9 The increase in the number of International Nurses in the next 12 months and the nursing skill mix review to support the introduction of the Nursing Associate role from January 2019 provides an additional workforce supply which has not previously been available and will complement the Group band 5 nursing workforce position.

1.10 Trust wide recruitment campaigns continue to attract experienced nurses as well as newly qualified nurses and midwives due to qualify in September 2018 and March 2019. There are circa 500 nurses, both newly qualified and experienced registered nurses all with conditional job offers, whose appointments are being processed through the Trust recruitment process. Over 75% of these recruits will qualify in September/October 2018. There is usually an attrition rate of 30% from offer to appointment as some students who accept job offers prior to graduating and then subsequently withdraw from the recruitment process accepting a post with another Trust.

1.11 The Trust has a successful international recruitment programme which has resulted in an increase in the number of international nurses joining MFT. A total of **56** international nurses have commenced in post since April 2018 with a further **64** nurses expected to arrive before the end of March 2019. This is a significant increase on the number of nurses recruited in 2017/18 (total **120** nurses expected compared to 40 nurses the previous year). The next international recruitment event is planned for early 2019.

1.11 In September 2016 the Trust, as part of the GM partnership, became a pilot site to train and develop the role of the Nursing Associate (NA). This is the first nationally developed new role within the workforce for a period of time and will be regulated by the Nursing and Midwifery Council from January 2019. The Nursing Associate will not replace the Registered Nursing workforce but will underpin this workforce and address the skills gap between Nursing Assistants and Registered Nurses. Work is being to profile the introduction of the NA role in the skill mix within the clinical areas to ensure inclusion is safe and appropriate.

1.12 There are currently **221** Trainee Nursing Associates (TNAs) in training across the Group. The first cohort of **81** TNAs will qualify in February 2019 and have all now received conditional job offers.

1.13 WTWA and MRI have the highest vacancy rates with particular hot spot challenges within general medicine, medical assessment, care of the elderly and orthopaedic surgery. Areas with high vacancies are a priority for recruitment and retention.

1.14 Each Hospital/MCS has systems in place to ensure patient safety which includes daily staff huddles and moving staff to meet the needs of patients.

1.15 The triangulation of ward staffing, patient safety and patient experience is presented biannually to the Quality and Performance scrutiny committee.

1.16 The Board of Directors is asked to receive this paper and to note the actions taken to recruit and retain the appropriate number of nurses and midwives to provide safe care.

1. Introduction

1.1 The bi-annual, comprehensive report is provided to the Board of Directors on Nursing and Midwifery staffing. The report details the Trust Group's position against the requirements of the National Institute of Health and Care Excellence (NICE) guidance for adult wards issued in July 2014[1],the National Quality Board (NQB) Safer Staffing Guidance 2016[2] and the NQB speciality staffing improvement guidance documents published by NHSI in January 2018[3].

1.2 The paper will provide analysis of the Trusts workforce position at the end of **August 2018** and the actions being taken to mitigate and reduce the vacancy position, specifically within the staff nurse and midwifery band 5/6 workforce.

1.3 Workforce modelling has been undertaken to present the information by Hospitals and Managed Clinical Services (MCS).

2. National Context

2.1 Since the publication of the Francis Report[4] and reviews undertaken by NICE and the NQB safer staffing guidance there has been an increased demand for Registered Nurses in the UK. The driver for safer staffing following the Mid Staffordshire Trust Enquiry saw over 40,000 additional posts for Registered Nurses created in the NHS.

2.2 The shortfall in nurse numbers across the UK is a well-recognised and documented challenge. Although there is no nationally agreed measure of the shortfall in the nursing workforce in England, recent figures presented by NHSI suggest the number is circa 43,000 vacancies[5].

[1] Safe staffing for nursing in adult in patient wards in acute hospitals July 2014
[2] Supporting NHS Providers to deliver the right staff, with the right skills in the right place at the right time. National Quality Board, July 2016
[3] NQB 2018 Safe, sustainable and productive staffing: An improvement resource for maternity services
[3] NQB 2018 Safe, sustainable and productive staffing An improvement resource for adult inpatient wards in acute hospitals
[3] NQB 2018 Safe, sustainable and productive staffing An Improvement resource for the district nursing service
[3] NQB 2018 Safe, sustainable and productive staffing An improvement resource for learning disability services
[4] Francis R (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry
[5] NHSI September 2018 – Mark Radford NHSI Improvement event Improving Workforce Retention

2.3 This growth in demand for more nurses has coincided with a number of other national challenges including:-

- A 20% increase in Nurses leaving the profession; for the first time, in 2016/17 the number of leavers has outstripped the number of nurses joining the NMC register and 45% more UK registrants left the register in 2016/17
- There has been a reduction in student Nurse commissions between 2009 and 2012 alongside the removal of bursary payments for student Nurses from 2017 which has resulted in a 20%reduction in the number of applicants applying to undertake Nurse training and a reduction of 6% in pre-registered students commencing training nationally.
- The uncertainty of the impact of Brexit and a significant reduction in EU Nurses applying to join the register
- An aging working profile predicted to reach retirement age within the next 5 years
- A reduction in Continual Professional Development (CPD) funding impacting on training and development opportunities for the Nursing and Midwifery workforce.
- Lack of infrastructure funding to support the development of new roles and new entry routes into the profession such as the graduate apprenticeship.

2.4 HEE published the draft Health and Care Workforce Strategy for England in 2017[6] with a final strategy now overdue for publication. Within the draft, there is a proposed set of principles for future NHS workforce decisions which aim to mitigate the risks associated with workforce planning and specifically support retention. These proposals include, securing the supply of staff, training and education, broad career pathways, widening participation, ensuring model modern employers, and joining up financial and workforce planning.

2.5 In January 2018, the House of Commons' Health and Social Care Committee[7] considered the impact of the shortage of Registered Nurses, calling upon the Government to expand the nursing workforce at scale and pace, increase opportunities for CPD, monitor the impact of the removal of the bursary and provide a clear professional identity for the Nursing Associates (NA). The government published an official response to the committee's recommendations in July 2018[8] outlining a number of initiatives which include:-

- Retention of nurses
- Increase supply of newly qualified nurses
- Introduction of the role of Nursing Associates
- Programmes to support overseas recruitment
- Workforce planning
- Support for return to practice initiatives

[6] HEE 2017, Facing the Facts, Shaping the Future, a Draft Health and Care Workforce Strategy
[7] House of Commons Health and Social Care Select Committee 2018, The Nursing workforce. 2nd Report of Session 2017.19
[8] Sec State for Health July 2018, Government response to House of Commons Health and Social Care Select Committee 2018, The Nursing workforce. 2nd Report of Session 2017.19

3. Greater Manchester Context

3.1 Due to the partnership between Chief Nurses and Higher Education Establishments (HEIs) across GM there has been a 3% increase in the number of pre-registration students (across the four fields) commencing nursing programmes in the academic year 2017/18 compared with programmes in the academic year 2016/17. Whilst the slight increase in numbers did not match the 420 additional Nursing and Midwifery Students requested by the GM Trusts to meet organisational workforce requirements; it is an improvement in comparison to the national position which is a 6% reduction in the number of students in comparison to the academic year 2016/17[9].

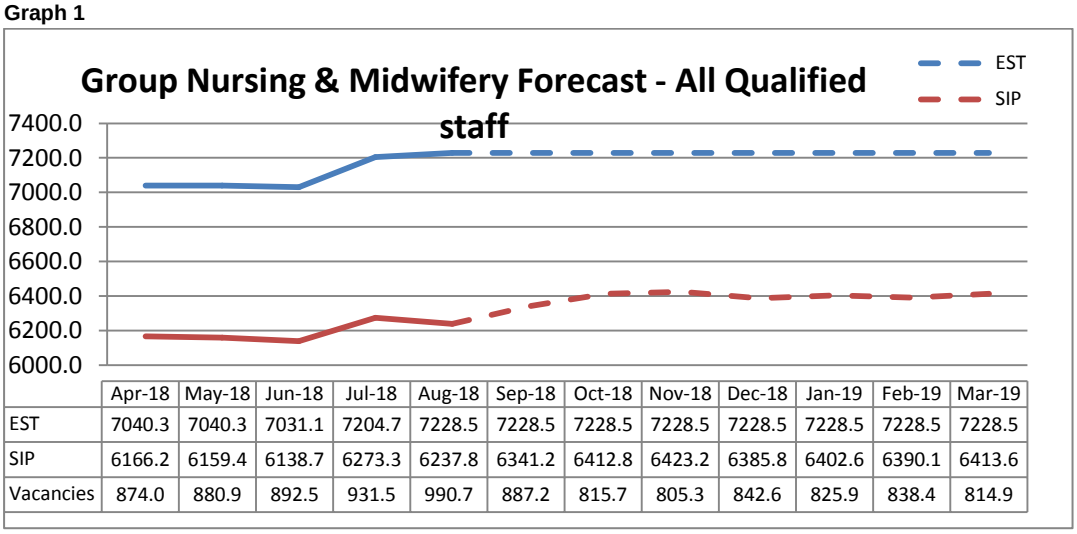
3.2 In June 2018 a GM nurse recruitment campaign, 'Be a Greater Manchester Nurse'[10] was launched which works with some of Manchester's music legends, to highlight the career opportunities for nursing in GM. The campaign was developed by the GM delivery Group supported by the GMHSCP to attract nurses to study, start their career, and develop and excel in GM. The campaign has brought together NHS Trusts, GP practices and the independent care sector to work together to celebrate the diversity of nursing. The Campaign will be extended later this year to attract more undergraduate students during 2019 in partnership with GM HEIs.

4. MFT (Group) Workforce Position

4.1 At the end of August 2018, there were a total of **990.7wte (13.7%)** qualified Nursing and Midwifery vacancies across the Group compared to **874.0wte (12.4%)** at the end of April 2018. This is an increase in overall Nursing and Midwifery vacancies of **116.7wte** since April 2018.

4.2 **Graph 1** illustrates the overall Nursing and Midwifery vacancy trajectory for 2018/19. The Trust Group vacancy position is expected to improve in Q3 following the graduation of student Nurses and Midwives who will take up posts within the Trust.

Graph 1



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
EST	7040.3	7040.3	7031.1	7204.7	7228.5	7228.5	7228.5	7228.5	7228.5	7228.5	7228.5	7228.5
SIP	6166.2	6159.4	6138.7	6273.3	6237.8	6341.2	6412.8	6423.2	6385.8	6402.6	6390.1	6413.6
Vacancies	874.0	880.9	892.5	931.5	990.7	887.2	815.7	805.3	842.6	825.9	838.4	814.9

[9] RCN 2018, Drop in Student Nurse Numbers https://www.rcn.org.uk
[10] https://www.greatermanchesternurses.co.uk

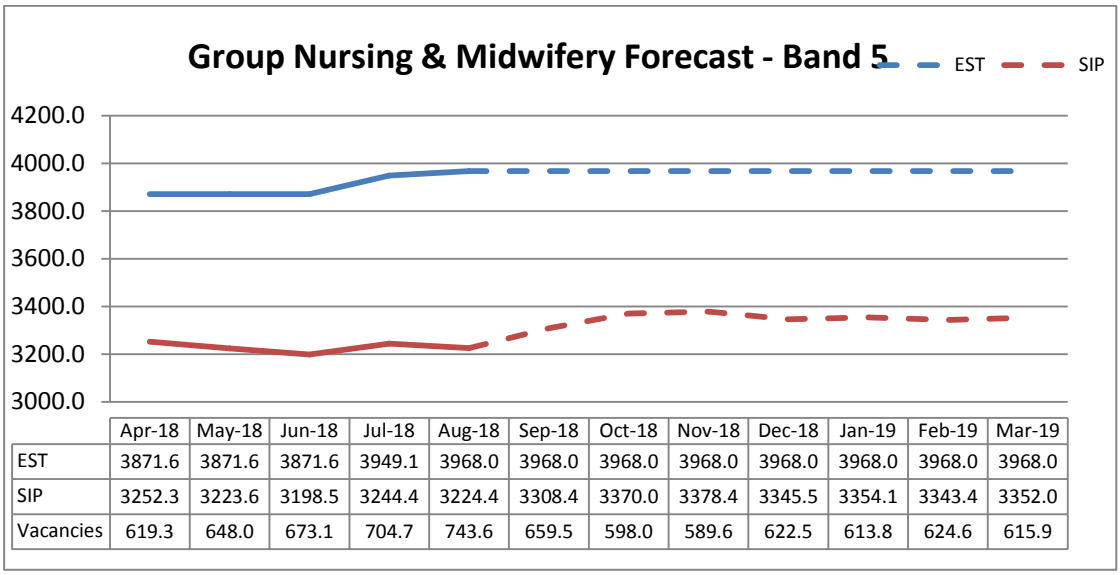
4.3 The overall number of Nursing and Midwifery vacancies will decrease by **2.5% (185wte**) by November 2018 resulting in an overall vacancy factor of **11.1% (805.3wte)**. Workforce modelling undertaken predicts that there will be **814.9wte (11.2%)** nursing and midwifery vacancies at the end of March 2019.

4.4 The majority of vacancies are within the Staff Nurse (band 5) workforce. At the end of August 2018 there were **743.6wte (18.7%)** staff Nurse (band 5) vacancies across the Trust compared to **619.3wte (16.0%)** at the end of April 2018. This is an increase of **124.3wte (2.7%)** nursing and midwifery band 5 vacancies.

4.5 When reviewing the number of Nurses leaving the Trust the highest attrition is found to be in critical care areas, Emergency Departments, Theatres and medical assessment units. There is no correlation between the number of leavers and high vacancies as each of these areas are able to attract nurses into the specialisms and have undertaken recruitment campaigns within the last 6 months. It is noteworthy that many nurses move to these areas internally from wards and departments. Work will focus on improving the retention of staff in these areas.

4.6 **Graph 2** illustrates the Group-wide band 5 workforce position until March 2019. This position will improve in November 2018 following the graduation and appointment of newly qualified Nurses and Midwives in Q3 when the number of band 5 Nurses and Midwives vacancies will reduce to **589.6wte (14.8%)** a reduction of **154wte (3.9%).**

Graph 2



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
EST	3871.6	3871.6	3871.6	3949.1	3968.0	3968.0	3968.0	3968.0	3968.0	3968.0	3968.0	3968.0
SIP	3252.3	3223.6	3198.5	3244.4	3224.4	3308.4	3370.0	3378.4	3345.5	3354.1	3343.4	3352.0
Vacancies	619.3	648.0	673.1	704.7	743.6	659.5	598.0	589.6	622.5	613.8	624.6	615.9

4.7 The workforce modelling undertaken predicts that there will be a further improvement in the Nursing and Midwifery workforce position at the end of March 2019. It is estimated that there will be an increase of **100wte** band 5 Nursing and Midwifery staff in post (SIP) across the Trust compared to the workforce position in April 2018. This increase is primarily due to the increase in domestic and International Nurses.

4.8 The predicted increase in the number of International Nurses in the next 12 months and the nursing skill mix review to support the introduction of the Nursing Associate role from January 2019 provides an additional workforce supply which has not previously been available and will support the Group band 5 nursing workforce position. It is predicted that the number of band 5 vacancies at the end of March 2019 will be **615.9wte (13.2%).** This will be an improvement to the position in April 2018 when the vacancy factor was **15.5%.**

5. MFT (Group) Recruitment and Retention

Domestic Recruitment

5.1 Trust wide recruitment campaigns continue to attract experienced nurses as well as newly qualified Nurses and Midwives due to qualify in September 2018 and March 2019. There are circa 500 nurses, both newly qualified and experienced registered nurses with conditional job offers whose appointments are being processed through the Trust recruitment process. Over 75% of these recruits are Student Nurses and Midwives who will qualify in September/October 2018. There is usually an attrition rate of 30% from offer to appointment as some students who accept job offers prior to graduating and then subsequently withdraw from the recruitment process accepting a post with another Trust. The Hospital/MCS Directors of Nursing and recruitment leads have implemented a series of interventions to keep appointed staff engaged with the Trust in order to reduce this rate.

International Recruitment

5.2 The Trust has a successful International Recruitment Programme which has resulted in an increase in the number of International Nurses joining MFT. A total of **56** International Nurses have commenced in post since April 2018 with a further **64** Nurses expected to arrive before the end of March 2019. This is a significant increase on the number of Nurses recruited in 2017/18 (total **120** Nurses expected compared to 40 Nurses the previous year). Since the start of the IR programme there has been a total of **204** International Nurses join the Trust in the last 2 years. The Trust is regarded by the NMC as being an exemplar site in successful delivery of the IR OSCE programme with an overall pass rate of 97%.

5.3 The next International recruitment event is planned for early 2019.

Nursing Associates

5.4 In September 2016 the Trust, as part of the GM partnership, became a pilot site to train and develop the role of the Nursing Associate (NA) which will be regulated by the Nursing and Midwifery Council from January 2019.

5.5 There are currently **221** Trainee Nursing Associates (TNAs) in training across the Group which equates to 40% of the trainees across GM.

5.6 The first cohort of **81** TNAs will qualify in February 2019 and have all received conditional job offers. The Nursing Associate will not replace the Registered Nursing workforce but will underpin this workforce and address the skills gap between Nursing Assistants and Registered Nurses. Work is being undertaken within the hospitals to profile the introduction of the NA role in the skill mix within the clinical areas to ensure inclusion is safe and appropriate.

Pre-Registration Nursing and Midwifery Training

5.6 The Higher Education Institutions (HEIs) are currently recruiting to the 2018/19 pre-registration Nursing & Midwifery programmes of education, based on the GM Directors of Nursing organisational workforce requirements. The GM target for the HEIs is to recruit an additional 350 Nursing students (across Adult, Child & Mental Health) and an additional 30 Midwifery students based on HEE previously commissioned numbers and in order to meet organisational workforce requirements. MFT has requested an additional 149 of these Nursing and Midwifery students.

5.7 An additional 227 nursing and midwifery Students commenced a programme of education in September 2018 of which at least 85 nursing & midwifery Students (across adult, child & midwifery fields) will undertake their placements within MFT.

5.8 MFT is continuing to work in partnership with the GM HEIs to look at innovative ways to attract students to train in GM and commence programmes of education in Jan/Feb/May 2019 in order to meet our overall target of an additional 149 nursing and Midwifery Students commencing pre-registration Nursing & Midwifery programmes of education.

6 Retention and Turnover

6.1 Retention is a key element of the workforce plans for the Trust. Notwithstanding the increase in supply of nurses and midwives to the Trust it is recognised that this alone will not achieve our aim of full establishments. At the end of August 2018 the Nursing and Midwifery retention rate was 87.0%. This indicator measures the percentage of staff still employed in the Trust 12 months after joining. The MFT retention rate is 87.93%. The 12 month rolling turnover rate for Nursing and Midwifery was 13.78%.

6.2 The Band 5 Nursing and Midwifery retention and turnover rates show some improvement when compared to the Shelford average. At the end of August 2018 the Trust retention rate for band 5 Nurses and Midwives was 75.93% compared to Shelford average of 75.87%, The Trust band 5 turnover rate was 18.17% compared to the Shelford average of 20.93%.

6.3 Whilst benchmarking provides the Trust with an understanding of the national picture a turnover of 18% is not sustainable. NHSI were recently invited to the Trust to discuss the work they have undertaken to improve retention across the NHS workforce. Information was provided relating to the financial cost of recruiting a single member of staff, equating to almost £18,000 for a larger Organisation when factoring productivity loss, the use of bank and agency, recruitment advertising, interviewer time and induction costs. NHSI go on to suggest that a 2% reduction in

annual turnover could save up to £500,000 per annum for a large Trust. In addition to improving quality and safety this provides a further incentive for retaining staff.

6.4 The Hospitals and MCS within MFT have developed individual retention plans to reduce the use of agency staff and improve staff turnover. These plans will be supported by the Corporate Nursing Workforce Team at Group level through the provision of workforce data and development of career pathways and opportunities including the planned appointment of career navigators who will offer careers advice and pastoral support. The retention plans will be monitored through the Accountability Oversight framework and progress noted to the HR Scrutiny committee.

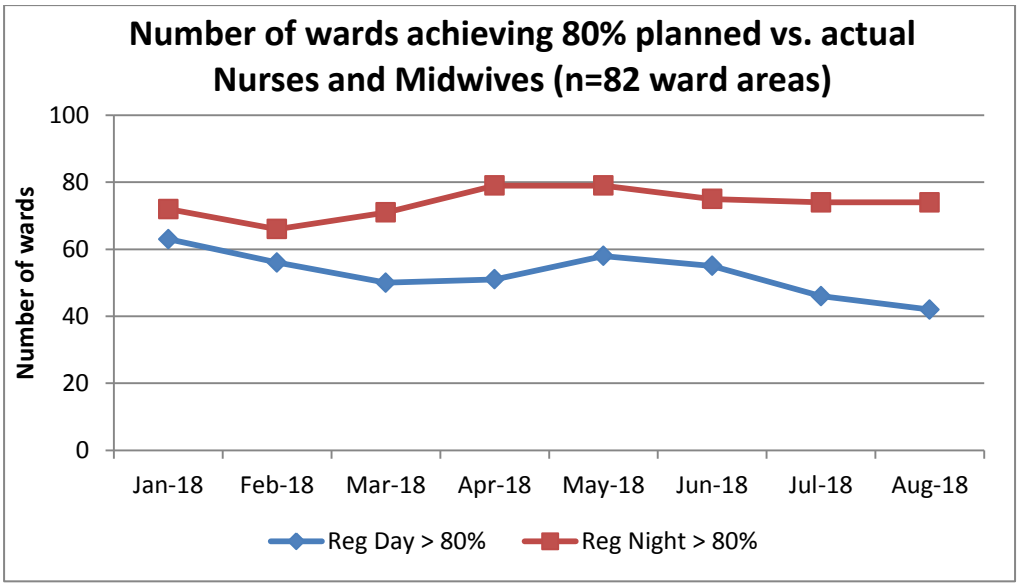
7 Safe Staffing

Planned versus Actual Staff on Duty

7.1 In line with the NQB requirements the Trust publishes Nursing and Midwifery staffing data on a daily basis at entrances to wards, using 'data at the door' poster boards. Staffing data is also submitted on a monthly basis through a Unify submission to NHSI detailing the planned and actual staffing levels extracted from the Health Roster System.

7.2 Graph 3 & 4 illustrate the Trust planned nurse staffing levels, split by registered and unregistered staffing hours and by day and night shifts.

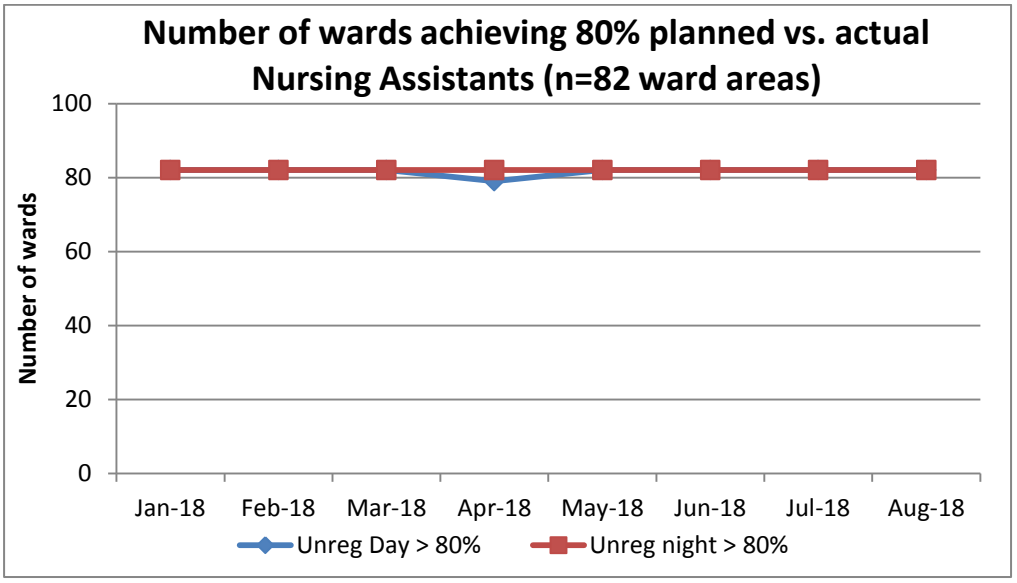
Graph 3



7.3 Since January 2018, an average of 77 wards (n=82) have achieved registered staffing levels above 80% for the night shifts. There has been an average of 47 wards achieving 80% of planned Registered Nurse staffing levels during day shifts with the lowest levels noted in July and August. This is reflective of the number of vacancies in this period and the holiday season when a decrease in bank and agency fill is noted. This is a similar trend to the figures in 2017 which then improves following the appointment of the graduate Nurses.

7.4 Established daily reviews of staffing requirements by senior Nursing and Midwifery staff and escalation processes are in place to mitigate the impact of when planned staffing levels are not achieved and ensure the safe delivery of care. Where registered nurse fill rates have dropped below 80% 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. Additional nursing assistant levels are increased in some areas to support this 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.

Graph 4



7.5 The average number of wards achieving above 80% nursing assistant staffing levels has shown a general trend of improvement since January 2018 with all wards achieving 80% or more unregistered staffing levels for both day and night shifts (graph 4).

Care Hours Per Patient Day (CHPPD)

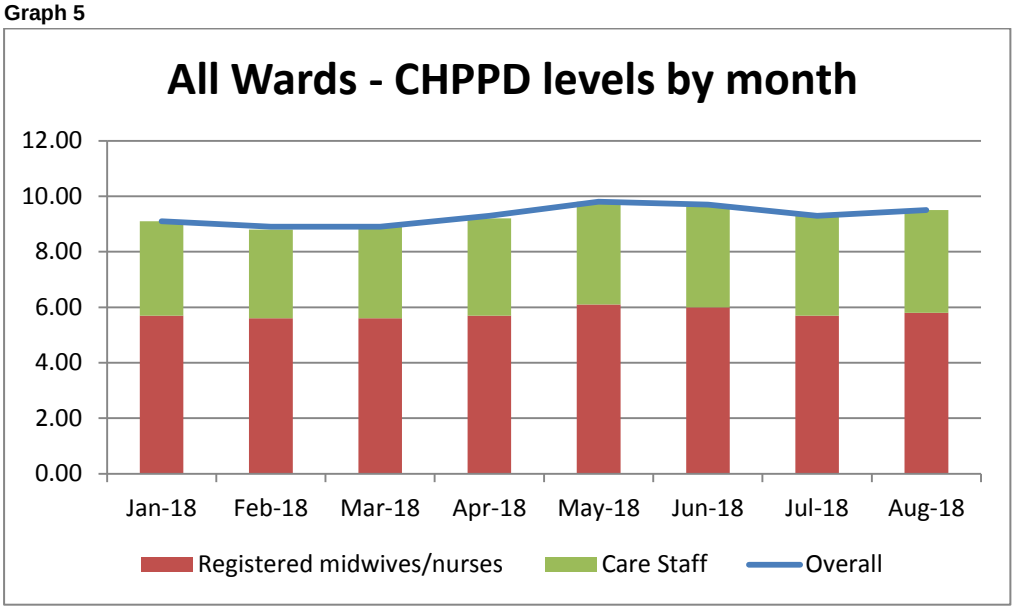
7.6 In May 2014, guidance was published from NHS England that required all Trusts to publish staff fill rate by hours (actual versus planned) via the Unify report. From April 2016, all Acute Trusts were required to report monthly staff fill rates and Care Hours Per Patient Day (CHPPD) via the NHSI Unify monthly report. From September 2018 the Trust is still required to report to NHSI monthly staffing fill rates however CHPPD will be the published metric to reflect care hours per patient. There is no national benchmark for CHPPD however NHSI will publish the data on the NHSI Model Hospital portal in order for Trusts to benchmark the data against other Trusts.

7.7 CHPPD is calculated by taking all the shift hours worked over the 24 hours period by registered nurses and nursing assistants and dividing this by the number of patients occupying a bed at midnight.

7.8 Whilst CHPPD is a simple measure, this must be reviewed alongside patient acuity and dependency data as CHPPD is not a metric to neither determine registered nurse requirements nor provide assurance for safe staffing. Work to attribute CHPPD to the Safer Nursing Care Tool (SCNT) nursing multipliers is underway across the Trust to allow a comparison of the required CHPPD (according to their level of acuity and dependency) with the care hours provided; this will allow for a more accurate determination of patient need and effective deployment of staff to ensure this is met. Caution should be applied on the interpretation of the metric as it does not consider activity, dependency or skill mix on the clinical area.

7.9 Graph 5 illustrates the Trust CHPPD level from January 2018. The Trust wide average CHPPD level is 9.3 hours per patient. The average CHPPD registered nurse level is 5.8 hours. The relevance of the metric can only be used when benchmarking similar services and is used on the Model Hospital data set to compare services.

Graph 5



Safe Care - Acuity and Dependency

7.10 The National Quality Board (NQB) [11]outlines the expectations and framework within which decisions on safe staffing levels should be made to support the delivery of safe, effective, caring, responsive and well-led care on a sustainable basis.

7.11 In line with NQB and NICE requirements, the Trust has used the Safer Nursing Care Tool (SNCT) since 2012 and has collected this information electronically, through the Allocate SafeCare tool since 2015. Patient acuity data is entered into the SafeCare module of Health Roster to provide an indication of the staffing levels required based on the acuity of the patients on the ward. These required hours are then compared to the actual staffing on the roster to identify whether there are any potential safety issues.

7.12 The SNCT tool does not differentiate between registered and support staff hours; therefore the analysis requires a very good understanding of the patient population and nursing requirements; professional judgment is acknowledged as an important factor to be considered when making decisions about safe staffing

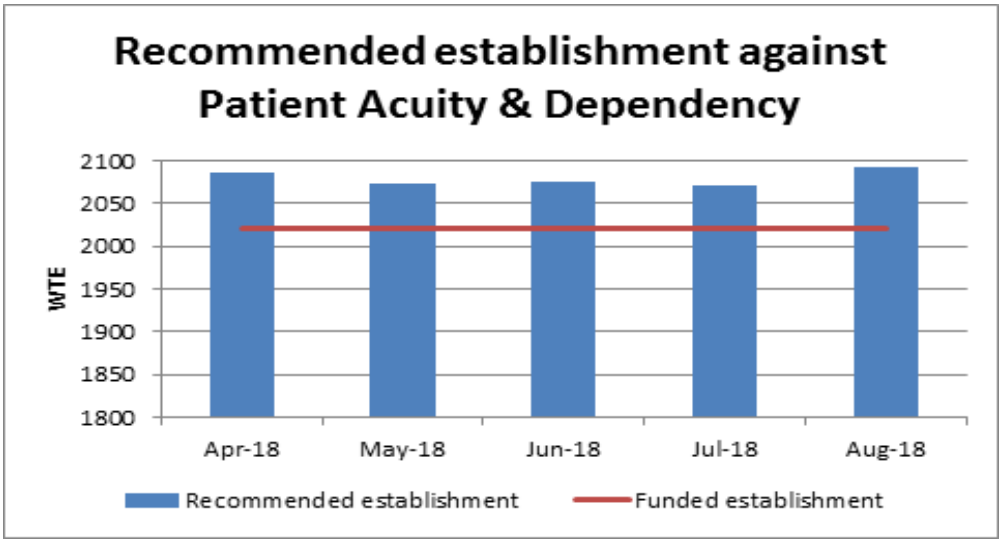
7.13 It should be noted that the tool is not designed to capture acuity and dependency data from wards with less than 16 beds, day case areas, maternity areas or departments, such as emergency departments and critical care units, therefore these areas are excluded from the data collection process.

7.14 Acuity and dependency data is analysed on a monthly basis, to monitor daily data compliance and ensure that data is validated to support nursing workforce establishment reviews. It is recommended that any establishment review is based on a minimum of 4 census periods. Graph 6 below illustrates the total recommended Nursing establishment across ward areas calculated following census data submissions compared to the actual funded establishment.

The results of the SNCT are set out below

[11] Supporting NHS Providers to deliver the right staff, with the right skills in the right place at the right time. National Quality Board, July 2016

Graph 6



7.15 The results illustrate that using SNCT the recommended nursing establishment is slightly higher than the funded nursing establishment across most ward areas. In the majority of areas the discrepancy is within 10% which equates to between 1 and 2 whole time equivalent nurses each month dependant on the acuity and dependency of a ward area. Further work is however needed to understand these findings. A Safer Nursing Care Point Prevalence Audit has been introduced to provide a sense check against the patient acuity and dependency data submitted daily into the Allocate SafeCare system. The audit is to be completed each quarter using the Shelford Safer Nursing Care Tool (SNCT). The acuity and dependency data is collected manually for each patient on a particular day and compared to the recommended daily staffing levels calculated by the Allocate tool. The finding from the last 2 audits have indicated that the recommended Nursing establishment for a 24 hour period across the majority of the wards appears to be consistent using both tools which would indicate the categorising of patient dependency by ward staff is accurate and reflects the acuity across the wards.

7.16 In order to validate these findings a systematic review is planned across all ward areas to review ward establishments, planned staffing requirements and skill mix following the introduction of the Nursing Associate. This work will be undertaken following the appointment of a Safer Care Matron who will lead on this work on behalf of the Chief Nurse. The initial results will be considered by the Hospital/MCS boards.

'Red Flags' and Escalation

7.17 Where a shortfall in Registered Nurse time occurs the Trust has a process to mitigate in real time through interventions by senior nurses in line with the 'Nurse Staffing Escalation Process' to enable the delivery of safe and effective patient care.

7.18 NICE guidance recommends Trusts have a mechanism to capture 'red flag' events. Red flag events can be defined as events that prompt an immediate response by the

Registered Nurse in charge of the ward on a given shift to ensure there is sufficient staff to meet the needs of the patients on the ward.

7.19 From July 2017 to date, a total of 468 red flag events were raised. There were a total of 437 red flags recorded as a 'shortfall in Registered Nurse time', which is consistent with the data captured in relation to planned staffing levels. The remaining red flags were recorded across a number of other reasons:

- Delay in providing pain relief - 6
- Missed Intentional Rounding – 18
- Unplanned/omission to complete observations - 7

7.20 Red flags are not used consistently across the Trust. It is recognised that this is not a good use of the system and a review of the indicators is currently ongoing with a plan to re-implement across all the hospital sites by December 2018.

7.21 Staffing levels are triangulated with complaints and adverse incidents to provide assurance on patient safety; staff are encouraged to complete an incident report when staffing levels are below the required parameters. The incident reports are reviewed by the Directors of Nursing and appropriate action taken. Senior Nursing daily staffing huddles take place across each of the Hospitals/MCS and staff are deployed to areas where there are shortfalls. To provide further assurance work has commenced to develop a monthly report triangulating the safer staffing fill data with the Friends and Family Test (FFT) and Harm free Care Safety Thermometer data.

Maternity Safe Staffing

7.22 In 2017 the NQB published an improvement resource to achieve safe, sustainable and productive staffing of maternity services[12]. This resource is designed to be used by those working in clinical settings and leading maternity services. The resource provides a systematic approach for identifying the organisational, managerial and clinical factors that support safe staffing of maternity services and makes recommendations for developing models of care, staffing, tools and monitoring, and acting on staffing issues and risk to meet the needs of women. . The Guidance endorses Birthrate Plus as a tool to ensure staff are deployed in the right place whilst NICE guidance supports one to one care in labour[13].

7.23 The Obstetric Strategy for Managing Capacity and Demand has used local intelligence and professional judgement and cross referenced the outputs with the Birthrate Plus ratios to agree midwifery establishments.

7.24 The table below details the midwife to birth ratio for the St Marys Managed Clinical Service. The table demonstrates the midwife to birth ratio complies with national recommendations of 1:28. The ratio will increase slightly in September 2018 whilst

[12] NQB 2018 Safe, sustainable and productive staffing: An improvement resource for maternity services
[13] NICE 2015, NICE guideline NG4: Safe midwifery staffing for maternity settings https://www.nice.org.uk/guidance/ng4

the service awaits the commencement in post of the newly qualified midwives due to start in September and October 2018.

St Marys Managed Clinical Service	No. births per annum	Midwife to Birth Ratio March 2018	Midwife to Birth Ratio September 2018	National Benchmark
Oxford Road Campus	9279	1:27	1:30	1:28
Wythenshawe	4235	1:26	1:26	1:28

Safe Staffing Tool for Community Services

7.25 The Manchester Local Care Organisation (MLCO) are working collaboratively with community health partners to look at methodology for measuring staffing levels and skill mix within community services. Preliminary fact finding has been undertaken using a demand based scheduling software system provided by a Manchester based company. The system advocates a command centre approach for community services using real time data and dashboards that give live capacity and demand information to enable the team to manage the service and its distributed workforce. Progress regarding this work will be reported to the MLCO Board.

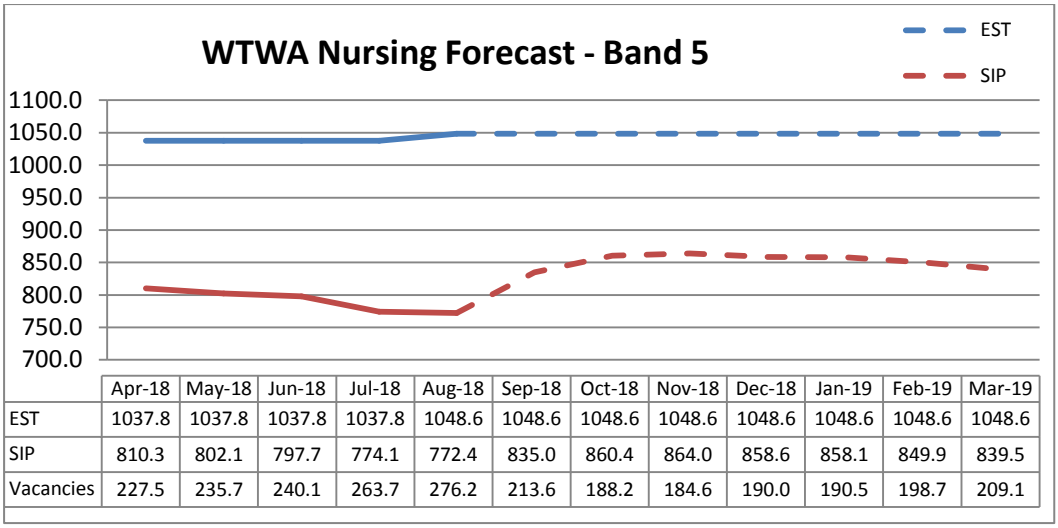
8 Workforce Position

Wythenshawe, Trafford, Withington and Altrincham Hospitals (WTWA) Workforce Position

8.1 At the end of August 2018, there were a total of **346.8wte (18.5%)** qualified Nursing vacancies across WTWA. This is an increase in overall Nursing vacancies of **35.7wte** since April 2018. The Hospitals vacancy position is expected to improve by the end of November 2018 when it is predicted there will be **234.9wte (12.7%)** vacancies. The Hospitals are expected to see some further improvement in Q4 as there are Nurses due to start in March 2019 following graduation. It is predicted there will be **252.3wte (13.4%)** vacancies by March 2019.

8.2 The majority of the vacancies are within the staff Nurse (band 5) workforce. **Graph 7** illustrates the WTWA band 5 workforce position until March 2019. At the end of August 2018 there was **276.2wte (26.3%)** band 5 vacancy which is an increase of **48.7wte** vacancies since April 2018. This position will improve significantly in November 2018 following the graduation and appointment of newly qualified Nurses in Q3 when the number of band 5 Nurses vacancies will reduce to **184.6wte (17.6%)**.

Graph 7



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
EST	1037.8	1037.8	1037.8	1037.8	1048.6	1048.6	1048.6	1048.6	1048.6	1048.6	1048.6	1048.6
SIP	810.3	802.1	797.7	774.1	772.4	835.0	860.4	864.0	858.6	858.1	849.9	839.5
Vacancies	227.5	235.7	240.1	263.7	276.2	213.6	188.2	184.6	190.0	190.5	198.7	209.1

8.3 The rolling 12 month turnover for Nursing is 15.7% across WTWA. The turnover for band 5 staff Nurses is 19.0%. When split across the Trafford and Wythenshawe Hospital sites the results are significantly different indicating that turnover at Trafford Hospital is far lower than that at Wythenshawe Hospital:-

- Trafford Hospital - all Nursing – 11.8%, band 5 Nursing is 11.7%
- Wythenshawe Hospital – all Nursing - 16.2%, band 5 Nursing is 20.7%

Wythenshawe Hospital

8.4 Across Wythenshawe Hospital, there were **219.5wte** band 5 staff nurse vacancies at the end of August 2018. This position is expected to improve to **131.9wte** vacancies by November 2018 once the newly graduated Nurses have commenced in post. At the end of August, there were 19 of the 38 wards/departments with greater than 20% nurse vacancy rate. The majority of these vacancies are within the Medical Division (elderly medicine, AMU) and surgery (orthopaedics).

8.5 There are 145 Band 5 staff Nurses due to commence employment at Wythenshawe Hospital before the end of November 2018, with a number of the Nurses recruited to work in acute medicine and surgery. Recruiting staff to work in elderly medicine continues to be a challenge with a smaller number of Nurses applying to work within this speciality. To ensure the delivery of safe patient care, wards within the Medical Division have recruited additional Nursing Assistants to support the gap in registered nursing establishments and have developed future workforce plans to include the Nursing Associate role.

Trafford Hospital

8.6 Within Trafford Hospital, there were **49.7wte** staff nurse vacancies reported in August 2018 with 11wte of these within INRU. The vacancy position is expected to improve at the end of November 2018 when there will be 37.7wte band 5 vacancies. At the end of August 2018 there were 5 out of 7 areas within Trafford hospital reported nurse vacancies of over 20%, all of which were elderly medicine and rehabilitation with the exception of AMU.

8.7 There are 15wte band 5 staff Nurses due to commence employment at Trafford Hospital before the end of November 2018. Whilst nursing turnover remains significantly lower than other areas within the Trust attracting Nurses to work at Trafford Hospital predominantly in elderly care, remains a challenge.

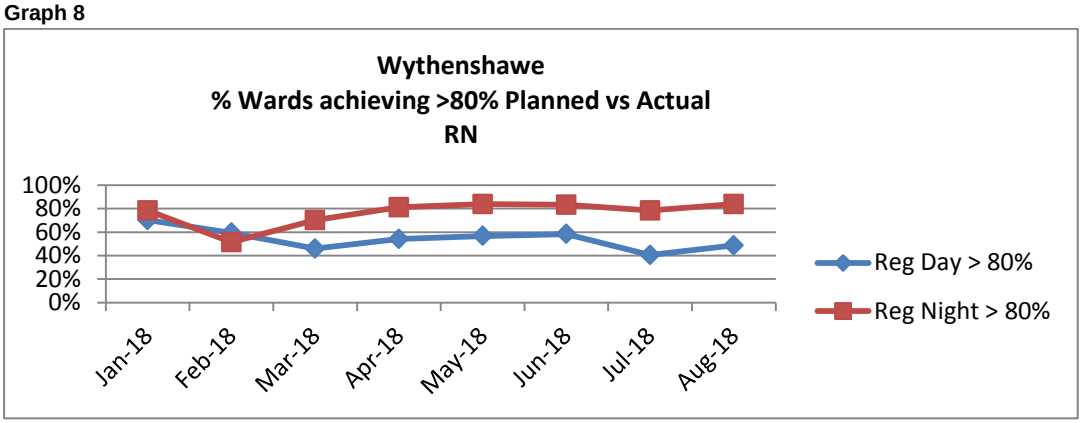
8.8 Trafford Hospital has been identified as an area where international Nurses want to relocate and work especially for nurses moving to the UK with young families. A support package is being developed in partnership with local Trafford agencies to support a cohort of 8 Nurses who will arrive at the end of October 2018.

Planned versus Actual Staff on Duty

Wythenshawe Hospital

8.9 **Graphs 8** shows that 31 of the 38 wards at Wythenshawe hospital are achieving more than 80% planned Registered Nurse staffing levels during the night. There are 21 of the 38 wards achieving 80% planned Registered Nurse staffing levels during the day shifts. This number has reduced during July and August 2018 due to the increase in nurse vacancies and reduced temporary staff fill rate during the peak holiday period. The elderly medical wards have the lowest registered nurse fill (actual staffing) rate averaging 60% per month during the day. To ensure patient safety and support the registered nurse workforce these areas have additional nursing assistants on duty with a 100% fill rate.

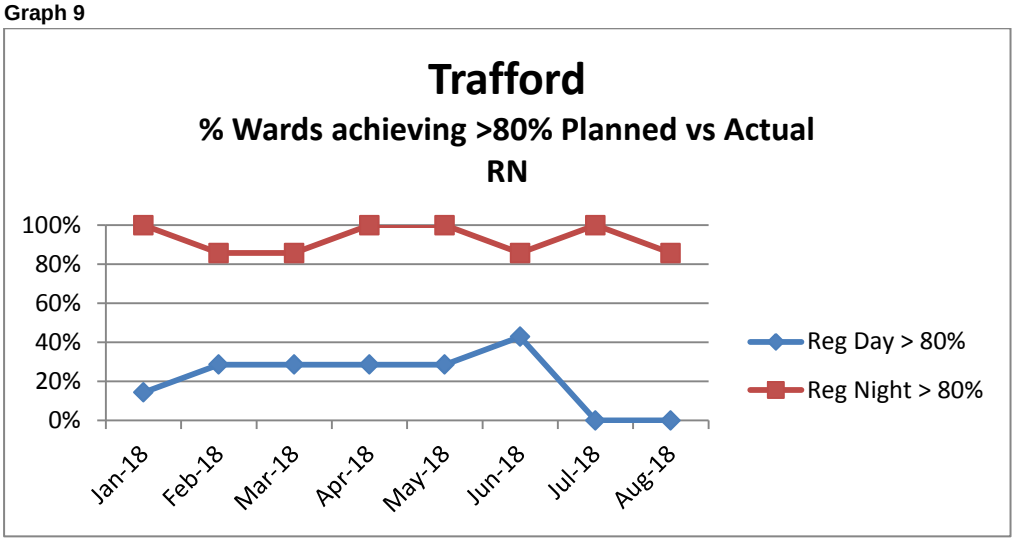
Graph 8



Trafford Hospital

8.10 **Graph 9** show that the majority of wards, (7 of the 8) are achieving more than 80% planned Registered Nurse staffing during the night. Priority has been given to ensure the night shifts are adequately staffed when staffing numbers are reduced and less senior cover is available within the hospital. This has resulted in a reduction in day shifts being filled with 2 of the 8 wards achieving 80% of planned Registered Nurse staffing levels. Ward 6 has the lowest fill rate averaging 59% Registered Nurse fill rate during the day and 89% during the night.

Graph 9



Establishment recommendation based on Acuity and Dependency

Wythenshawe Hospital

8.11 The acuity and dependency data has been collected across 30 in patient wards at Wythenshawe Hospital. The average monthly establishment for both registered and support staff nurses were 1082wte. Between January and August 2018, the average recommended establishment was 1034wte based on the acuity and dependency collected via the SafeCare system. When reviewed at ward level, 50% of the wards are within 10% of their budgeted establishment. Wards A4, A6, A1, A5, F14, A7, Jim Quick, Opal, F2 and Pearce consistently report a recommended establishment greater than 10% of the budgeted establishment.

Trafford Hospital

8.12 The acuity and dependency data has been collected across 7 in patient wards at Trafford hospital. The average monthly establishment for both registered nurses and support staff was 283wte. Between January and August 2018, the average recommended establishment was 306wte based on the acuity and dependency data collected via SafeCare. Wards 2, 4 and 6 consistently report a recommended establishment greater than 10% of the budgeted establishment.

8.13 An establishment review will be undertaken across WTWA by the Director of Nursing which will focus on the patient acuity and skill mix across both hospitals. An update on this work will be presented to the WTWA Management Board.

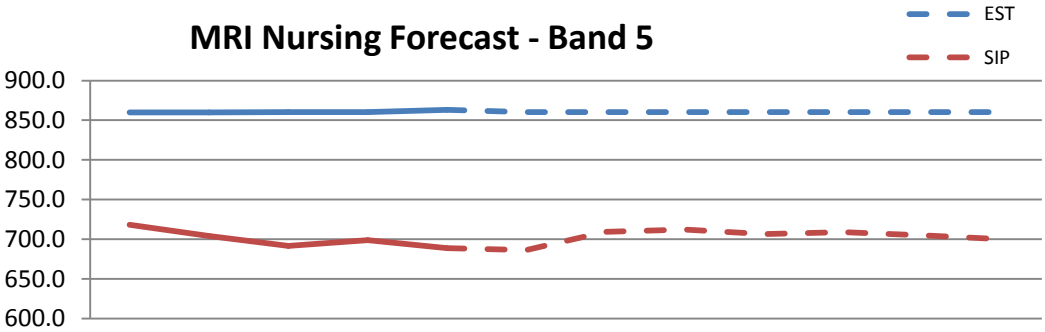
9 Manchester Royal Infirmary (MRI)

MRI Workforce Position

9.1 At the end of August 2018, there were a total of **220.8wte (14.1%)** qualified nursing vacancies across MRI. This is an increase in overall nursing vacancies of 25.6wte since April 2018. The Hospital vacancy position is predicted to improve by the end of November 2018 when it is predicted there will be **212.2wte** vacancies' **(13.6%).** It is predicted there will be **223.2wte (14.3%)** vacancies by March 2019. This position is expected to improve following recent successful recruitment events and the increase in availability of nurses through the international nurse recruitment programme

9.2 The majority of the vacancies are within the staff nurse (band 5) workforce**. Graph 10** illustrates the MRI workforce position until March 2019. At the end of August 2018 there were **a 174.1wte (20.1**%) band 5 vacancy which is an increase of **32.5wte** vacancies since April 2018. This position will improve in November 2018 following the graduation and appointment of newly qualified nurses in Q3 when the number of band 5 nurse vacancies will reduce to **147.8wte (17.1%)**

Graph 10



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
EST	860.0	860.0	860.1	860.1	862.9	860.1	860.1	860.1	860.1	860.1	860.1	860.1
SIP	718.4	704.3	691.8	698.7	688.8	686.4	709.3	712.3	706.5	709.1	705.0	700.1
Vacancies	141.6	155.7	168.3	161.4	174.1	173.7	150.8	147.8	153.6	151.0	155.1	160.0

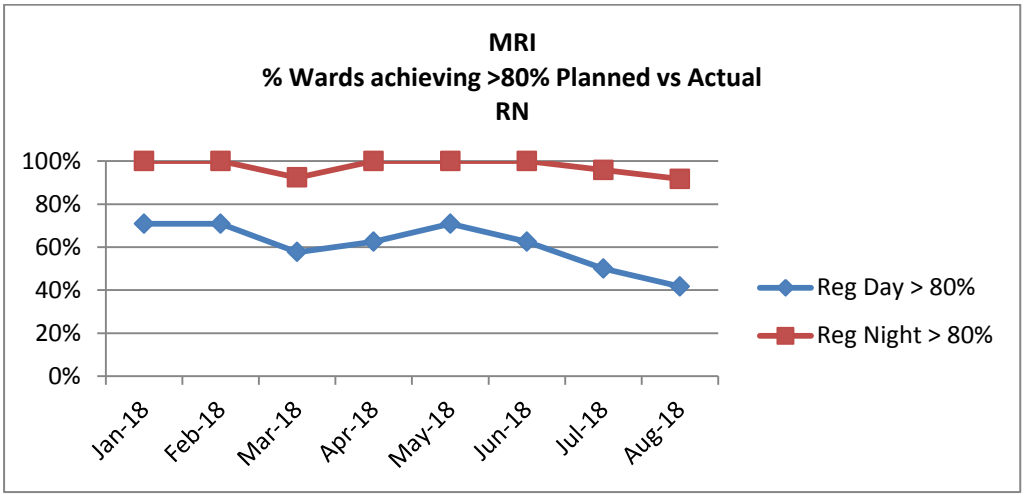
9.3 The 12 month turnover for Nursing within MRI is **16.4%** with the highest turnover in the Division of Surgery (17.5%). The turnover within the Staff Nurse workforce is 22.7% with the highest turnover in the Division of Medicine (24.0%).

9.4 Within the wards and departments at the MRI there are 12 wards that have a Registered Nurse vacancy rate above 20% including respiratory, elderly and acute medicine, haematology, renal, hepatobiliary and surgery. Over the next three months, 81 Band 5 nurses are due to commence in post with a number of these nurses allocated to work in these areas with the highest vacancies. The implementation of an acute medical rotation which includes six months within a respiratory ward has increased the number of nurses applying for these areas. Future workforce plans will include the Nursing Associate role to support the registered nursing workforce.

MRI Planned versus Actual Staff on Duty

9.5 **Graph 11** shows that 24 of the 26 wards at MRI hospital are achieving more than 80% planned Registered Nurse staffing levels during the night. There are 18 of the 26 wards achieving 80% planned Registered Nurse staffing levels during the day shifts. This number has reduced during July and August 2018 due to the increase in nurse vacancies and reduced temporary staffing fill during the holiday period. To ensure patient safety (for patients requiring enhanced levels of care/supervision) and support the Registered Nursing workforce, these areas have additional Nursing Assistants on duty with a fill rate of 100% during the day in these areas.

Graph 11:



MRI Establishment recommendation based on Acuity and Dependency

9.6 The acuity and dependency data is collected by 23 in patient wards within the MRI. The average monthly establishment for both registered and unregistered nurses was 996wte. Between January and August 2018, the average recommended establishment was 937wte based on the acuity and dependency data input into the Safe Care system. When validating the data, inconsistencies were found due to reduced compliance within the MRI in inputting data (68% data compliance) and therefore the total establishment data for the hospital cannot be considered valid for this period.

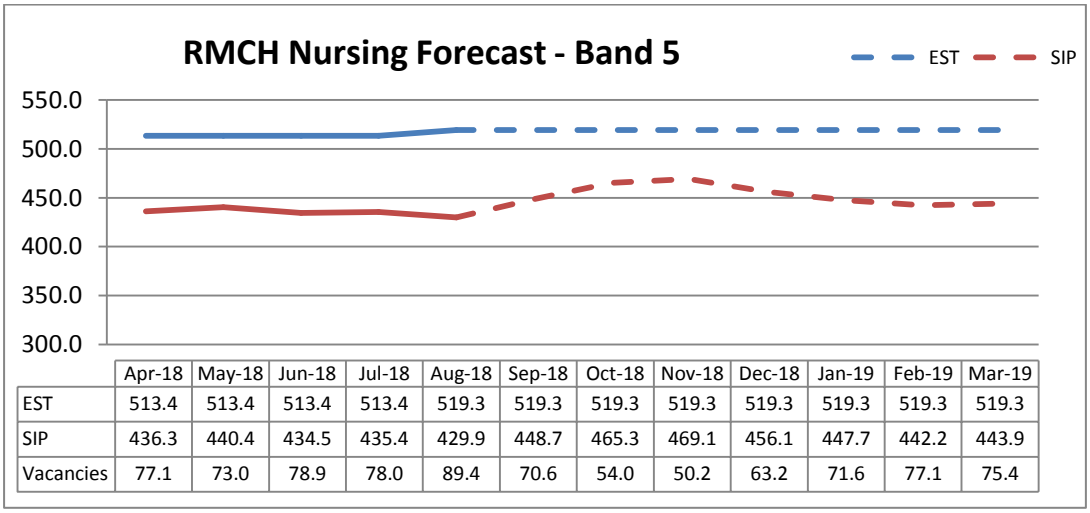
10 Royal Manchester Children's Hospital

RMCH Workforce Position

10.1 At the end of August 2018, there were a total of **107.1wte (10.4%)** registered nurse vacancies across RMCH. This is an increase in overall nursing vacancies of **12.6wte** since April 2018. The hospital vacancy position is expected to improve by the end of November 2018 when it is predicted there will be **60.2wte** vacancies **(6.9%).** It is predicted there will be **79.7wte (9.2%)** vacancies by March 2019 (based on the number of leavers in previous years). This number of vacancies is expected to reduce following recruitment campaigns to attract Paediatric Nurses graduating in March 2019.

10.2 The majority of the vacancies are within the Staff Nurse (band 5) workforce**. Graph 12** illustrates the workforce position in RMCH until March 2019. At the end of August 2018 there were **89.5wte (17.2%)** band 5 nursing vacancies as a result of the reduced workforce supply during Q1 and 2. This position will improve significantly in November 2018 following the graduation and appointment of newly qualified Nurses and Midwives in Q3 when the number of band 5 Nurses and Midwives vacancies will reduce to **50.2wte (9.6%).**

Graph 12



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
EST	513.4	513.4	513.4	513.4	519.3	519.3	519.3	519.3	519.3	519.3	519.3	519.3
SIP	436.3	440.4	434.5	435.4	429.9	448.7	465.3	469.1	456.1	447.7	442.2	443.9
Vacancies	77.1	73.0	78.9	78.0	89.4	70.6	54.0	50.2	63.2	71.6	77.1	75.4

10.3 Within RMCH there are two areas with more than 20% Registered Nurse vacancies, ward 78 and Paediatric High Dependency Unit (PHDU). There are 47wte Band 5 Staff Nurses with a confirmed start dates over the next three months with a further 79 candidates with conditional offers of employment undergoing recruitment checks. The vacancy position on Ward 78 and PHDU is predicted to improve following commencement of the new starters.

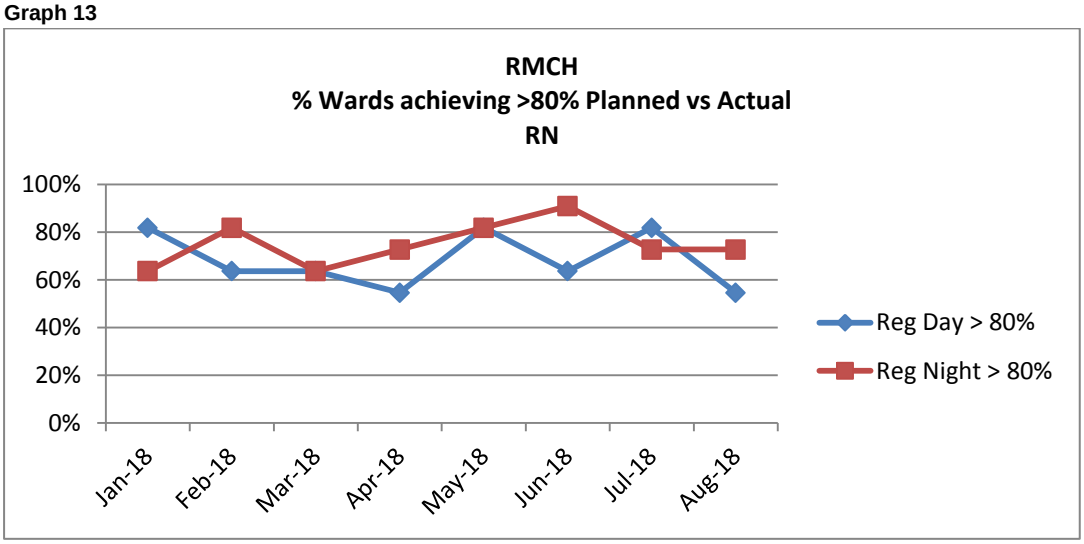
10.4 The rolling 12 month turnover for Nursing is 13.54% within RMCH which is slightly below the Trust average. The turnover for Band 5 Staff Nurses is 18.43% which is higher than the Trust average.

10.5 The workforce modelling undertaken takes into consideration starters and leavers in previous years in RMCH. It is predicted there will be **75.4wte (14.5%)** band 5 vacancies at the end of March 2019. A paediatric recruitment open day is planned in November 2018. It is anticipated that this event will attract Paediatric Student Nurses who will graduate in April 2019 resulting in a further reduction in band 5 vacancies.

RMCH Planned versus Actual Staff on Duty

10.6 **Graph 13** shows 8 of the 11 wards at RMCH are achieving more than 80% planned registered nurse staffing levels during the night. 7 of the 11 wards achieving 80% planned Registered Nurse staffing levels during the day shifts. Paediatric Intensive Care (PICU) report the lowest registered nurse fill rate with an average of 67% across both day and night shifts, however due to the complexity of the patients and the variance in dependency; the planned staffing levels may not always be required.

Graph 13



RMCH Establishment recommendation based on Acuity and Dependency

10.7 The acuity and dependency data has been collected across 5 in patient wards across RMCH. The average monthly establishment for both registered nurses and support staff was 226wte. Between January and August 2018, the average recommended establishment was 213wte based on the acuity and dependency data collected via the SafeCare system. There are 4 wards within RMCH who are close to the recommended establishment. Ward 75 consistently reports a recommended establishment greater than 10% of the budgeted establishment. Further work will be completed to investigate this variance considering the patient acuity and nursing skill mix which will be reported to the RMCH Board.

11 St Mary's Hospital

SMH Workforce Position

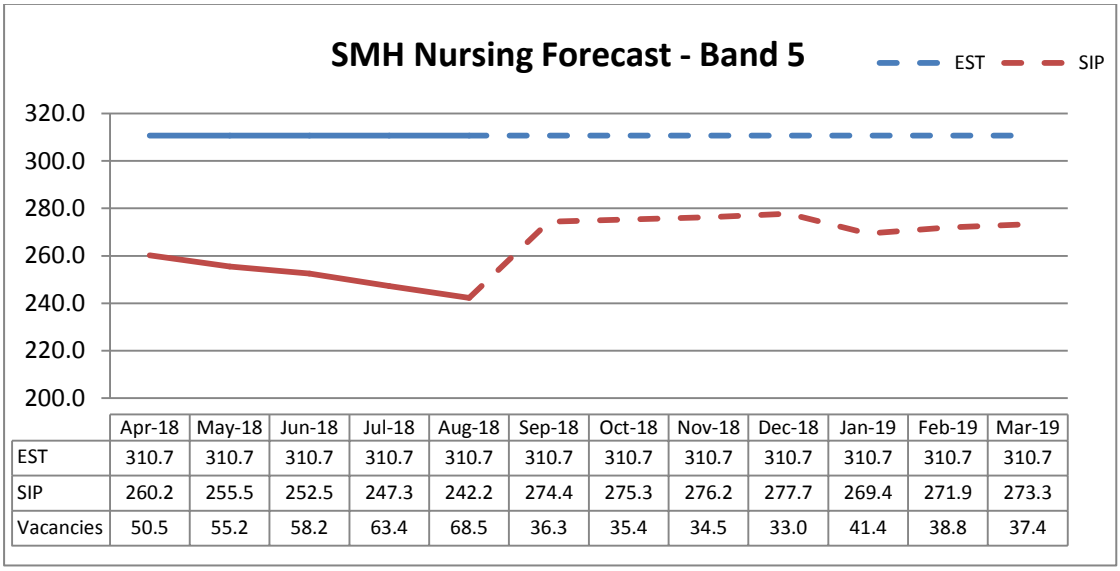
11.1 At the end of August 2018, there were a total of **107.8wte (10.1%)** qualified nursing and midwifery vacancies across SMH. This is an increase in the overall nursing and midwifery vacancies of **29.0wte** since April 2018. The Hospital vacancy position is expected to improve by the end of November 2018 when it is predicted there will be **32.6wte** (**3.0%)** vacancies. It is predicted there will be **37.7wte (3.5%)** vacancies by March 2019.

11.2 The nursing and midwifery rolling 12 month turnover is **12.58%** within SMH which is slightly below the Trust average.

SMH Band 5 Nursing Workforce

11.3 The majority of the vacancies are within the nursing (Staff Nurse Band 5) workforce within SMH**. Graph 14** illustrates the nursing workforce position in SMH until March 2019. At the end of August 2018 there were **68.5wte (22.0%)** Band 5 Staff Nurse vacancies. This position will improve in November 2018 following the graduation and appointment of newly qualified nurses in Q3 when the number of Band 5 Staff Nurse vacancies will reduce to **34.5wte (11.0%)**. It is predicted that the vacancy position will remain static in Q4.

Graph 14



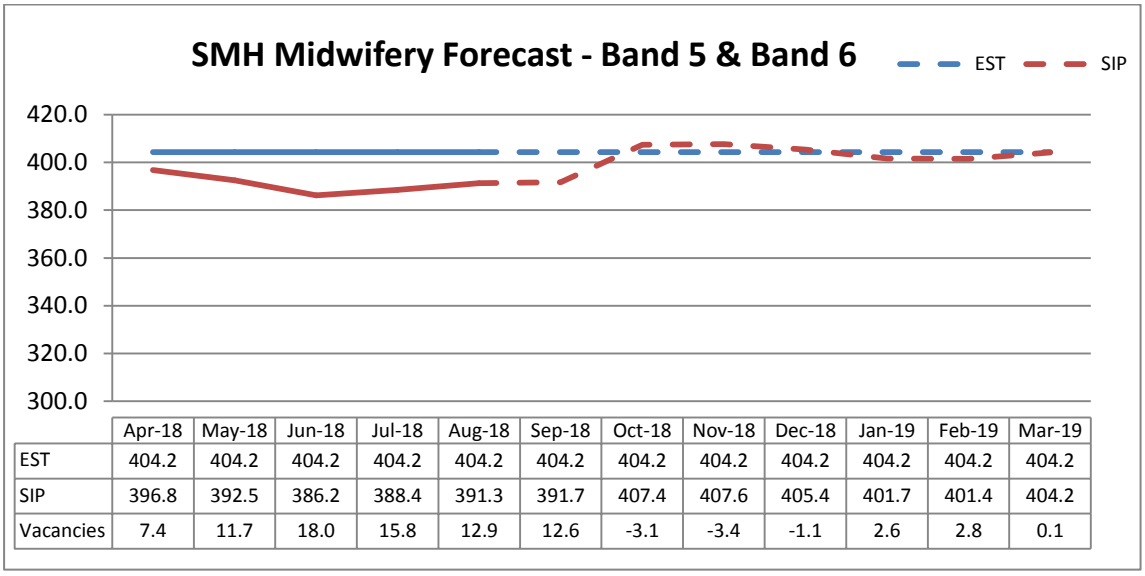
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
EST	310.7	310.7	310.7	310.7	310.7	310.7	310.7	310.7	310.7	310.7	310.7	310.7
SIP	260.2	255.5	252.5	247.3	242.2	274.4	275.3	276.2	277.7	269.4	271.9	273.3
Vacancies	50.5	55.2	58.2	63.4	68.5	36.3	35.4	34.5	33.0	41.4	38.8	37.4

11.4 The Band Staff Nurse 5 vacancies in SMH occur across Gynaecology and the Neonatal Unit (NICU) with **40wte** of the vacancies within NICU. There are no ward/departments within SMH that have a vacancy rate that exceed 20%. A total of **25wte** Band 5 Staff Nurses will commence employment in NICU over the next three months with a further 5wte predicted to start in Gynaecology.

SMH Band 5 & 6 Midwifery Workforce position

11.5 **Graph 15** illustrates the Midwifery workforce position in SMH until March 2019. At the end of August 2018 there were **12.9wte** band 5 & 6 midwifery vacancies. It is predicted that following the start of newly qualified midwives in September and October 2018 the Hospital will be fully established.

Graph 15



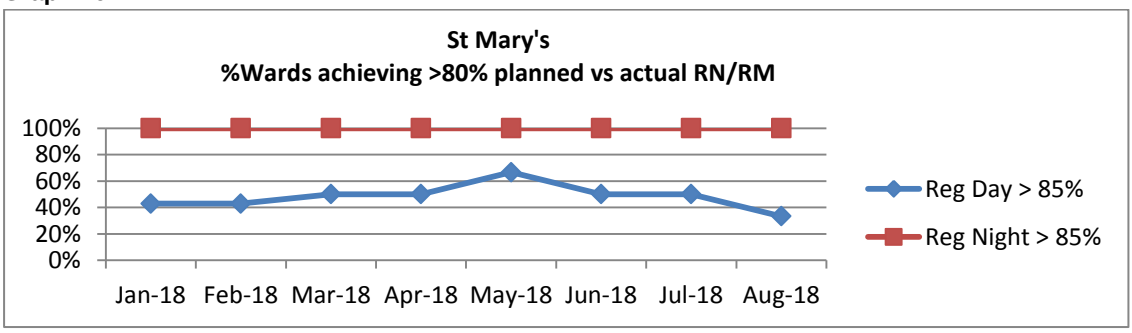
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
EST	404.2	404.2	404.2	404.2	404.2	404.2	404.2	404.2	404.2	404.2	404.2	404.2
SIP	396.8	392.5	386.2	388.4	391.3	391.7	407.4	407.6	405.4	401.7	401.4	404.2
Vacancies	7.4	11.7	18.0	15.8	12.9	12.6	-3.1	-3.4	-1.1	2.6	2.8	0.1

11.6 The number of midwifery vacancies remains low across maternity services. Within the next three months, 54wte Band 5 midwives are due to commence in post which is anticipated to cover all existing vacancies and predicted turnover over the next six months.

SMH Planned versus Actual Staff on Duty

11.7 Graph 16 shows an average of 100% of wards at SMH are achieving more than 80% planned Registered Nurse staffing during the night and 48% during the day although there is considerable fluctuation in monthly reports. NICU and Ward 62 consistently report registered nurse staffing levels above 85% of those planned. Across the maternity areas, fill rate varies slightly with no one area reporting significantly higher or lower than the others.

Graph 16



SMH Establishment Recommendation Based on Acuity and Dependency

11.8 In line with national guidelines and recommendations, acuity and dependency data is only captured in adult and paediatric in-patient ward areas, and does not include day surgical areas and neonatal units. As this does not apply to any area within St Mary's Hospital, this data is not reported.

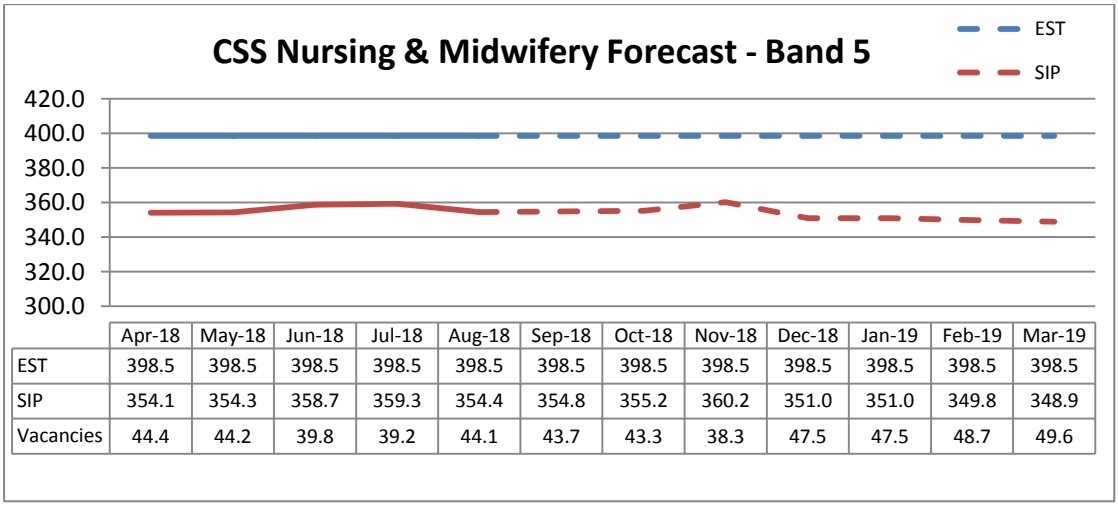
12 Clinical Support Services MCS (CSS)

CSS Workforce Position

12.1 At the end of August 2018 there were a total of **71.8wte (11.4%)** qualified nursing vacancies across the CSS managed clinical services. The vacancy position is expected to improve by the end of November 2018 when it is predicted there will be **55wte** vacancies **(8.8%).** It is predicted there will be **57.1wte (8.9%)** vacancies by March 2019.

12.2 The majority of the vacancies are within the Staff Nurse (band 5) workforce**. Graph 17** illustrates the CSS band 5 workforce position until March 2019. At the end of August 2018 there were **44.1wte (11%)** band 5 nursing vacancies (28.1wte in CTCCU, 16wte within HDU/ICU on Oxford Road Campus). This position will improve in November 2018 following the graduation and appointment of newly qualified nurses in Q3 when the number of band 5 nurse vacancies will reduce to **38.3wte (9.6%).**

Graph 17



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
EST	398.5	398.5	398.5	398.5	398.5	398.5	398.5	398.5	398.5	398.5	398.5	398.5
SIP	354.1	354.3	358.7	359.3	354.4	354.8	355.2	360.2	351.0	351.0	349.8	348.9
Vacancies	44.4	44.2	39.8	39.2	44.1	43.7	43.3	38.3	47.5	47.5	48.7	49.6

12.3 There are 34wte Band 5 Nurses due to commence in post before the end of November 2018. The MCS continue to recruit International Nurses through the Trust IR recruitment campaign. It is predicted that a further 20 international nurses will be recruited before the end of March 2019.

12.4 Within CSS the rolling 12 month turnover for Nursing is 11.1%. The band 5 rolling turnover is 13.3%, and below the Trust average.

CSS Establishment Recommendation Based on Acuity and Dependency

12.5 Acuity and dependency data is not reported within critical care areas

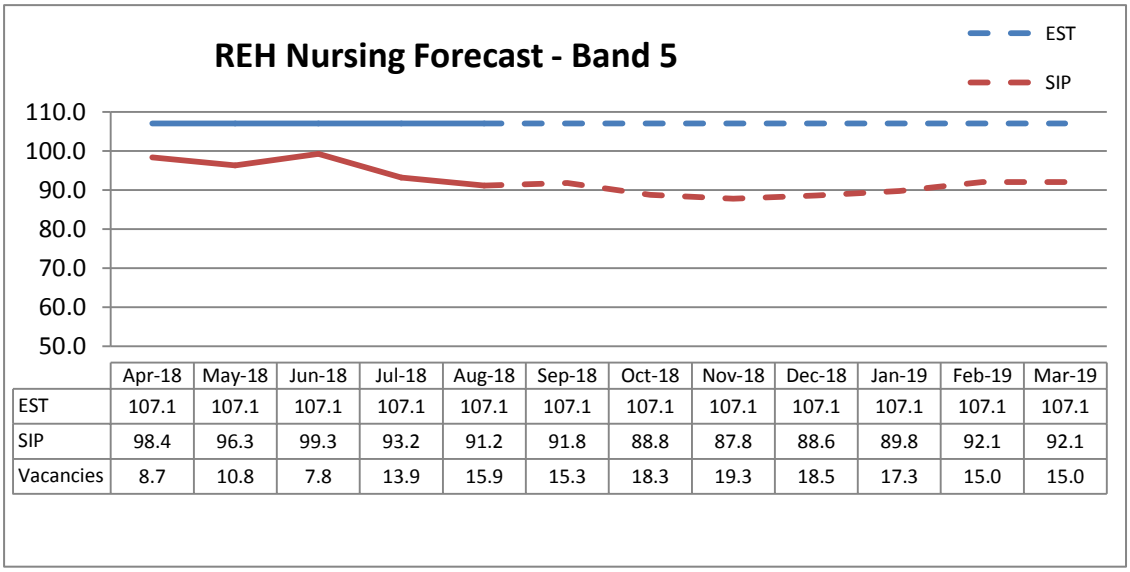
13 Royal Eye Hospital (REH)

REH Workforce Position

13.1 At the end of August 2018, there were a total of **17.7wte (9.8%)** qualified Nursing vacancies across REH. This is an increase in overall nursing vacancies of **7.7wte** since April 2018. It is predicted there will be **20.0wte** vacancies by the end of November 2018.

13.2 The majority of the vacancies are within the Staff Nurse (band 5) workforce, **Graph 18** illustrates the band 5 workforce position until March 2019. As the number of registered nurses working within REH is smaller than the other hospitals or MCS there is less accuracy when determining the workforce trajectory.

Graph 18



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
EST	107.1	107.1	107.1	107.1	107.1	107.1	107.1	107.1	107.1	107.1	107.1	107.1
SIP	98.4	96.3	99.3	93.2	91.2	91.8	88.8	87.8	88.6	89.8	92.1	92.1
Vacancies	8.7	10.8	7.8	13.9	15.9	15.3	18.3	19.3	18.5	17.3	15.0	15.0

13.3 There are 7wte Band 5 staff nurses due to commence in post over the next three months. At the end of November 2018 it is predicted there will be **19.3wte** band 5 vacancies. REH attracts a higher percentage of experienced qualified nurses looking to transfer from other areas of the Trust and therefore it is anticipated that the vacancy rate will therefore be less than is forecast over the next six months.

REH Planned versus Actual Staff on Duty

13.4 Planned and actual staffing data is submitted by ward 55 in REH. The ward consistently achieves more than 85% planned Registered Nurse staffing during both day and night.

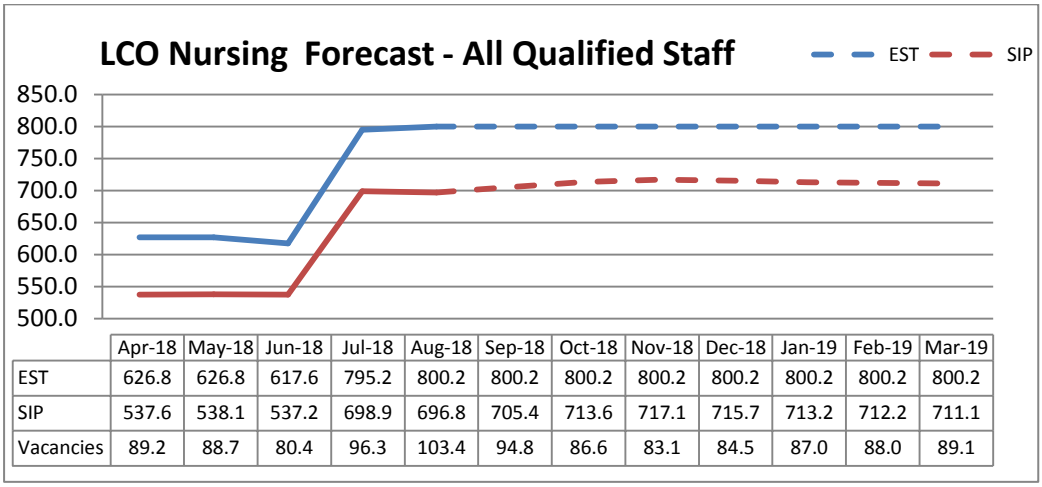
REH Establishment Recommendation Based on Acuity and Dependency

13.5 The acuity and dependency data has been collected on Ward 55 within REH. The average monthly establishment for both registered and unregistered nurses was **27.2wte**. Between January and August 2018, the average recommended establishment was **18.3wte** based on the acuity and dependency data input into the SafeCare system. Due to the patient profile and turnover of day-case beds within the wards further investigation into the validity of the results is required.

14 Manchester Local Care Organisation (MLCO)

14.1 At the end of August 2018, there were a total of **103.4wte (12.9%)** qualified Nursing vacancies across the MLCO. The vacancy position is expected to improve by the end of November 2018 when it is predicted there will be **83.1wte (10.3%)** vacancies. **Graph 19** illustrates the workforce modelling and trajectory until the end of March 2019 when it is predicted there will be **89.1wte (11.1%)** nursing vacancies (based on the number of leavers in previous years).

Graph 19



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
EST	626.8	626.8	617.6	795.2	800.2	800.2	800.2	800.2	800.2	800.2	800.2	800.2
SIP	537.6	538.1	537.2	698.9	696.8	705.4	713.6	717.1	715.7	713.2	712.2	711.1
Vacancies	89.2	88.7	80.4	96.3	103.4	94.8	86.6	83.1	84.5	87.0	88.0	89.1

15. Summary

15.1 It is recognised that there are Nursing and Midwifery staffing challenges nationally. MFT are working to reduce vacancies and become an employer of choice focusing on opportunities for career development and maximising recruitment opportunities. Where appropriate new roles such as the introduction of the Nursing Associate, enhanced, advanced and consultant roles are welcomed by the Trust to improve career opportunities and specifically retention.

15.2 WTWA and MRI have the highest vacancy rates with particular hot spot challenges within general medicine, medical assessment, care of the elderly and orthopaedic surgery. Areas with high vacancies are a priority for recruitment and retention

15.3 The Trust works in partnership with NHS Professionals who manage the Trust Bank responding to the Trusts temporary staffing demands. This mitigates concerns in relation to safe staffing of the clinical areas and meeting patient care needs. Whilst the number of wards achieving 80% planned staffing levels has reduced since May 2018 measures are in place to maintain patient safety through effective staff redeployment following senior nurse review.

15.4 The Trust has been very successful in attracting and recruiting nurses and midwives and there is recognition across the Group that the focus must be on retention. Across the Trust each hospital/MCS has established a workforce plan together with a retention strategy progress against which will be monitored through the AOF and the HR Scrutiny committee.

15.5 In order to support the hospitals/MCS retention strategies the corporate work programme will support the following work streams:-

- Career navigation
- Opportunities for Nurses and Midwives to retire and return
- Modular based Preceptorship Programme
- Review of support worker roles with focus on development opportunities
- Develop and embed the Nursing Associate role
- Expand International recruitment programme

15.6 The Trust retention programmes are intended to support a sustainable workforce retaining the expertise and experience of Nursing and Midwifery staff and reducing the rate at which staff leave. Investment in these areas will reduce the reliance on the use of bank and agency and support financial sustainability. Progress on these work streams will be reported to the Hospital/MCS management boards by the Directors of Nursing and Midiwfery, the HR Scrutiny Committee in December 2018 and the Board of Directors in March 2019.

16 Conclusion

16.1 The Board of Directors are asked to receive this paper and note progress of the work undertaken to address the Nursing and Midwifery vacancy position across the Group

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Adrian Roberts - Chief Finance Officer
Paper prepared by:	Ursula Denton - Director of Finance
Date of paper:	23rd October 2018
Subject:	Proposed Amendments to Standing Financial Instructions (SFIs)
Purpose of Report:	Indicate which by ✓ • Information to note • Support • Resolution • Approval ✓
Consideration of Risk against Key Priorities:	Requirement of the MFT Constitution (and supporting Annexes)
Recommendations:	To approve the proposed amendments to SFIs (previously reviewed by the Audit Committee)
Contact:	Adrian Roberts 0161 276 6692

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

Proposed Amendments to the Standing Financial Instructions (SFIs)

1. Background

The Standing Financial Instructions for Manchester University NHS Foundation Trust were ratified by the Interim Board of Directors in September 2017.

2. Updates

The document has been reviewed in the light of the past 12 months of operation and a small number of amendments and additions are proposed.

The proposed amendments and additions are set out in the schedule below and the full document is attached for reference.

3. Recommendation

The Board of Directors is requested to approve the proposed amendments and additions to the Standing Financial Instructions.

Proposed amendments to Trust Standing Financial Instructions

Ref	Proposed Amendment	Revision / Addition
	5.3 Debt Recovery	
5.3.4	Debt write off will be managed in line with the debt write off procedures with overall authorisation by the Group Director of Finance.	Addition
	7.3 Staff Appointments	
7.3.1	(b) they are within the approved limit of the annual plan i.e. the approved financial budget	Addition
	7.6 Funded Establishment	
7.6.3	No appointment can be made without a funded / established post on the ledger and ESR systems.	Addition
	8.4 Prepayments	
	Prepayments are only permitted where exceptional circumstances apply. In such instances:	Existing – no change
8.4	The sole exception being with regard to maintenance contracts where the industry standard terms are for prepayment. In these circumstances the contract details will be tracked and the prepayment adjustment will be enacted on a monthly basis.	Addition
	8.5 Official orders	
8.5.(f)	(f) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash; in exceptional circumstances a confirmation order can be raised prior to payment of associated invoices e.g. once specific activity volumes are confirmed or in the event of equipment repair.	Addition
	10.2 Asset Registers	
10.2.4	Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate). Prior approval will be required from the Group Director of Finance for assets with a value in excess of £75,000, including in circumstances where assets are replaced / superseded by new items e.g. re medical equipment. (See 12.1.2)	Addition
	12.1 Disposals and Condemnations	
12.1.2	When it is decided to dispose of a Trust asset, a Trust official with the appropriate delegated authority will notify the Head of Financial services. The Head of Financial services will establish the carrying amount of the asset and determine the financial impact of the disposal, taking professional advice where necessary. (see 10.2.4)	Addition
12.1.5	In the case of obsolete assets the Trust may approve the gift of the item to a registered charity including those working overseas e.g. obsolete medical equipment. This is subject to confirmation that appropriate decontamination procedures can be carried out at negligible costs or where these costs will be refunded by the charity. Packaging and transport would be the responsibility of the charity.	Addition

DOCUMENT CONTROL PAGE	
Title	**Title: Standing Financial Instructions** **Version: 2** **Reference Number:**
Supersedes	**Supersedes: Standing Financial Instructions Version 1 – September 2017** **Significant Changes: Annual review process post adoption in Sept 2017;** **Amendments / additions to 5.3.4,7.3.1,7.6.3, 8.4, 8.5 (f), 10.2.4, 12.1.2 and 12.1.5**
Originator or modifier	**Originated By: Adrian Roberts, Ursula Denton** **Designation: Chief Finance Officer, Group Director of Finance** **Modified by: Adrian Roberts, Ursula Denton** **Designation: Chief Finance Officer, Group Director of Finance**
Ratification	**Referred for approval by: Audit Committee** **Date of Referral: 5th September 2018**
Application	**All Staff**
Circulation	**Issue Date: (tbc)** **Circulated by: Group Director of Finance** **Dissemination and Implementation:**
Review	**Review Date: 1/10/2020** **Responsibility of: Chief Finance Officer**
Date placed on the Intranet: (tbc)	**EqIA Registration Number : 20/16**

1. Key Objectives

1.1 Introduction

1.1.1 These Standing Financial Instructions (SFIs) detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and the Independent Regulator's relevant guidance. They should be used in conjunction with the schedule of decisions reserved to the Board and the Schedule of Reservation and Delegation of Powers and the standing orders adopted by the Trust.

1.1.2 These SFIs identify the financial responsibilities that apply to everyone working for the Trust and its constituent organisations including any trading units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Chief Finance Officer. These SFIs do not set out in full the requirements of the Independent Regulator's guidance and all relevant guidance of the Independent Regulator should be consulted. Such guidance will also change over time and these SFIs do not record or reference all such applicable guidance.

1.1.3 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Chief Finance Officer must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's Standing Orders (SOs).

1.1.4 **Failure to comply with SFIs and SOs is a disciplinary matter that could result in dismissal and/or criminal prosecution.**

1.1.5 If for any reason these SFIs are not complied with full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these SFIs to the Chief Finance Officer as soon as possible.

1.1.6 Officers of the Trust should note that the SFIs, SOs and Schedule of Reservation and Delegation of Powers do not contain every legal obligation applicable to the Trust. The Trust and each officer of the Trust must comply with all requirements of legislation (which shall mean any statute, subordinate or secondary legislation, any enforceable community right within the meaning of section 2(1) European Community Act 1972 and any applicable judgment of a relevant court of law which is a binding precedent in England) and all guidance and directions binding on the Trust. Legislation, guidance and directions will impose requirements additional to the SOs, SFIs and Schedule of Reservation and Delegation of Powers. All such legislation and binding guidance and directions shall take precedence over these SFIs, SOs and the Schedule of Reservation and Delegation of Powers. The SFIs, SOs and Schedule of Reservation and Delegation of Powers shall be interpreted accordingly.

1.1.7 All policies and procedures of the Trust, to the extent that they are consistent with this SFI, must be followed by all Governors, Directors and Officers of the Trust in addition to the provisions of this SFIs (whether specifically referenced in this schedule or not).

1.2 Responsibilities and delegation

1.2.1 The Board of Directors

The Board exercises financial supervision and control by keeping under review at Group level:

(a) formulating the financial strategy;

(b) requiring the submission and approval of the Annual Operational Plan and budgets within overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

(d) defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Delegation document.

1.2.2 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Reservation of Matters Reserved to the Board' document. All other powers have been delegated to such other Committees as the Trust has established.

If ambiguity in the interpretation of reserve matters, Scheme of Delegation or any specific proposed transaction which does not fit into the above, then the Chief Finance Officer will have responsibility for providing clarification and ensuring matters are referred to the Board of Directors as deemed necessary.

1.2.3 The Chief Executive and Chief Finance Officer

The Chief Executive and Chief Finance Officer will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board of Directors, and as Accountable Officer to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chairman and the Board of Directors for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.2.4 It is a duty of the Chief Executive to ensure that Members of the Board of Directors, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these Instructions.

1.2.5 The Chief Finance Officer

The Chief Finance Officer is responsible for:

(a) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Chief Finance Officer include:

(d) the provision of financial advice to other members of the Board and employees;

(e) the design, implementation and supervision of systems of internal financial control;

(f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.2.6 **All Employees**

All staff of the Trust are severally and collectively responsible for:

(a) the security of the property, assets and resources of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources;

(d) conforming to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

1.2.7 **Contractors and Their Employees**

Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.2.8 For all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Chief Finance Officer.

2. AUDIT

2.1 Audit Committee

The Committee has been formally constituted by the Board in accordance with its Standing Orders and will report through to the Board of Directors.

The Committee is authorised to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any requests made by the Committee.

The Committee is authorised to obtain outside legal and other independent professional advice and to secure the attendance of outsiders with relevant experience, expertise if it considers it necessary

2.2 Scope and Duties

2.2.1 To provide the Board of Directors with a means of independent and objective review of financial systems, internal financial control, financial information used by the Trust and compliance with law, guidance and codes of conduct and accountability.

2.2.2 To monitor the implementation of policies and procedures and standards of probity and business conduct for the Board of Directors and staff.

2.2.3 To review the annual financial statements before submission to the Board, focusing particularly on:-

(a) Changes in/and compliance with accounting policies and practices

(b) Major judgmental areas

(c) Significant adjustments resulting from the audit

2.2.4 To review the establishment of maintenance of an effective system of internal control and risk management:-

2.2.5 Review the adequacy of all risk and control related disclosure statements together with any accompanying Head of Internal Audit Annual Opinion Statement prior to endorsement by the Board. This will encompass all risks that affect the Trust not just financial risks.

2.2.6 Review the structure processes and responsibility for identifying managing key risks facing the organisation.

2.2.7 Review policies for ensuring that there is compliance with relevant regulatory, legal, and code of conduct requirements as set out in the relevant guidance

2.2.8 Review and monitor tenders waivered

2.2.9 Review the operational effectiveness of policies and procedures

2.2.10 Review the policies and procedures for all work related to fraud, bribery and corruption as set out in the Trust's contractual responsibilities contained within the NHS Standard Contract and as required by NHS Protect.

2.2.11 Review and monitor the Trust's Board Assurance Framework.

2.2.12 To consider the appointment of the Local Counter Fraud Service (LCFS) and to oversee, in conjunction with the Chief Finance Officer, the delivery of the LCFS service.

2.2.13 To consider the appointment of the Internal Audit Services, the audit fee and any questions of resignation and dismissal.

2.2.14 To review the internal audit programme considering the major findings of internal audit (non-fraud or corruption) investigations and management's response and ensure co-ordination between the Internal and External Auditors.

2.2.15 To ensure that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.

2.2.16 To consider the appointment of the External Auditors following approval by the Council of Governors.

2.2.17 To discuss with External Audit before the audit commences, the nature and scope of the audit and ensure co-ordination as appropriate with External Auditors within the local health economy.

2.2.18 To review External Audit reports including value for money reports and annual audit letters, together with the management response.

2.2.19 To review proposed changes to Standing Orders and Standing Financial Instructions.

2.2.20 To examine circumstances associated with each occasion when Chairman's Action is taken to waive Standing Orders and/or Standing Financial Instructions.

2.2.21 To review schedules of losses and compensation and make recommendations to the Board of Directors.

2.2.22 To receive appropriate internal and external reports if they identify a significant risk and monitor progress against any action plan. These will include NHSLA Assessment, Care Quality Commission reviews and Health and Safety Executive recommendations.

2.3 Chief Finance Officer

2.3.1 The Chief Finance Officer is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function; ensuring that the internal audit is adequate and meets the NHS internal audit standards, the Audit Code for NHS Foundation Trusts and the Guide for Governors: Audit Code for NHS Foundation Trusts;

(b) ensuring that the Trust maintains adequate counter fraud and corruption arrangements and deciding at what stage to involve the LCFS and/or the police in cases of fraud, misappropriation and other regularities in conjunction with NHS Protect; and

(c) ensuring there are appropriate terms of reference for the internal audit function, and that these are reflected in the SFIs

2.3.2 The Chief Finance Officer or designated Auditors/LCFS are entitled, without necessarily giving prior notice, to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature

(b) access at all reasonable times to any land, premises, and members of the Board or Officers of the Trust

(c) the production of any cash, stores or other property of the Trust under a member of the Board and/or Officer's control; and

(d) explanations concerning any matter under investigation

2.4 Role of Internal Audit

2.4.1 In accordance with Public Sector Internal Audit Standards there are two key roles of internal audit:

- The Provision of an independent and objective opinion to the Accountable Officer, the Board, and the Audit Committee on the degree to which risk management, control and governance support the achievement of the organisations agreed objectives.
- The provision of an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements.

2.4.2 The Head of Internal Audit will provide an annual opinion statement, in accordance with Public Sector Internal Audit Standards, which will be based on a systematic review and evaluation of risk management, control and governance which comprises the policies, procedures and operations in place to:

(a) establish, and monitor the achievement of, the Trust's objectives;

(b) identify, assess and manage the risks to achieving the Trust's objectives;

(c) ensure the economical, effective and efficient use of resources;

(d) ensure compliance with established policies (including behavioral and ethical expectations), procedures, laws and regulations;

(e) safeguard the Trust's assets and interests from losses of all kinds, including those arising from fraud, irregularity or corruption; and

(f) ensure the integrity and reliability of information, accounts and data, including internal and external reporting and accountability processes

2.4.3 Where key systems are being operated on behalf of the Trust by anybody external to the Trust, the Head of Internal Audit must ensure arrangements are in place to form an opinion on their effectiveness.

2.4.4 Where the Trust operates systems on behalf of other bodies, the Head of Internal Audit must be consulted on the audit arrangements proposed or in place.

2.4.5 Whenever a matter arises which involves, or is thought to involve, irregularities concerning cash, stores or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Finance Officer must be notified immediately.

2.4.6 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Chief Executive of the Trust.

2.4.7 The Operational Chief Finance Officer shall produce written procedures for the issue and clearance of audit reports. These shall include the appropriate following action and the steps to be taken when managers fail to take remedial action within the appropriate time period.

2.4.8 Where in exceptional circumstances the use of normal reporting channels could be seen as possibly limiting the objectivity of the audit, the Head of Internal Audit shall have access to report directly to the Chair or Vice Chair of the Board, Chair of the Audit Committee or Chief Executive.

2.4.9 The Head of Internal Audit shall be accountable to the Operational Chief Finance Officer. The reporting system for internal audit shall be agreed between the Operational Chief Finance Officer, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with Public Sector Internal Audit Standards. The reporting system shall be reviewed at least every three years.

2.5. External Audit

2.5.1 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors.

2.5.2 The Audit Code for NHS Foundation Trusts ("The Audit Code") contains directions of the Independent Regulator under Schedule 7 paragraph 24 of the National Health Service Act 2006, with respect to the standards, procedures and techniques to be adopted by the Auditor.

2.5.3 The Trust shall apply and comply with the Audit Code.

2.5.4 The Auditor shall be required by the Trust to comply with the Audit Code.

2.5.5 SFI 2.3.2 relates equally to internal and external audit.

2.5.6 In the event of the Auditor issuing a public interest report the Trust shall forward a report to the Independent Regulator within 30 days (or such shorter period as the Independent Regulator may specify) of the report being issued. The report shall include details of the Trust's response to the issues raised within the public interest report.

2.6. Fraud and Corruption & Security Management

2.6.1 The Trust shall take all necessary steps to counter fraud, bribery and corruption and deal effectively with security management issues affecting NHS funded services in accordance with:

(a) the NHS Anti-Fraud Manual published by NHS Protect (previously known as the Counter Fraud and Security Management Service (CFSMS));

(b) The requirements of the NHS Standard Contract clauses that relate to anti-crime measures;

(c) the policy statement "Applying appropriate sanctions consistently" published by NHS Protect;

(d) any other reasonable guidance or advice issued by NHS Protect that affects efficiency, systemic and/or procedural matters; and

(e) the security management manual

2.6.2 The Chief Executive and Chief Finance Officer shall monitor and ensure compliance with the above.

2.6.3 The Trust shall nominate a suitable person to carry out the duties of the local counter fraud specialist (LCFS) and local security management specialist (LSMS) in accordance with relevant NHS Protect guidance and NHS Standard Contract clauses.

2.6.4 The Chief Finance Officer shall instruct the Internal Auditor to investigate any breaches of the Standing Orders and Standing Financial Instructions as he/she may deem appropriate and necessary. Where there is evidence to suggest misappropriation has taken place, the Chief Finance Officer shall instruct the LCFS to investigate as he/she deems appropriate and necessary.

2.6.5 The LCFS and LSMS shall report to the Group Director of Finance and shall work with staff in NHS Protect in accordance with the Department of Health anti-fraud manual and NHS Standard Contract clauses.

2.6.6 The LCFS will provide periodic updates, including a written annual report, on anti-fraud, bribery and corruption activities undertaken across the Trust.

3. ANNUAL ACCOUNTS AND REPORTS

3.1.1 NHS I may, with the approval of the Secretary of State, give directions to the Trust as to the content and form of its accounts. The accounts are to be audited by the Trust's external Auditor.

The following documents will be made available to the Comptroller and Auditor General for examination at his request

(a) the accounts;
(b) any records relating to them; and
(c) any report of the external Auditor on them.

3.1.2 The Trust is to prepare in respect of each financial year annual accounts in such form as NHS I may direct with the approval of the Secretary of State. NHS I may with the approval of the Secretary of State direct a Trust:

(a) to prepare accounts in respect of such period or periods as may be specified in the direction;
(b) that any accounts prepared by it by virtue of paragraph (a) are to be audited in accordance with such requirements as may be specified in the direction.

3.1.3 In preparing its annual accounts or in preparing any accounts by virtue of 4.1.3 (a) the Accounting Officer shall cause the Foundation Trust to keep proper accounts and proper records in relation to the accounts that comply with any directions given by NHS I with the approval of the Secretary of State as to:

(a) the methods and principles according to which the accounts are to be prepared;

(b) the content and form of the accounts.

3.1.4 The annual accounts, any report of the external Auditor on them, and the annual report are to be presented to the Council of Governors at a General Meeting.

3.1.5 The Trust shall:

(a) lay a copy of the annual accounts, and any report of the external Auditor on them, before Parliament; and

(b) send copies of those documents to NHS I within such a period as NHS I may direct:
(i) a copy of any accounts prepared by virtue of 4.1.3 (a); and
(ii) a copy of any report of an auditor on them prepared by virtue of 4.1.3 (a).

3.1.6 Responsibility for complying with the requirements relating to the form, preparation and presentation of the accounts shall be delegated to the Chief Executive.

3.2 Annual Report

3.2.1 The Trust is to prepare annual reports and send them to NHS I, the Independent Regulator. The reports are to give:

(a) information on any steps taken by the Trust to secure that (taken as a whole) the actual membership of its public constituencies and of the classes of the staff constituency is representative of those eligible for such membership;

(b) information on the Trust's policy on pay and on the work of the committee established and such other procedures as the Trust has on pay; and

(c) information on the remuneration of the directors and on the expenses of the governors and directors; and

(d) any other information NHS I, the Independent Regulator requires.

3.2.2 The Trust is to comply with any decision by NHS I with regard to:

(a) the form of the reports;

(b) when the reports are to be sent;

(c) the periods to which the reports are to relate.

3.3 Annual Plan

3.3.1 The Trust is to give information as to its forward planning in respect of each financial year to NHS I. The document containing this information is to be prepared by the Directors, and in preparing the document, the Board of Directors must have regard to the views of the Council of Governors.

4. BANKING

4.1 General

4.1.1 The Chief Finance Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/ Directions issued from time to time by NHS I or HM Treasury. In line with 'Cash Management in the NHS' Trusts should minimize the use of commercial bank accounts and consider using the Government Banking Service (GBS) accounts for all banking services.

4.1.2 The Board shall approve the banking arrangements.

4.2 Bank and GBS Accounts

4.2.1 The Chief Finance Officer is responsible for:

(a) bank accounts and the Government Banking Service (GBS) accounts

(b) establishing separate bank accounts for the Trust's non-exchequer (Charitable) funds

(c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made

(d) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn

(d) monitoring compliance with the Independent Regulator's guidance on the level of cleared funds

4.3 Banking Procedures

4.3.1 The Chief Finance Officer will prepare detailed instructions on the operation of bank and GBS accounts which must include:

(a) the conditions under which each bank and GBS account is to be operated;

(b) those authorised to sign cheques or other orders drawn on the Trust's accounts.

4.3.2 The Chief Finance Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

4.4 Tendering and Review

4.4.1 The Chief Finance Officer will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

4.4.2 Competitive tenders should be sought at least every five years. The results of the tendering exercise should be reported to the Board. This review is not necessary for GBS accounts.

5. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

5.1 Income Systems

5.1.1 The Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

5.1.2 The Chief Finance Officer is also responsible for the prompt banking of all monies received.

5.2 Fees and Charges

5.2.1 The Trust shall follow the Department of Health advice in the Payment by Result (PbR) guidelines and any other applicable guidance in setting prices for contracts with NHS Commissioners for all services falling within PbR from time to time.

5.2.2 The Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is being considered the guidance in the Department of Health's Commercial Sponsorship – Ethical Standards in the NHS shall be followed.

5.2.3 All employees must inform the Chief Finance Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

5.2.4 As per the 2012 Health and Social Care Act the Trust shall ensure the following:

(a) the income received from providing goods and services for the NHS is greater than their income from other sources.

(b) publish information within the forward plan on all their non-NHS work and to explain its impact on the delivery of goods and services for the NHS.

Should the Trust wish to increase the share of its income from non-NHS sources (including private work) by more than five percentage points in any one year, prior approval from the Council of Governors must be sought

5.3 Debt Recovery

5.3.1 The Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts.

5.3.2 Income not received should be dealt with in accordance with losses procedures.

5.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated in accordance with the Trust's Overpayment Policy.

5.3.4 Debt write off will be managed in line with the debt write off procedures with overall authorisation by the Group Director of Finance.

5.4 Security of Cash, Cheques and other Negotiable Instruments

5.4.1 The Chief Finance Officer is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

5.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

5.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Finance Officer.

5.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

6. NHS CONTRACTS AND SERVICE LEVEL AGREEMENTS FOR THE PROVISION OF SERVICES

6.1 Contracts and Service Level Agreements

The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable service contracts with NHS England, Clinical Commissioning Groups (typically via a lead CCG) and other commissioners for the provision of NHS services. This responsibility is delegated to the Chief Finance Officer with the Contracts Director overseeing this on a day to day basis. Where the Trust enters into a relationship with another organisation for the supply or receipt of other services, clinical or non-clinical, the responsible officer should ensure that, where this is material, an appropriate contract is present and signed by both parties.

The Trust will look to adhere to the terms and conditions of the NHS standard contract in so far as these are mutually acceptable and balance risk in a reasonable way. In discharging this responsibility, the Chief Finance Officer with the Contracting Director and Income shall pay particular attention to:

- the contract term and conditions precedent;
- the standards relating to the service quality requirements inclusive of the service specifications
- the costing and pricing of services, referencing to national and local tariffs
- provision of information and activity
- the payment terms and conditions
- governance requirements to include;
    - provider roles and responsibilities
    - performance and contract management

6.2 Stakeholder Partnership and Risk Management

A robust contract management framework is based on effective stakeholder relationships, working together across the health and social care system, to provide high quality, sustainable and value for money services. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of services. Where appropriate risk will be managed across the care system and responsibilities shared to influence outcomes and delivery of integrated services.

6.3 Reports to Board

The Chief Finance Officer with the Contracting Director will ensure that the Board and other management forums have appropriate oversight of contract agreements and contract performance (typically through the monitoring of performance KPIs, quality standards and information on divisional activity and income by high level points of delivery

7. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE BOARD OF DIRECTORS AND EMPLOYEES

7.1 Remuneration

The Remuneration Committee has been established by the Group Board of Directors to ensure that proper systems exist to advise on the appropriate level of remuneration for the Group Chief Executive Officer, the Group Executive Directors and other staff paid on non-standard pay scales.

7.2 Scope and Duties

7.2.1 To determine the framework or broad policy for the remuneration of the Group Chief Executive, the Group Executive Directors and other staff paid on non-standard pay scales (Very Senior Managers on local Terms & Conditions; Other Medical & Dental Staff on ad hoc salaries etc) with responsibility to monitor the comparative remuneration of senior staff covered by the NHS Agenda for Change.

7.2.2 To determine the framework or broad policy for the application or removal of national or local incentive payments e.g. Clinical Excellence Awards.

7.2.3 To advise on, and oversee contractual arrangements for such staff including a proper calculation and scrutiny of termination payments, taking account of relevant national guidance and legal advice.

7.2.4 The Council of Governors will decide the remuneration and allowances, and the other terms and conditions of the non-executive Directors.

7.2.5 The Group Board of Directors' emoluments will be accurately reported in the required format in the Group's annual report.

7.3 Staff Appointments

7.3.1 No officer or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so within the Scheme of Delegation; and

(b) they are within the approved limit of the annual plan i.e. the approved financial budget

7.3.2 The Board will approve procedures presented by the Directors of Finance and Human and Corporate Resources in line with the Scheme of Delegation for the determination of commencing pay rates, condition of service, etc, for employees

7.4 Processing Payroll

7.4.1 The Chief Finance Officer is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates;

(d) agreeing method of payment.

7.4.2 The Chief Finance Officer will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of employee and Officers;

(h) procedures for payment by cheque, bank credit, or cash to employees and Officers;

(i) procedures for the recall of cheques and bank credits;

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) separation of duties of preparing records and handling cash;

(m) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

7.4.3 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Chief Finance Officer's instructions and in the form prescribed by the Chief Finance Officer;

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or Officer’s resignation, termination or retirement. Where an employee fails to report for duty or to fulfill obligations in circumstances that suggest they have left without notice, the Chief Finance Officer must be informed immediately.

7.4.4 Regardless of the arrangements for providing the payroll service, the Chief Finance Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

7.5 Contracts of Employment

7.5.1 The Board shall delegate responsibility to the Director of Human and Corporate Resources for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;

(b) dealing with variations to, or termination of, contracts of employment.

7.6 Funded Establishment

7.6.1 The workforce plans incorporated within the annual budget will form the funded establishment.

7.6.2 The funded establishment of any department may not be varied without the approval of an authorised officer in line with the Scheme of Delegation.

7.6.3 No appointment can be made without a funded / established post on the ledger and ESR systems.

8. NON-PAY EXPENDITURE

8.1 Delegation of Authority

8.1.1 The Scheme of Delegation sets out the delegated powers.

8.2 Requisitioning

8.2.1 Wherever possible a requisitioner shall use the End User Requisitioning (EUR) facility to order goods and services via catalogues supported by Trust negotiated contracts.

8.2.2 Where a service or good is not available on catalogue then the requisitioner should consult with the Supplies department. In choosing the item to be supplied (or the service to be performed) best value for money for the Trust should always be sought. Where the advice of the Supplies department is not acceptable to the requisitioner, the Chief Finance Officer (and/or the Chief Executive) shall be consulted.

8.3 System of Payment and Payment Verification

The Chief Finance Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

8.3.1 The Chief Finance Officer will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions (Procurement) and regularly reviewed;

(b) prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of Trust employees (including specimens of their signatures) authorised to certify invoices.

(ii) Proper Certification

8.4 Prepayments

Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate, for a period similar to the contract term, plus 2%).

(b) The appropriate officer must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) The Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

The sole exception being with regard to maintenance contracts where the industry standard terms are for prepayment. In these circumstances the contract details will be tracked and the prepayment adjustment will be enacted on a monthly basis.

8.5 Official orders

(a) that written assurance has been obtained from each provider that they themselves are compliant with the requirements of the anti-bribery legislation

(b) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

(This provision needs to be read in conjunction with and the principles outlined in the national guidance contained in HSG 93(5) "Standards of Business Conduct for NHS Staff" and the 'adequate procedures' requirements of the Bribery Act 2010 as outlined in the Trust's Anti-Fraud, Bribery and Corruption Policy);

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Chief Executive;

(f) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash; in exceptional circumstances a confirmation order can be raised prior to payment of associated invoices.

(g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

(h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(j) changes to the list of employees and Officers authorised to certify invoices are notified to the Chief Finance Officer;

(k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Finance Officer;

(l) petty cash records are maintained in a form as determined by the Chief Finance Officer.

8.6 Joint Finance Arrangements with Local Authorities and Voluntary Bodies

8.6.1 Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act shall comply with procedures laid down by the Chief Finance Officer which shall be in accordance with these Acts.

9. EXTERNAL BORROWING AND INVESTMENTS

9.1 Borrowing

9.1.1 The Trust must ensure compliance with guidance from the Independent Regulator. The degree to which the organisation's generated income covers its financing obligations is a key determinant of the Trust's financial stability and will therefore be clearly referenced in determining appropriate levels of borrowing over time.

9.2 Public dividend capital

9.2.1 On authorisation as a Foundation Trust the public dividend capital held immediately prior to authorisation continues to be held on the same conditions.

9.2.2 Additional public dividend capital may be made available on such terms the Secretary of State (with the consent of the treasury) decides.

9.2.3 Draw down of public dividend capital should be authorised in accordance with the mandate held by the Department of Health cash funding team, and is subject to approval by the Secretary of State.

9.2.4 The Trust shall be required to pay annually to the Department of Health a dividend on its public dividend capital at a rate to be determined from time to time, by the Secretary of State.

9.3 Commercial borrowing

9.3.1 The Trust may borrow money from any commercial source for the purposes of or in connection with its functions, subject to NHS I guidance. Any exercise of this freedom will take full account of the considerations referenced in 9.1.1.

9.4 Investments

9.4.1 The Trust may invest money (other than money held by it as charitable Trustee) for the purposes of or in connection with its functions. Such investment may include forming, or participating in forming, or otherwise acquiring membership of bodies corporate.

9.5 Investment of Temporary Cash Surpluses

9.5.1 Temporary cash surpluses must be held only in such public and private sector investments as approved in the Trust's treasury management policy which should be drawn up by the Chief Finance Officer and pursuant to all applicable guidance including Managing Operating Cash in NHS Foundation Trusts published by the Independent Regulator.

9.5.2 The Chief Finance Officer shall report periodically to the Board of Directors concerning the performance of investments held.

9.5.3 The Chief Finance Officer will prepare detailed procedural instructions on investment operations and on the records to be maintained. The Trust's treasury management policy will incorporate guidance from the Independent Regulator as appropriate.

9.5.4 The Trust shall comply with all relevant guidance published on investments from time to time in force.

10. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

10.1 Capital Investment

10.1.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

(c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges;

(d) shall ensure that the Trust complies with prevailing regulatory requirements and best practice.

10.1.2 For every capital expenditure proposal (other than replacement equipment or rolling programmes) the relevant Hospital Chief Executive, or for Trust level proposals the responsible Executive Director shall ensure:

(a) that a business case is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) a robust assessment of risks together with appropriate mitigation plans for these risks,

(iii) a benefits realisation programme with clear accountable officers and time line set out for delivery and monitoring

(iv) the involvement of appropriate Trust personnel and external agencies;

(v) appropriate project management and control arrangements;

(b) that the appropriate Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case.

10.1.3 The Director of Estate & Facilities shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.

10.1.4 For capital schemes where the contracts stipulate stage payments, the responsible Executive Director will issue procedures for their management, incorporating the recommendations of "Estatecode".

10.1.5 The Chief Finance Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

10.1.6 The Director of Estates & Facilities, in consultation with the Chief Finance Officer shall issue to the Director responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender;

(c) approval to accept a successful tender (see overlap with Scheme of Delegation)

10.1.7 The Chief Finance Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

10.2 Asset Registers

10.2.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

10.2.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in accordance with the International Financial Reporting Standards (IFRS) and any other standards applicable for the periods concerned.

10.2.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads;

(c) lease agreements in respect of assets held under a finance lease and capitalised.

10.2.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate). Prior approval will be required from the Group Director of Finance for assets with a value in excess of £75,000, including in circumstances where assets are replaced / superseded by new items e.g. re medical equipment. (See 12.1.2)

10.2.5 The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

10.2.6 The value of each asset shall be depreciated using methods as allowed in the IFRSs.

10.3 Procedure for the Security of Assets

10.3.1 The overall control of fixed assets is the responsibility of the Chief Executive.

10.3.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Finance Officer. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset;

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

10.3.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Finance Officer.

10.3.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to Trust property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

10.3.5 Any damage to the Trust’s premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

10.3.6 Where practical, assets should be marked as Trust property.

11. STORES AND RECEIPT OF GOODS

11.1 General position

11.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

11.2 Control of Stores, Stocktaking, condemnations and disposal

11.2.1 Subject to the responsibility of the Chief Finance Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Finance Officer. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated estates manager.

11.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as Trust property.

11.2.3 The Chief Finance Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

11.2.4 Stocktaking arrangements shall be agreed with the Chief Finance Officer and there shall be a physical check covering all items in store at least once a year.

11.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Finance Officer.

11.2.6 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI on Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

11.3 Goods supplied by NHS supply Chain

11.3.1 For goods supplied via the NHS supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept those goods. Generally goods will be ordered through the Materials Management system and will be ordered to regularly agreed stock levels. Any discrepancies to order should be reviewed and resolved with NHS supply Chain.

12. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

12.1 Disposals and Condemnations

12.1.1 Procedures

The Executive Chief Finance Officer is responsible for preparing detailed procedures for the disposal of assets including condemnations and transfers, and to ensure that these are notified to all Trust Departments.

12.1.2 The authorisation of a disposal has been delegated by the Executive Chief Finance Officer to the Head of Financial Services.

When it is decided to dispose of a Trust asset, a Trust official with the appropriate delegated authority will notify the Head of Financial services. The Head of Financial services will establish the carrying amount of the asset and determine the financial impact of the disposal, taking professional advice where necessary. (see 10.2.4)

12.1.3 All unserviceable articles shall be disposed of in line with the Transfer and Disposals of Assets Policy.

12.1.4 A Trust official with delegated authority for disposal of the asset shall satisfy themselves as to whether or not there is evidence of negligence in use and shall report any such evidence to the Head of Financial Services who will take the appropriate action.

12.1.5 In the case of obsolete assets the Trust may approve the gift of the item to a registered charity including those working overseas e.g. obsolete medical equipment. This is subject to confirmation that appropriate decontamination procedures can be carried out at negligible costs or where these costs will be refunded by the charity. Packaging and transport would be the responsibility of the charity.

12.2 Losses and Special Payments

12.2.1 **Procedures**

The Chief Finance Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

12.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Chief Finance Officer or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Chief Finance Officer and/or Chief Executive.

Where a criminal offence is suspected, the Chief Finance Officer must immediately inform the police if theft or arson is involved. In cases of fraud or corruption, or of anomalies which may indicate fraud or corruption, the Chief Finance Officer must inform the Trust's LCFS in accordance with the NHS Standard Contract clauses.

The Chief Finance Officer must notify NHS Protect, via the LCFS. The Chief Finance Officer should also notify the Board, Audit Committee and External Audit as/when appropriate to do so.

12.2.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Finance Officer must immediately notify:

(a) the Board,

(b) the External Auditor.

12.2.4 Within limits delegated to it by the Department of Health, the Board shall approve the writing-off of losses.

12.2.5 The Chief Finance Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

12.2.6 For any loss, the Chief Finance Officer should consider whether any insurance claim can be made.

12.2.7 The Chief Finance Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

12.2.8 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health, Monitor and H.M. Treasury.

12.2.9 All losses and special payments must be reported to the Audit Committee at every meeting.

13. PATIENTS' PROPERTY

13.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

13.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets; (notices are subject to sensitivity guidance)
- hospital admission documentation and property records;
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

13.3 The Chief Finance Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

13.4 Where Department of Health instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Chief Finance Officer.

13.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

13.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

13.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

14. FUNDS HELD ON TRUST

14.1 Corporate Trustee

14.1.1 The Trust is responsible, as a corporate Trustee, for the management of funds it holds on Trust and shall comply with Charities Commission latest guidance and best practice.

14.1.2 The discharge of the Trust's corporate Trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

14.1.3 The Chief Finance Officer shall ensure that each Trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

14.2 Accountability to Charity Commission and Secretary of State for Health

14.2.1 The Trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on Trust and to the Secretary of State for all funds held on Trust.

14.2.2 The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Board of Directors members and Trust Officers must take account of that guidance before taking action.

14.3 Applicability of Standing Financial Instructions to funds held on Trust

14.3.1 In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on Trust.

14.3.2 The over-riding principle is that the integrity of each of the Trust and the Charity must be severally maintained and statutory and regulatory obligations met. Materiality must be assessed separately from Exchequer activities and funds.

15. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT

The Chief Finance Officer shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff (The Trust's 'Standards of Business Conduct and Hospitality Policy'). This policy follows the guidance contained in the Department of Health circular HSG (93) 5 'Standards of Business Conduct for NHS Staff' and is also deemed to be an integral part of these Standing Orders and Standing Financial Instructions.

Staff are also reminded that the offering, promising, giving, requesting, receiving or agreeing to receive gifts, hospitality and other benefits in kind, under certain circumstances, may also constitute offences under the Bribery Act 2010. (Further advice and guidance can be sought from the LCFS).

16. RETENTION OF RECORDS

16.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health guidelines.

16.2 The records held in archives shall be capable of retrieval by authorised persons.

16.3 Records held in accordance with the latest NHS Code of Practice shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.

17. INSURANCE

17.1 Insurance: Risk Pooling Schemes administered by NHSLA

The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority or self insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

17.2 Insurance arrangements with commercial insurers

17.2.1 The Chief Finance Officer shall ensure that insurance arrangements exist in accordance with the risk management programme.

17.3 Arrangements to be followed by the Board in agreeing Insurance cover

17.3.1 Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Finance Officer shall ensure that documented procedures cover these arrangements.

17.3.2 Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

17.3.3 All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Chief Finance Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

18. TENDERING AND CONTRACTING PROCEDURE

18.1 The Scheme of Delegation (SoD) and the Trust's Procurement of Goods and Services policy, specify the procurement arrangements that should be applied.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Professor Cheryl Lenney – Chief Nurse
Paper prepared by:	Karen Meadowcroft, Corporate Director of Nursing Debra Armstrong, Assistant Chief Nurse
Date of paper:	October 2018
Subject:	Quarter 2 Complaints Report, Financial Year 2018 / 19
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Resolution • Approval
Consideration of Risk against Key Priorities:	Patient & Staff Experience
Recommendations:	To note the content of the report and the progress of the Complaints Transformation Programme.
Contact:	**Name**: Debra Armstrong – Assistant Chief Nurse **Tel:** 0161 276 5061

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

1. Executive Summary

1.1. Members of the Group Board of Directors are asked to note the Quarter 2, 2018/19 complaints report for Manchester University NHS Foundation Trust, covering the period 1st July – 30th September 2018.

1.2 This report provides an overview of the Complaints and PALS performance for Quarter 2, 2018/19.

1.3 During Quarter 2, 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/Managed Clinical Services (MCS)/ Manchester Local Care Organisation (MLCO) across the Group. An integral part of the integration has involved the reporting alignment of formal complaints to Hospitals/ MCS/MLCO for services they manage.

1.4 During Quarter 2, 2018/19 there was a total of 1,336 PALS concerns received. This compares to 1,324 concerns received in Quarter 1; which equates to a 0.90% increase in concerns compared to Quarter 1, 2018/19. Numerically this equates to an increase of 12 PALS concerns.

1.5 During Quarter 2, 2018/19, there were a total of 403 new formal complaints received. This compares to 461 received in Quarter 1, 2018/19, 420 received in Quarter 4, 2017/18 and 408 formal complaints received in Quarter 3, 2017/18. There was a 12.6% decrease in formal complaints (decrease of 58 in number) received in Quarter 2, 2018/19. There continues to be a natural variation of complaint numbers at Hospitals/MCS/MLCO level and the Assistant Chief Nurse continues to monitor the variation closely.

1.6 The Manchester Royal Eye Hospital had an increase of 5 (31.25%) complaints received in Quarter 2, 2018/19. All other Hospitals had a decrease in the number of complaints, with the largest decrease being at Manchester Royal Infirmary (MRI), which had a reduction of 15 cases (-11.19%) in Quarter 2, 2018/19 compared to Quarter 1, 2018/19. The reduction is no statistically significant as this only represents 1 data point. The MRI performance is monitored via the Accountability Oversight Framework (AOF) and additional support has been provided from the Corporate Nursing team.

1.7 During Quarter 2, 2018/19 there was a notable decrease in the number of complaint responses resolved at over 41 days, compared to the number of complaint responses resolved at over 41 days in Quarter 1 (2018/19). The elevated number of complaints resolved at over 41 days in Quarter 1 was correlated to the Complaint Improvement Programme at Wythenshawe hospital, which resulted in the closure of 139 complaints registered before April 2018, within Quarter 1.

1.8 There was an increase (positive) in the proportion of complaints closed within 25 days with 35.9% of the total complaints closed in Quarter 2, 2018/19 compared to 25.1% of the total closed in Quarter 1, 2018/19. There was a decrease (positive) of cases closed at 41 days or more days between Quarter 1 (61.0%) and Quarter 2 (43.0%), 2018/19.

1.9 The NHS Complaint Regulations (2009) stipulate that complaints must be acknowledged in writing no later than 3 working days after the complaint is received. The Trust achieved 100.0% compliance with this Key Performance Indicator during Quarter 2, 2018/19.

1.10 In accordance with the agreed schedule, the Complaints Scrutiny Group, which is chaired by a Non-Executive Director met twice during Quarter 2, 2018/19. The Division of Medicine and Surgery at Wythenshawe, Trafford, Withington and Altrincham Hospitals (WTWA), each presented a case at the July 2018 meeting and Saint Mary's Hospital (SMH) presented a case at the September 2018 meeting. The learning identified from the cases presented is detailed in section 5 of this report.

1.11 The Group Board of Directors is asked to note the information within the report and the ongoing integration and development of the complaints system during Quarter 2, 2018/19 and the targeted support from the Corporate Nursing team.

2. Overview of Quarter 1 Performance

PALS

2.1 During Quarter 2, 2018/19 there was an increase in PALS concerns with 1,336 PALS concerns being received, compared to 1,324 in Quarter 1. This equates to a 0.9% increase in concerns compared to Quarter 1, 2018/19 and is numerically an increase of 12 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. The number of cases escalated and de-escalated has been collated across all Hospitals/ MCSs since 01st April 2018 as an integral part of the implementation of the new Trust Ulysses Complaint Module.

2.3 There were 14 PALS cases escalated for formal investigation during Quarter 2, this compares to 20 PALS cases escalated during Quarter 1, 2018/19. Cases are in the main escalated due to the complexity of the complaint received and following discussion with the complainant advising that formal investigation should be undertaken.

2.4 Conversely 7 formal complaint cases were de-escalated during Quarter 2, 2018/19 compared to 4 in Quarter 1, 2018/19

2.5 As seen in Quarter 1, 2018/19 the Hospital with the highest number of PALS concerns raised during Quarter 2, 2018/19 was Manchester Royal Infirmary with 381 cases (28.51%), followed by Wythenshawe with 301 cases (22.52%) of the PALS cases received.

2.6 The majority of PALS concerns during Quarter 2, 2018/19 related to the Outpatient areas, which accounted for 950 (71.1%) of the 1,336 contacts received. This compares to 893 (67.4%) of concerns raised during Quarter 1, 2018/19 relating to the Outpatient areas.

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

Table 1: Closure of PALS concerns within timeframes.

	Quarter 3, 2017/18		Quarter 4, 2017/18		Quarter 1, 2018/19		Quarter 2, 2018/19	
Days to close	Number of cases resolved within timeframe	Percentage of cased closed within timeframe	Number of cases resolved within timeframe	Percentage of cased closed within timeframe	Number of cases resolved within timeframe	Percentage of cased closed within timeframe	Number of cases resolved within timeframe	Percentage of cased closed within timeframe
0-5	949	53.2%	900	62.5%	789	65.3%	839	63.0%
0-7	1107	62.1%	1075	74.6%	922	76.3%	126	72.0%
8-14	281	15.8%	292	20.3%	247	20.4%	313	23.0%
15+	394	22.1%	74	5.1%	40	3.3%	63	5.0%

2.8 In Quarter 2, 2018/19 the number of cases taking longer than 14 days to close increased from 40 cases (3.3%) to 63 (5.0%) cases. This represents an increase (negative) in the number of long-standing cases. All cases that are unresolved at 12 days are now discussed with the PALS Manager who in turn escalates outstanding actions to senior members of the Hospital/ MCS/ MCLO teams. This process has been in place since the beginning of Quarter 2, 2018/19 and it is anticipated that by the end of Quarter 3, 2018/19 the longer standing cases will have reduced.

New Formal Complaints

2.9 The Group Board of Directors Complaint Report (Quarter 1, 2018/19) outlined the changes in reporting as complaints were reallocated to the MCS. This has resulted in an increase in the number of complaints recorded by Clinical Scientific Services, Royal Manchester Children's Hospital, Saint Mary's Hospital and Corporate Services as formal complaints from all hospital sites are now aligned to these MCS. This has conversely resulted in a reduction of formal complaints assigned to Wythenshawe Hospital.

2.10 During Quarter 2, 2018/19, there were a total of 403 new formal complaints received. This equates to a 12.58% decrease in formal complaints (decrease of 58 in number) received in Quarter 2, compared to Quarter 1, 2018/19.

2.11 The largest decrease in the number of complaints received from Quarter 1 to Quarter 2, 2018/19 was at Manchester Royal Infirmary which had a reduction of 15 cases (-11.19%). The reduction is not statistically significant as this only represents 1 data point. The MRI performance is being monitored via the Accountability Oversight Framework (AOF) and supported by the Corporate Nursing team.

2.12 The Manchester Royal Eye Hospital had an increase of 5 (31.25%) complaints received in Quarter 2, 2018/19. It is important to note that where a relatively small number of complaints are received, large percentage variations can be caused by relatively small numerical fluctuations hence the numerical figures are also reported.

2.13 During Quarter 2, 2018/19, there were 140 new complaints made relating to inpatient services and 178 relating to outpatient services. For inpatient services, this represents a decrease of 7.89% compared to Quarter 1 (152) and for outpatient Services, this represents a decrease of 14.42% compared to Quarter 1 (208). The area with the highest number of outpatient complaints for Quarter 2, 2018/19 was MRI with a total of 48 of the 178 total (27.0%). Themes identified for Inpatient service were delayed operations and general nursing care and themes for outpatient services were poor communication and general medical care.

2.14 The national statutory requirement for the acknowledgement stage of formal complaints handling, according to the NHS Complaints Regulations (2009), is to acknowledge 100% of all complaints no later than 3 working days after the complaints are received. The Trust achieved 100.0% compliance with this key performance indicator (KPI) during both Quarter 1 and 2, 2018/19.

Current Complaints

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

2.16 At the end of Quarter 2, 2018/19 there was 284 unresolved formal complaints compared to 329 unresolved at the end of Quarter 1, 2018/19. This is a 13.68% decrease (positive) at the end of Quarter 2, compared to the end of Quarter 1 equating to 45 fewer complaints within the unresolved category. The unresolved complaints comprised 132 (46.48%) which had been registered between 0-25 days, 76 (26.76%) between 26-40 days and 76 (26.76%) had been registered for 41 or more days.

2.17 There were 76 cases unresolved at 41 or more days at the end of Quarter 2, 2018/19 compared to 63 complaints unresolved at 41 or more days at the end of Quarter 1, 2018/19.

2.18 The oldest complaint case closed during Quarter 2, 2018/19 was registered at Wythenshawe Hospital on 4th February 2018 and was 155 days old when closed on 19th September 2018. The complaint involved The Christie Hospital NHS Foundation Trust, which resulted in a meeting being held on 7th August 2018 between the complainant and members staff of staff from Wythenshawe Hospital and The Christie Hospital following completion of the complaint investigation.

2.19 Manchester Royal Infirmary had the highest number of unresolved cases at the end of Quarter 2, 2018/19 with 98 open cases compared to 113 open cases in Quarter 1, 2018/19, Of the cases open at the end of Quarter 2, 42 (42.86%) were within 0-25 days, 22 (22.45%) were within 26-40 days old and 34 (34.69%) were over 41 days old. This improvement has been supported by the corporate team.

Resolved Complaints

2.20 **Table 2** provides a comparison of formal complaints resolved within each timeframe from Quarter 3, 2017/18 to Quarter 2, 2018/19. Following the implementation of the new single Ulysses Complaint Module in Quarter 1, 2018/19 it has become apparent that the data regarding closure of formal complaints in Quarter 1, 2018/19 was under reported in the Quarter 1 Complaint Report. The data provided in Table 2 for the Quarter 1, 2018/19, provides the amended data for Quarter 1.

Table 2: Comparison of formal complaints resolved by timeframe

	Quarter 3 2017/18	Quarter 4 2017/18	Quarter 1 2018/19	Quarter 2 2018/19
Formal complaints resolved	404	295	541	446
Resolved in 0-25 days	153 (37.9%)	78 (26.4%)	136 (25.1)%	160 (35.9%)
Resolved in 26-40 days	128 (31.7%)	88 (29.8%)	76 (14.0%)	94 (21.1%)
Resolved in 41+ days	123 (30.4%)	129 (43.7%)	329 (61.0%)	192 (43.0%)

2.21 The proportion of cases resolved within 0-25 working days increased (positive) from Quarter 1, 2018/19 to Quarter 2, 2018/19 by 10.8%. There was an increase of 7.1% (negative) in the number of cases resolved between 26-40 days, between Quarter 1 2018/19 and Quarter 2, 2018/19 conversely; there was a decrease (positive) in the number of cases resolved at 41+ days of 18%.

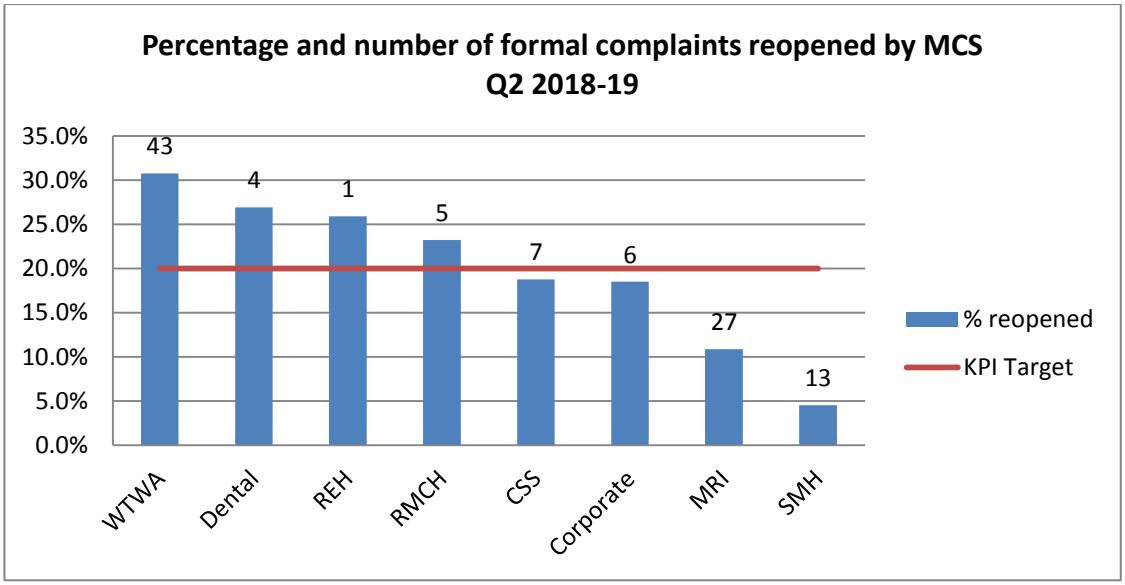
Reopened Complaints

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 an increase in the number of formal complaints re-opened (dissatisfied) during Quarter 2, 2018/19 (106). This compares to 66 in Quarter 1, 2018/19, which is an increase (negative) of 60.6%. Overall dissatisfied cases accounted for 20.8% of all complaints received during Quarter 2, 2018/19.

2.23 The 43 re-opened cases received by Wythenshawe, Trafford, Withington and Altrincham Hospitals (WTWA) in Quarter 2, is predominantly associated with complainant dissatisfaction with the extensive time period in responding to complainants. This is reflective of the increased number of complainants responded to following the implementation of the improvement programme in Quarter 4, 2017/18 and Quarter 2 2018/19.

2.24 **Graph 1** illustrates Hospital/MCS/MLCO performance against this threshold in Quarter 2, 2018/19; WTWA 31% (43 re-opened cases), University Dental Hospital 27% (4 re-opened cases), Manchester Royal Eye Hospital 26% (1 re-opened case), Royal Manchester Children's Hospital 23% (5 re-opened) exceeded the 20% threshold during Quarter 2, 2018/19; with all the other Hospitals/MCS/MLCO recording reopened cases below the threshold. It should be noted, however, that small fluctuations in the total number of complaints received in a Hospital/MCS/MLCO can result in large percentage changes for those sites with overall low number of complaints. 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 8.6 of this report.

Graph 1: Percentage of re-opened Formal Complaints (Quarter 2, 2018/19).



Trust-Wide Compliments

2.25 The registration of compliments received by the Group Chief Executive is managed by the PALS Team and the Hospital/MCS/MLCO management teams manage registration of locally received compliments on the Ulysses Complaint Module. All responses are managed locally by the Hospitals/ MCSs/ MLCO. There is recognition that compliments come via various technological platforms such as Twitter or websites and exploration of the gathering of compliment in line with technological development warrants exploration.

2.26 The Trust receives many formal compliments from patients, their families and friends and action continues to be undertaken to increase recording of such invaluable feedback. **Table 3**, below, shows the numbers of compliments registered for each Hospital/MCS/MLCO and relevant Division where applicable. The number of compliments registered during Quarter 2, 2018/19 was 112. This compares to 144 Quarter 1, 2018/19, which represents a decrease of 32 (22.2%) between Quarter 1, 2018/19 and Quarter 2, 2018/19.

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

	Number of Compliments received by Division				
Hospital/MCS	**Division**	**Q3**	**Q4**	**Q1**	**Q2**
Unknown	Division not recorded	20	9	10	0
MLCO	Manchester Local Care Organisation	-	-	16	4
CSS	Clinical Scientific Services	4	4	2	5
Corporate	Corporate Services	0	2	0	4
MREH/UDHM	University Dental Hospital of Manchester	0	0	3	1
	Manchester Royal Eye Hospital	7	12	21	9
RMCH	Royal Manchester Children's Hospital	3	5	5	5
St. Mary's	St Marys Hospital	6	8	6	8
MRI	Specialist Medical Services	6	11	8	19
	Medicine And Community Service	40	43	11	11
	Surgery	25	36	21	10
	Unknown	0	0	6	3
Wythenshawe, Trafford, Altrincham and Withington	Trafford and Altrincham Hospitals	19	15	10	27
	Wythenshawe and Withington Hospitals	69	79	25	6
	Total	**199**	**224**	**144**	**112**

2.27 At the July meeting of the Board of Directors it was agreed that compliments would be recorded but that this would no longer serve as a metric for measuring good practice due to the number of compliments received which are not formally recorded**.**

3. Care Opinion and NHS Website feedback

3.1 Care Opinion and the NHS Website (previously NHS Choices, rebranded in September 2018) 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 4.**

3.3 The Care Opinion and NHS Website feedback demonstrates that more than two thirds of the overall comments (67.7%) received Quarter 2 of 2018 were positive. This represents an improvement compared to Quarter 1, 2018/2019 when the overall positive comments represented 55.2% of the total. Negative comments equate to 16.9% of the overall total received during the second quarter of 2018/19, which compares to 32.4% during Quarter 1, 2018/19. Mixed responses relate to 15.4% of comments in Quarter 2, compared to 12.4% in Quarter 1 (2018/19).

Table 4: Number of Care Opinion postings by Hospital/ MCS/Division in Quarter 2, 2018/19

Number of Postings received by Hospital/ MCS/ Division (Quarter 2, 2018/19)			
Hospital/ Managed Clinical Service (MCS)/ Division	Positive	Negative	Mixed
MRI - Medicine (MRI)	6	1	2
MRI - Specialist Medical Services (MRI)	3	0	0
MRI Surgery (MRI)	1	0	1
MRI Combined Total	10	1	3
Trafford General Hospital	5	0	1
Altrincham Hospital	5	2	2
Clinical Support Services, Wythenshawe and Withington	1	0	0
Scheduled Care (Maternity), Wythenshawe and Withington	0	0	0
Scheduled Care (Surgery), Wythenshawe and Withington	10	1	1
Unscheduled Care, Wythenshawe and Withington	1	1	0
Heart and Lung	1	0	0
Medical Specialities	0	1	0
WTWA Combined Total	23	5	4
Clinical Scientific Services	2	1	1
Corporate Services (Estates and Facilities)	1	0	0
University Dental Hospital of Manchester	1	1	0
Manchester Royal Eye Hospital	0	1	2
Royal Manchester Children's Hospital	5	1	0
St Marys Hospital	2	1	0
Overall MFT Total	**44**	**11**	**10**

3.4 **Table 5** provides three examples of the feedback received and the subsequent responses posted on Care Opinion and NHS Website during Quarter 2, 2018/19.

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

Quarter 2 , 2018/2019
Comment Ear, Nose & Throat, Wythenshawe Hospital
Anonymous gave Ear, Nose & Throat at Wythenshawe Hospital a rating of 5 stars Praise for staff in the Speech, Voice and Swallowing Dept I attended an appointment with my son at the Speech, Voice and Swallowing Department on the 2nd August 2018. My son has Asperger's syndrome and struggles to attend anywhere for the first time alone so, although he is an adult, I attended with him. Our experience from arriving at the hospital, to leaving after the appointment, was a dream! This is an unusual experience for us, as previous hospital visits/stays have been fraught with long waits and misunderstandings with no account taken of my son's disability. First, there was no waiting to be seen! The relief and surprise on my son's face was heart-warming. The efficiency continued - the practitioners were all very respectful, patient and non-judgemental. It was a pleasure to observe their professionalism and not once did I feel the need to intervene or explain

anything about my son's difficulties and differences. We would like to thank them all for this positive experience and we hope this message is both conveyed to them and reported to management.

Response

Thank you for your positive comments posted on the NHS Choices website regarding the care and treatment you received from the Ear, Nose and Throat Department of the Wythenshawe Hospital. It was very kind of you to take the time to write and compliment the staff as it is lovely to receive positive feedback which reflects their hard work and dedication.

We were pleased to read that both yours and your son's experience, using our services was a positive one and that you and your son were treated with dignity and respect.

We can assure you that your kind comments have been forwarded to the Manager of the ENT department so that this can be shared with the wider team.

Comment Cardiology, Manchester Royal Infirmary

Felt my dignity and concerns were addressed amazing staff!
I came into MRI after I was at stepping hill for a short time concerning my heart I'm 22 and on arrival in the cardiology wards the drs and nurses were quick to give me the treatment and tests needed, within 10-15 mins of having my echocardiogram the drs were quick to take me into theatre for a angiogram all while this was going on the nurses and drs were quick to put my mind at ease, within 30 mins after the angiogram I was told I had no blockages and was placed on the ward for obs overnight, the healthcare assistants were amazing. By the day after I was placed on that ward they told me on the rounds I'd be moved for further tests and obs. On that ward the nurses and healthcare assistants were great there as well. I left on the Saturday with a diagnosis and treatment plan. Can't thank them all enough as a support worker myself it's a great feeling to know I'm receiving quality care. Thanks to all the healthcare staff at MRI I'm now on the mend you do a cracking job!

Thank you for taking the time to post your positive comments on the NHS website following your recent attendance at the Cardiology Department of the Manchester Royal Infirmary. It was very kind of you to take the time to write and compliment the staff as it is good to receive feedback which reflects the hard work and dedication of our staff. It was reassuring to read that you received quality care.

We can assure you that we have passed on your thoughts to the Head of Nursing, Specialist Medical Services, Manchester Royal Infirmary, so that your comments can be shared with the teams involved in your care.

Comment Patient Advice and Liaison Team, Corporate Services

Two weeks ago, I received a letter from the hospital saying that my surgical procedure had been cancelled. I went into a panic because I had been waiting for this procedure for some time to relieve the pain I have been having. It had come to a point that even standing let alone walking was excruciating. I checked with the hospital - initially Trafford Hospitals because that was where my procedure was going to be done, only to be told that it was the MRI that had cancelled my theatre procedure. As I couldn't get hold of the theatre coordinator, I called PALS. It was a good thing that I was able to get through. I explained my predicament and I was told that they would look into it. The PALS staff I spoke with said that they would try to find someone from the Division of Surgery to ring me back directly. In the end it was all sorted. The nice thing about this was that PALS gave me a courtesy call to check on whether the division contacted me. I think that this was a personal touch which I'm grateful for. I know how busy PALS can be and to make this simple gesture makes you feel that you're not a nuisance or that you're just one of the many using the hospital's services. They genuinely cared. This simple gesture makes a lot of difference. Thank you PALS.

Response
Thank you for your positive comment posted on the NHS Choices website regarding the treatment you received from the Patient Advice and Liaison Service (PALS) of the 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. We were pleased to note that the service was able to assist you with your concern about your procedure. We were also pleased to read that you felt that PALS' courtesy call made you feel that they genuinely cared about your concern. We can assure you that we have passed on your thoughts to the Manager of the PALS so that your kind comment can be shared with the wider team.

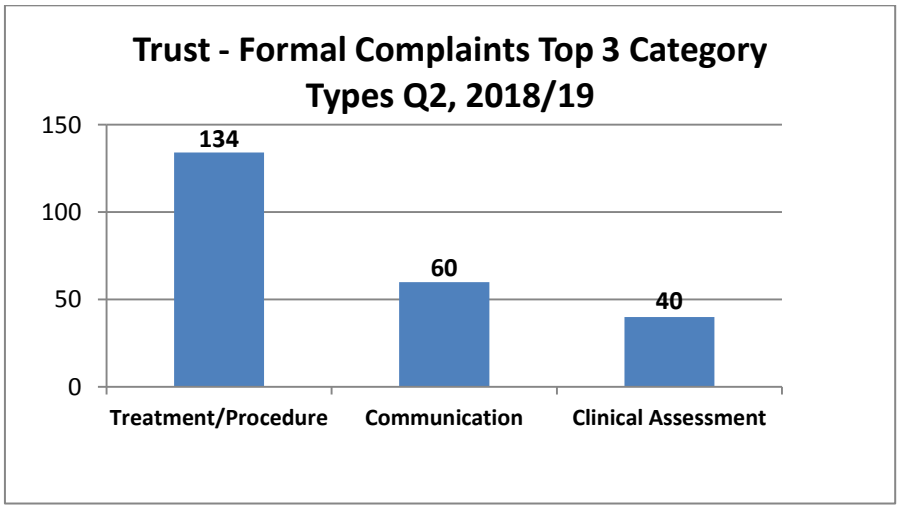
4. Themes from Complaints and PALS contacts

4.1 In Quarter 2, 2018/19 the medical staffing group were cited in 38.5% of all PALS contacts, compared to 42.0% in Quarter 1, 2018/19. This group was also cited in 45% of formal complaints in Quarter 2, compared to 52.0% in Quarter 1, 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 Customer Services Lead provides educational input with regard to customer service and complaints management on the New Consultants Programme.

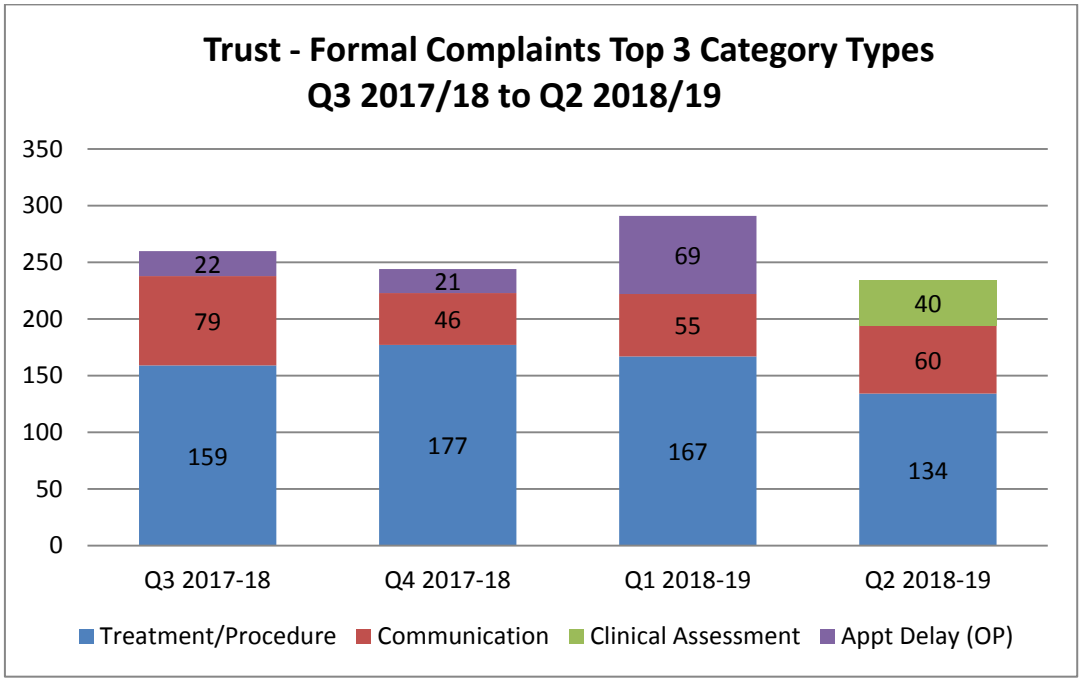
4.2 The Trust-wide top three category types for formal complaints for Quarter 2, 2018/19 are shown in **Graph 2a.** The top three category types for formal complaints from Quarter 3, 2017/18 to Quarter 2, 2018/19 are shown in **Graph 2b**.

4.3 'Treatment/Procedure' and 'Communication' remain in the top three categories; however, in Quarter 2, 2018/19 'Clinical Assessment (Diagnostics/Scan) is the third category replacing 'Appointment, delay/cancellation (OP) which was in the top 3 categories on Quarter 1, 2018/19.

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



Graph 2b: Formal Complaints – Top 3 Categories Q2, 2018/19 Quarter 1, 2018/19, Quarter 3, 2017/18 and Quarter 4, 2017/18



4.4 **Theming Complaints**

Following implementation of the new Ulysses Complaints Module for MFT in Quarter 1, 2018/19, work continues to theme complaints to the new MFT Trust Values; ***Everyone Matters, Working Together, Dignity & Care & Open and Honest.*** As the dataset develops it will be included in future reports from 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 2, 2018/19. The Medicine and Surgery Divisions from Wythenshawe, Trafford, Withington and Altrincham Hospitals (WTWA), each presented a case at the July 2018 meeting. Saint Mary's Hospital (SMH) presented a case at the September 2018 meeting.

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

Table 6: Actions identified at the Trust Complaints Scrutiny Committee during Quarter 2, 2018/19.

Division/ Hospital	Learning	Actions
WTWA (Medicine)	Call bell out of reach	▪ Regular audits to be undertaken ▪ Matron rounds to be undertaken

	Lack of support & detection of mental health problem (Delirium	▪ Look into what other areas across MFT offer to support patients with Delirium ▪ Consider and adopt good practice
WTWA (Surgery)	Issues identified with End of Life Care	▪ To continue with ongoing improvements to End of Life Care
	Copy of the Lead Trust's complaint response not shared with MFT	▪ Copy of final response to be requested from the Lead Trust. Following the meeting the complaint response was requested, received and shared with the WTWA team.
SMH	Scan not performed prior to discharge	▪ Implementation of additional screening tool ▪ Guidelines strengthened
	Not all complaint documentation reviewed on the Ulysses Complaints Module	▪ Divisional Lead to review all documents upon notification of complaint

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, UK government departments and other public organisations.

6.2 The Trust had 28 cases under the review of the Parliamentary and Health Service Ombudsman at the end of Quarter 2, 2018/19 compared to 25 under review at the end of Quarter 1, 2018/19. **Table 7** 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 7: Overview of PHSO Cases open as at 30th September 2018

Hospital/MCS Division	Case/s	Progress	
CSS	6	Investigation on-going:	Awaiting draft report (3 cases) Awaiting final report (3 cases)
RMCH	1	Investigation on-going:	Awaiting draft report (1 case)
MRI (SMS)	4	Investigations on-going:	Awaiting draft report (3 cases) Awaiting final report (1 cases)
MRI (DMACS)	8	Investigations on-going:	Awaiting draft report (4 cases) Awaiting final report (3 cases) Scoping (1 case)
MRI (Surgery)	6	Investigations on-going:	Awaiting draft report (3 cases) Awaiting final report (3 cases)

SMH	1	Investigations on-going	Awaiting final report (1 case)
WTWA	12	Investigations on-going:	Awaiting draft report (7 cases) Awaiting final report (3 cases) Propose to investigate (1 case) Scoping (1 case)
Dental	2	Investigations on-going	Awaiting draft report (1 case) Awaiting final report (1 case)
Corporate	1	Investigations on-going	Awaiting draft report (1 case)
Total	**41***		

*Please note the total number of cases (41) displayed in Table 8 is higher than the 28 cases under review as a number of the 28 PHSO ongoing cases involve multiple Hospitals/MCS's.

6.3 The PHSO closed 5 cases in Quarter 2, 2018/19; of these cases 1 case was partially upheld and 4 cases were not upheld, indicating that these complaints were managed effectively by the Trust.

Table 8: PHSO closed cases in Quarter 2, 2018/19 presented by outcome.

Division/ Hospital	Outcome	Date original complaint received	PHSO Rationale/ Decision	Recommendations
WTWA	Not upheld	10/4/2017	No failings found	None
SMH	Not upheld	21/12/2017	No failings found	None
MRI (Surgery)	Partially upheld	15/9/2017	Failings in care, treatment and communication	Provide a full acknowledgement and apology for the impact of the failings identified in the report. Explain what actions have been taken to address the failings identified in the report
MRI (DMACS) & WTWA	Not Up-held	11/5/2018	No failings found	None
MRI (Surgery) & CSS	Not Up-held	2/3/2018	No failings found	None

6.4 The PHSO Strategy, ***'Our Strategy 2018-2021: Delivering an exemplary ombudsman service'*** launched earlier this year, sets out the PHSO's vision to be an exemplary public services ombudsman. They commit to do this by providing an independent, impartial and fair complaints resolution service, while using their casework to help raise standards and improve public services.

The Strategy outlines 3 key objectives for 2018-2021:

Objective 1: to improve the quality of our service, while remaining independent, impartial and fair

Objective 2: To increase the transparency and impact of our casework

Objective 3: To work in partnership to improve public services, especially frontline complaint handling

The starting point for delivering these objectives has been to refocus on the Ombudsman's core role in making final decisions on complaints, including on those cases in the NHS where complainants have raised issues regarding what they perceive as clinical failings.

6.5 In the Quarter 1 Complaints Report the Group Board of Directors were asked to note that the PHSO introduced a new clinical standard in August 2018, the ***'Ombudsman's Clinical Standard',*** in an attempt to provide greater clarity and predictability as to how the PHSO consider the appropriateness of care and treatment.

6.6 Following the launch of the 'Ombudsman Clinical Standard' the PHSO published a consultation paper, the September 2018 as part of their ***'Clinical Advice Review'***.

The PHSO explained that as part of their commitment in their new three-year strategy the Clinical Advice Review Consultation formed a major aspect of their evaluation of the PHSO's clinical advice process, to ensure that their use of clinical advice is consistent with their new organisational values of independence, fairness, excellence and transparency.

For complaints about NHS clinical care and treatment in England, the PHSO are consulting on the principles that underpin their use of clinical advice, the level of transparency that they have with complainants and organisations they investigate with regard to sharing information, as well as the recently published ***'Ombudsman's Clinical Standard'.***

Information about the consultation was circulated to the Group/ Hospital/ MCS Medical Directors to circulate to clinicians so that they have the opportunity to respond to the consultation. In addition the Assistant Chief Nurse (Quality and Professional Practice) attended a round table discussion organised by the PHSO's office, chaired by Sir Alex Allan, Non-Executive Director, PHSO, and Sir Liam Donaldson, Independent Adviser to Ombudsman's Clinical Advice Review and the Ombudsman, Rob Behrens. The intention of the round table discussion was to seek the views of healthcare professionals, complaint handlers and those with experience of using clinical advice in other settings. The Assistant Chief Nurse discussed relevant cases studies with the PHSO specifically examples when MFT clinicians had different views compared to the Clinical Advisors and the process for debate.

6.7 In September 2018, the PHSO also published ***'Complaints about the NHS in England (Quarter 1 – 2018/2019)'***. The report presents statistics on complaints about the NHS in England from April to June 2018 (Quarter 1). It presents national data about the NHS complaints received, assessed and investigated by the PHSO, as well as the recommendations made by the Trust during this period.

6.10 When the PHSO identifies failings, they make recommendations to organisations to put things right. Each case can have more than one recommendation. In Quarter 1, for complaints about the NHS the PHSO upheld or partly upheld they made the following recommendations to organisations to put things right:

- Formal Apologies – 125 complaints
- Payments – 75 complaints involved payments to make up for financial loss or to recognise the impact of what went wrong. This totalled £44,426 from the NHS organisations the PHSO investigated.
- Service improvements – 103 complaints involved recommendations such as changing procedures or training staff
- Other Actions – 31 complaints involved other actions such as asking an organisation to correct errors in medical records.

In Quarter 1 MFT were required to make 1 payment of £100 and none in Quarter 2.

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 10** demonstrates how learning from a selection of complaints has been applied in practice to contribute to continuous service improvement within the Hospitals/ MCSs.

Table 10: Examples of the application of learning from complaints to improve services, Quarter 2, 2018/19

Hospital	Learning & Improvements
CSS	**Imaging : Communication, Patient Experience and Dignity** A woman with chronic conditions that affected her mobility underwent an investigation in the Radiology Department. She expressed concerns regarding how she was communicated with and felt that she was not listened to. She felt there was little consideration or support offered regarding her mobility issues and there was a lack of information before the procedure regarding what to expect. She also felt that the medical knowledge of the staff involved made communication difficult. As a direct result of this complaint the following actions were taken : ▪ The type of examination undertaken will be undertaken on a dedicated list with sufficient time allowed to ensure patients are fully supported and ensure they have a good standard of care throughout their investigations. ▪ The departmental team will ensure there is always a female radiographer in the CT scanner to ensure there is no delay in the process of identifying a chaperone to support patients when intimate procedures are being undertaken. ▪ The departmental team will ensure that two fully trained CT Radiographers are in the department or a Senior CT radiographer with a significant number of years' experience to supervise and support junior staff. ▪ The Lead Radiographer will facilitate further training related to medicines commonly administrated in the department for all staff administering medicines to patients, to ensure they are aware of the contraindications of the medicines.

	▪ The complaint was shared amongst the team and all staff informed off the requirement to assist patients to change when help is required. **Allied Health Professionals: Communication, Service Improvement and Patient Experience** A woman who has high functioning autism and has struggled with debilitating monthly migraine headaches for the past sixteen years attended the Conditions Management Course at the Therapy Outpatients Department, which is managed by the Occupational Therapy Team. The patient was concerned that despite working extremely hard to maintain her physical and mental wellbeing that this course did not meet her needs and left her feeling demoralised and stressed. In response to this complaint the following actions have been taken: ▪ Feedback was given directly to the Senior Specialist Occupational Therapist and the Specialist Occupational Therapist who lead the course. ▪ A review been undertaken of the content of the course, specifically in relation to the concerns raised by the patient including establishing ground rules, individual goal setting and improved resource information. ▪ The senior team attended the course to observe and feedback the other issues the patient raised such as building empathy, acknowledgement of achievements and confidence of delivery. They also considered any training needs for the staff involved in delivering the course. ▪ The team also undertook a review of the mechanism for feedback from the attendees of the course, including the possibility of anonymising the post-course feedback, to make it easier for patients to provide honest feedback.
MREH	**Prescription Transcribing Error** A patient contacted the PALS to make a formal complaint about an incorrect prescription for his glasses. The patient explained his frustration and wanted to know why the incorrect glasses had been prescribed. The patient underwent a refraction test (a vision test that identifies what prescription is required in glasses or contact lenses) and a pair of progressive varifocal lenses was dispensed. Once the lenses were received and checked by the Dispensing Optician they were posted to the patient. The patient returned to the hospital a few days later to advise that he was not happy with the glasses. The Dispensing Manager checked the strength of the lenses against the electronic prescription and confirmed the glasses had been made according to the electronic prescription that had been generated. The manager thought that the patient was not satisfied with the thickness of the lenses in the new glasses and so he ordered new lenses for the patient made from a high refractive index material and when received these were posted to the patient. The higher the refractive index of the glasses lens material, the thinner the finished glass.

	However the patient returned again to the hospital explaining that he was still having problems with the new glasses. The patient's medical records were requested, and on checking the records the Dispensing Manager noted that there had been a typographical error when transferring the prescription information from the paper prescription to the electronic version. As a direct result of this complaint if a patient identifies that they are experiencing problems with their new glasses that have been dispensed, the Dispensing Optician's initial action will be to request the patient's medical records and check the original prescription.
MRI (Surgery)	**Communication issues leading to late cancellation of surgery** A complaint was received from a patient who waited for 1½ hours for an outpatient appointment due to a reception administrative error. The investigation into the concerns raised, identified that the patient arrived for their outpatient appointment at 09.30 hours after fasting since 20.00 hours the night before. The receptionist did not put the patient's notes out for the nursing staff hence the nursing team did not realise that the patient had arrived. This led to the patient experiencing an extended delay in being seen by the doctor. The investigation into the concerns raised by the patient identified that this incident was a genuine human error. A full review of the booking-in process in the Outpatient Department has been undertaken by the Assistant Directorate Manager and the Matron. In addition the implementation of a computerised booking and patient call facility is underway for the Outpatient Department to minimise the risk of this type of incident recurring in the future.
MRI (Medicine)	**Infection prevention precautions leading to isolation** A recent complaint was received and investigated by the Acute Medical Unit team, the learning from which is applicable across the organisation. The complaint raised a number of issues regarding communication between staff and the patient when infection prevention precautions were taken and the patient placed in a side room for isolation purposes. Whilst there were a number of issues raised, it was clear from the investigation that when the patient was isolated and precautions, such as face masks, were used as part of the precautions this led to the patient feeling isolated. The patient also felt that the ward team became guarded following the infection prevention precautions being put in place. It was recognised that this is not the standard of care we would wish for our patients to receive. Further, while the ward team felt that they had explained the precautions to the patient, there was a disparity with the patients understanding, which added to the distress caused. As a result of the complaint, discussions have taken place on the ward regarding the learning from the complaint and the steps that the ward team could take to prevent this experience for patients in the future.

MRI (SMS)	**Issues with ordering process** A complaint was received that outlines the frustration caused to a patient who tried to ring to order supplies from the Diabetes Centre. **Lessons Learnt:** The process at the Diabetes Centre for ordering supplies was complex, after calling the phone number given and opting for the 'ordering line' a patient was put through a series of automated messages, which eventually led to a voicemail where they were told they could leave a message, at that point the phone would cut out with no option to leave a message. The patient then opted for the 'appointments line' where she got through to a member of staff who took down her details. The staff member said she did not deal with orders so promised to pass the message on to a colleague who would call her back. This did not happen and the patient was left without supplies or any communication. The patient made a formal complaint about her experiences. As a direct result of the complaint: ▪ The Diabetic Centre's team have revised the process for ordering supplies and established a robust process for placing orders via email or phone, which are now recorded. ▪ The Diabetic Centre's team have introduced a process to confirm all orders with the patient, received from both emails and telephone calls. ▪ All administration staff have been reminded of the importance of recording messages and sharing these messages with appropriate staff at the team meeting. ▪ All administrative staff have been briefed and trained on the new ordering processes.
SMH	**Positive Communication, Environment of Care, Leadership.** **Recognising Domestic Abuse** A patient attended the Emergency Gynaecology Unit (EGU) a number of times during her pregnancy in 2016, complaining of stomach ache, bleeding and sickness. The team examined the lady and undertook scans on every occasion, but no cause for her symptoms were found and there was no reported cause for concern. The lady attended with her partner who remained present at all times, speaking on her behalf, and asking questions for her. The lady did not disclose the fact that she was a victim of domestic abuse but in her complaint in 2018, advised that she felt that both the nursing and medical personnel had missed a lot of warning signs and she felt very let down. When reviewing the electronic patient records, the Ward Manager identified that on 3 occasions the nursing staff had indicated that the lady had been 'unable to answer' when asked if there was any domestic violence / abuse and on one occasion had answered no. The normal practice of the nursing staff, if they were concerned or identified unhealthy behaviours, would be to create a situation in which the lady can safely by separated from her partner and given an opportunity to voice any concerns. However, in an area like EGU, partners are very often concerned and involved in the care and share

	the women's worries and fears over the pregnancy, so the nursing and medical team did not identify this behaviour as significant. **Actions:** ▪ The Ward Manager has shared the lady's concerns with the team to raise their awareness and understanding that although when asked, women may still not disclose abuse that they should always consider the environment and behaviour of individuals at the time and consider the previous history. ▪ The Information Technology Department have been asked to change the options on the Electronic Patient Record, Domestic Abuse Section to 'unable to ask question safely' with a free text box to state the reason why. This will enable the next member of staff reviewing the patient in EGU to identify that the question has not been answered and highlight the need for follow up. ▪ The team in EGU follow the Trust policy for Domestic Violence and Abuse Policy and receive training about asking the question safely. All staff complete mandatory online safeguarding training and have a full day face to face safeguarding training every three years. The Ward Manager has ensured that all members of her team are up to date with their training
RMCH	**Surgical and Nursing Care – Delayed Diagnosis** A complaint was received from a patient's mother concerned that her son's knee was dislocated following hip reconstruction surgery and no one realised for several days. She alleged there was insufficient padding on the cast resulting in her son suffering cuts and she was also concerned that the nursing care regarding pain management and cannula care was poor. On investigating the concerns it was identified that the child had corrective hip surgery on 3rd May 2018 and as a result a hip spica (orthopaedic cast used to immobilize the hip or thigh) was fitted to promote healing of the hip joints. The spica was well padded during theatre. The patient was admitted to the Paediatric High Dependency Unit post operatively so that he could be closely observed and receive sufficient analgesia. Spica casts may need trimming and additional padding added and this should be done within 24 hours of the spica being fitted. Unfortunately, the necessary adjustments were not made within 24 hours on this occasion. There were concerns raised about the patient's pain following surgery and the patient was reviewed daily by the orthopaedic team. X-rays had been taken which did not demonstrate any fracture or dislocation. Regular pain relief was administered throughout the patient's admission. As a result of the complaint and to avoid a similar incident happening in the future the following actions have been agreed: ▪ The Paediatric Orthopaedic Team has reviewed the 'Care Plan for a Child with a Hip Spica' and upload to the hospital internet in July 2018 to ensure current guidance is available to all staff. ▪ Nursing staff in Paediatric Critical Care and on Ward 78, receive refresher training on how to care for a patient with a spica cast.

	▪ Nursing staff on wards to be reminded about how they should move/handle patients unless otherwise agreed with family. ▪ Ward Manager, Ward 78 to ensure all children with communication difficulties are supported to communicate effectively, by ensuring the correct tools/aids are available and involving other health care professionals and their families. ▪ Ward 78 will continue the quality improvement work looking at effective pain management
UDHM	**Communication about appointments** A patient contacted PALS enquiring about her next appointment with one of the undergraduate students and was told 'that she had been discharged from the hospital'. The patient wanted to know why she had been discharged in the first instance and why this had not been communicated to her. The patient stated that she had been left with treatment that was half-finished and felt that this was a risk to her health. The patient had arranged with the treating undergraduate student to postpone two of her arranged appointments as she was scheduled to undergo surgery at Manchester Royal Infirmary (MRI). The investigation into the concerns raised identified that the communication with the student regarding the postponement of the patient's appointments were not recorded within the Electronic Patient Record (EPR) and so this information was not visible to PALS when the patient contacted them enquiring about her appointment. The PALS team assumed the patient was discharged as patients who do not regularly attend their appointment are discharged. The investigation also identified that the student had completed her training and had left the University and therefore if the patient had not enquired about her appointment she would not have been contacted for a further appointment. Following discussion with the Director of Undergraduate Education in response to this complaint and other informal PALS queries related student patients being lost in the system; he confirmed that, patients undergoing student treatment will become the responsibility of the supervising clinician/consultant rather than the University Year Lead. This will ensure that patients are not lost in the system when a student graduates from the University and will ensure continuity of treatment.
WTWA (Heart and Lung)	**Respiratory – Wilson Ward** An acutely unwell patient who subsequently deteriorated, and was at the end of their life was placed in a noisy bay with frail patients who had dementia. A complaint received by a family member identified that communication was poor about the patient had been placed in this area. In addition, concerns had been raised by family members about aspects of nursing care including oral hygiene and management of the patient's oedematous legs. Actions: ▪ The Matron and Ward Consultant met with the patient's family following receipt of the formal complaint to understand their concerns. ▪ A 'Mouth Care Matters' campaign will be launched and the launch will have a specific focus on Wilson Ward.

WTWA (Division of Medicine)	▪ Tissue Viability link nurses have been identified on the ward to ensure nursing staff receive education and training and have the appropriate skills to manage patients' skin integrity in line with Trust policy. ▪ Divisional Matron to work with the Ward Manager and Patient Flow Team to ensure patients are allocated an appropriate bed to meet their needs. ▪ Strengthen leadership roles across the division for the nurse in charge role to ensure patients and relatives are effectively communicated with in a timely manner. **Communication regarding End of Life Care:** A gentleman was admitted to the Stroke Unit following an Ischaemic stroke. The patient deteriorated quickly and passed away days after admission. The patient's daughter stated in her complaint that the family understood that her father was being nursed on a rehabilitation ward, she felt that although he looked very unwell that this meant he had the potential to get better. The complaint stated that the team on the ward did not communicate with the family that the patient was at the end of his life and when he passed away it was a significant shock to the family. The family felt angry and stated that had they known his death was so imminent they would have made different plans and spent more time with him. **Actions:** ▪ The Ward Manager has shared the complaint with the multi-professional team on the ward. ▪ The treatment plan and how this is to be communicated with patients and their families is now discussed at daily MDT board rounds on the Stroke Unit. ▪ The use of the RESPECT form has been introduced since this incident and all medical staff are encouraged to have conversations with patients and their relatives regarding future care and their wishes at end of life. ▪ Divisional Matron has liaised with the Palliative Care Team to arrange additional education and training to support staff in having difficult conversations.
Trafford	▪ All ward nursing staff are booked to attend Sage and Thyme training. A complaint was received from the daughter of an elderly patient on Ward 6. There were concerns that appropriate care was not being provided to her mother due to insufficient staffing levels, leading to deterioration in the patients' health. A review of ward based staffing was undertaken at Trafford Hospital, including Ward 6 and actions and improvements were identified and taken. **Actions:** ▪ Ward 6 closed 8 beds due to nurse staffing vacancies. This has resulted in the appropriate staffing numbers being available to meet the care needs of the patient whilst recruitment to vacant posts is underway.

WTWA (Division of Surgery)	▪ Meal Time Champions have been introduced on Ward 6, to ensure that all patients received their chosen meals and that the MFT Meal Time Standards were met. ▪ An Improving Quality Session is planned, to focus on the completion of hydration charts to improve compliance against required standards. ▪ The Matron for Medicine has relocated to an office closer to Ward 6 to enable monitoring of the ward and is undertaking Matrons Assurance Rounds to monitor the standards of care provided to patients. ▪ The complaint has been shared with the Ward 6 multi-professional team. **Communication** A patient was admitted to the Treatment and Day Case (TDC) unit for a skin graft procedure. The area being harvested for a skin graft had topical anaesthetic cream applied prior to the procedure. The nurse caring for the patient was facing the patient and reassuring her, but had their back turned away from the operation site. During the harvesting of the skin the patient experienced pain. As the nurse was under the impression that the skin graft procedure was complete, no further local anaesthetic was requested for the patient. However, the surgeon required more skin to be harvested to complete the skin graft and therefore performed a second harvest procedure, which the patient found very painful. The patient raised concerns that she felt that no-one advocated for her during the procedure and that she experienced a very painful procedure. **Findings:** ▪ As the nurse was facing the patient during the procedure, she could not see that the surgeon required further skin, which necessitated a second harvest from the donor site. Had the nurse been aware of the second harvest she would have advised the Surgeon that additional local anaesthetic was required. ▪ Although the clinical team recognised that the first skin harvest was painful, they underestimated the level of pain that was experienced by the patient. **The following actions were taken immediately following receipt of the complaint:** ▪ The Acute Pain Team completed a number of training sessions in the TDC Unit. ▪ The complainant has met with the Clinical Director and Lead Nurse, who were able to answer her concerns and provide assurance regarding lessons learnt. ▪ The complaint has been discussed with the Theatre team and medical staff involved. The complaint has been shared as a 7 minute briefing paper at staffing huddles. ▪ The cognitive pain score has been introduced across the theatre complexes to provide an additional method to assess patients' pain. ▪ The complaint was used as means of educating theatre staff and sharing lessons learnt.

8. Developments and Service Improvements

8.1 Benefits of the new MFT Ulysses Complaint Module.

Following the introduction of the new single Ulysses Complaint Module in Quarter 1, 2018/19, work has continued throughout Quarter 2 tailoring and configuring the MFT Module to meet the specific needs of the Hospitals/ MCSs and MLCO. The system provides a single streamlined clinical governance process across all sites using the same data sets. The database is accessible for all staff across all sites within MFT and enables a more robust data sharing throughout the Trust. Key aspects of this reporting alignment has been successfully achieved and work will continue until full alignment is realised by Quarter 4 2018/19.

8.2 Single Hospital Service

Work continued during Quarter 2, 2018/19 to align the complaints processes of the legacy Trusts to ensure Manchester University NHS Foundation Trust maintains compliance with the NHS Complaints regulations (2009).

Following the devolvement of accountability for complaints management, which included Quality Control processes and monitoring to the Hospital/MCS/MLCO Chief Executives in Quarter 1, 2018/19 performance continues to be monitored at a Group level via the Accountability Oversight Framework (AOF).

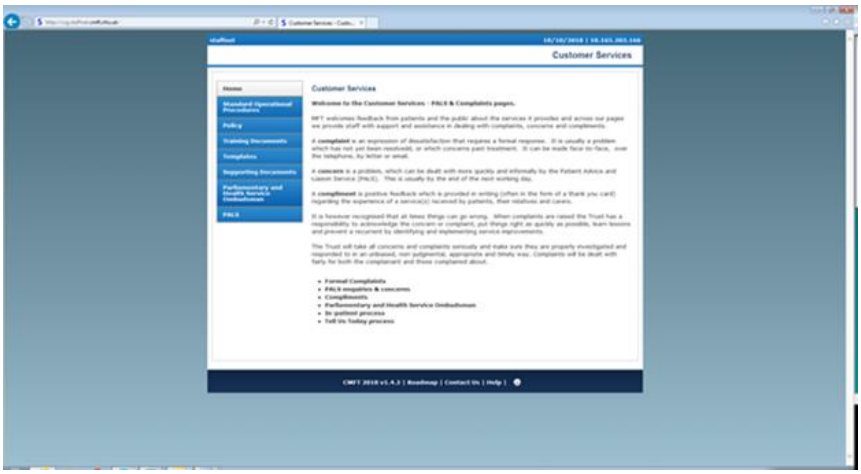
In Quarter 1 Corporate Nursing support was given to Wythenshawe when a backlog was identified. In Quarter 2 Corporate Nursing support has been given to the MRI as both the number of complaints and complaints over 41 days were increasing.

8.3 MFT Complaints, Concerns and Complaints Policy (2018)

During Quarter 2, 2018/19 the MFT Compliments, Concerns and Complaints Policy (2018) was ratified at the Group Quality and Committee and circulated widely across the Trust. The policy provides a framework for MFT to meet the requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations (2009) and provides staff with support and assistance in dealing with complaints, concerns and compliments.

In addition during Quarter 2, 2018/19 the Corporate PALS team have updated the ‘Customer Services’ section on the new MFT Trust Intranet. The key aspects of the updates include links to:

- The Compliments, Concerns and Complaints Policy (2018)
- Safeguard training documents
- Writing a good complaint response
- Writing a good compliment response
- The MFT PALS Leaflet
- Guidance on the Tell us Today process
- The informal PALS inpatient process



8.4 **'Tell us Today'** is a service that enables inpatients and their families to escalate concerns in real time via a dedicated telephone number to a senior nurse/ manager so that the issues can be resolved, the patient's experience improved and potentially a formal complaint averted.

'Tell us Today' has been aligned with the ***'What Matters to Me'*** Programme and was re-launched on Monday 17th September 2018. As a result all promotional material has been re-designed, condensed and simplified in order to ensure all inpatient concerns received via the **'Tell us Today'** are captured appropriately. Since the launch there have been no contacts recorded.

'Tell us Today' now appears as a combined graphic on the bedside entertainment screens and is highly visible to patients and visitors.

8.5 **Planned relocation of PALS office at Wythenshawe Hospital**

Plans are currently underway to re-locate the Wythenshawe PALS service to a more visible, accessible location within Entrance 5, Wythenshawe Hospital. An update on progress will be provided in future reports.

8.6 **Educational Sessions**

Following the previous successful educational sessions for staff involved in responding to complaints, further Complaints Educational Sessions were arranged by the Corporate PALS team and facilitated at Wythenshawe Hospital, Royal Manchester Children's Hospital and Manchester Royal Infirmary during Quarter 2, 2018/19.

Further Complaints Educational Sessions and Safeguard Master Classes will be held across the Hospitals and will be arranged throughout Quarter 3 and 4, 2018/19.

8.7 Complainant's Satisfaction Survey

The Complaints Satisfaction Survey is based upon ***'My Expectations'***[1] paper and has been developed by the Picker Institute. It is sent to complainants covering all MFT Hospitals/MCS/MLCO and during Quarter 2, 2018/19 33 responses to the survey were received.

8.8 Survey results for Quarter 2, 2018/19 indicate:

- 68.97% of complainants felt that they received acknowledgement of their complaint within an acceptable time frame.
- 61.29% of complainants felt that they were taken seriously when they first raised their complaint.
- 56.67% of complainants found it easy to make their complaint.
- 94.0% of complainants felt they were made aware of their right to take their complaint further, if they were not completely satisfied with the outcome and/or recommendations.
- 51.85% of complainants felt that their complaint was handled professionally by the Trust.

8.9 Comments received during Quarter 2, 2018/19 include the following:

- Was quite impressed by how seriously it was taken.
- Perhaps the manager in charge could have simply picked up the phone and called me?
- I worked clinically in the NHS for 37 years, so understand the process well, which may affect my perception. A clearer explanation of why it takes so long would be useful for those who have no knowledge/experience. The formal response should be checked for accuracy – both factual and grammatical.
- I thought the whole process was dealt with in a very professional manner and I thank you for that under the constant pressures you must be under. We all make mistakes we are only human after all nice to know that everything can be resolved.
- Perhaps the manager in charge could have simply picked up the phone and called me?
- Please pass my thanks to the Complaints team who dealt with my case very quickly and professionally.
- The complaint should have been taken seriously and lessons learnt from it. I felt my complaint was just dismissed out of hand.

9. Equality and Diversity Monitoring Information

9.1 **Table 11** provides Equality and Diversity information gathered from complainants for Quarter 2, 2018/19. The collection of Equality and Diversity data has improved since the introduction of the new Complaints Satisfaction Survey, however it is clear that this is not consistent across all Hospitals/MCS/MLCO. Work continues to improve the quality of data across the Trust.

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

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

Table 11: Quarter 2, 2018/19 Equality and Diversity monitoring information

Disability	
Yes	38
No	76
Not Disclosed	289
Total	**403**
Disability Type	
Learning Difficulty/Disability	0
Long-Standing Illness Or Health Condition	20
Mental Health Condition	8
No Disability	0
Other Disability	3
Physical Impairment	7
Sensory Impairment	0
Not Disclosed	365
Total	**403**
Gender	
Male	185
Female	199
Transgender	0
Not disclosed	19
Total	**403**
Sexual Orientation	
Heterosexual	105
Lesbian / Gay/Bi-sexual	6
Do not wish to answer	1
Not disclosed	291
Total	**403**
Religion/Belief	
Buddhist	1
Christianity (All Denominations)	64
Do Not Wish To Answer	287
Muslim	7
No Religion	30
Other	9
Sikh	0
Jewish	4
Hindu	1
Not disclosed	0
Total	**403**
Ethnic Group	
White – British	99
White – Irish	1
White – Other	3
Asian or Asian British – Bangladeshi	0
Asian or Asian British – Indian	2
Asian or Asian British – Pakistani	5
Asian or Asian British – Other Asian	2
Black or Black British – Caribbean	3
Black or Black British – African	4
Black or Black British – other Black	2
Mixed – White and Asian	1

Mixed - White and Black Caribbean	4
Mixed – Other Mixed	0
Any other ethnic group	5
Do not wish to answer	65
Not stated	207
Total	**403**

10. Conclusion

10.1 The Group Board of Directors is asked to note the content of the Quarter 2, 2018/19 Complaints Report and the on-going work of both the corporate teams and the Hospital/MCS/MLCO teams to ensure that the Trust is responsive to concerns raised and learns from patient feedback in order to continuously improve the patient's experience. 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.
- Pilot the use of the newly developed audit tool to review the quality of complaint responses.
- 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)'.***

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Professor Cheryl Lenney, Chief Nurse
Paper prepared by:	Karen Meadowcroft, Corporate Director of Nursing Debra Armstrong, Assistant Chief Nurse, Quality and Professional Practice Lynne Birchall, Head of Nursing, Quality and Patient Experience Pat Jones, Macmillan Lead Cancer Nurse Tracy Kelly, Macmillan Lead Cancer Nurse
Date of paper:	November 2018
Subject:	To provide an analysis of the results of the National Cancer Patient Experience Survey (2017).
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support ✓ • Resolution • Approval
Consideration Of Risk Against Key Priorities:	Delivering an excellent experience for cancer patients, their families and their significant others.
Recommendations:	Members of the Board of Directors are asked to note the content of the report and support the actions required to ensure continuous improvement.
Contact:	Karen Meadowcroft Corporate Director of Nursing Tel:01612768862

1. Executive Summary

1.1 The ***Annual National Cancer Patient Experience Survey*** [NCPES] (2017) provides useful insight which can support continuous improvement of the services provided by Manchester University NHS Foundation Trust (MFT). These findings inform improvement activity for cancer patients at both a strategic and at a local level.

1.2 The results of the NCPES (2017) were published on 28th September 2018 by an external provider (Quality Health) on behalf of NHS England and this report provides an analysis of the results.

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

1.4 Many positive elements of cancer patient experience are identified by the NCPES (2017). Overall, the results for the former CMFT and former UHSM are categorised as 'within the expected range' for Trusts of similar size. It is worthy of note that when comparisons are drawn between other acute care providers within Greater Manchester and the Shelford Group Trusts both former organisations compare favorably.

1.5 Results which fall below the national average will require further analysis by tumour specific teams to identify areas for their local improvement activity. Tumour specific information is available where 21 or more responses have been received. The challenge remains for those tumour groups where responses were less than 21 to consider how we can encourage patients to respond to the future surveys.

2. Introduction

2.1 The results of the NCPES (2017) were published on 28th September 2018 by the external provider (Quality Health) commissioned by NHS England, this paper provides a detailed analysis of the results.

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

2.3 The paper presents the results for the former CMFT and former UHSM compared to the national position and provides a comparison with other acute care providers within Greater Manchester and the Shelford Group Trusts.

2.4 The 2017 results demonstrate overall that the results for the former CMFT and former UHSM are 'within the expected range' for Trusts of similar size and compare favourably with both acute care providers within Greater Manchester and the Shelford Group Trusts.

3. Background

3.1 Understanding patients' experiences of cancer care and treatment provides key information about the quality of services, and this can be used to drive improvement in cancer services both locally and nationally[1].

3.2 The NCPES is designed to monitor national progress on cancer care and is scheduled on an annual basis as outlined in the 'National Cancer Strategy: Achieving World Class Cancer Outcomes', (2015). The NCPES (2017) is the 7th iteration of the survey since 2010.

3.3 The survey is commissioned and managed by NHS England. The survey was undertaken on behalf of the legacy Trusts by independent providers Quality Health who administered the survey observing nationally approved methodology. The 2017 NCPES involved a mixed mode methodology, with questionnaires sent by post with two reminders where necessary and an option to complete the survey online by adult NHS patients (aged 16 years and above) with a confirmed primary diagnosis of cancer. Patients who were discharged from the former CMFT and former UHSM after an inpatient or day case episode for cancer related treatment in the months of April, May and June 2017 were included in the survey.

4. Methodology and Sample

4.1 The NCPES methodology used reflects the Care Quality Commission (CQC) standard for reporting comparative performance, based on the calculation of 'expected ranges'. This methodology flags Trusts as outliers only if there is statistical evidence that their scores deviate from the range of scores that would be expected for Trusts of the same size.

4.2 The adjusted sample size (whereby excluded patients are removed from the submitted sample, for example due to death) for the former CMFT was 648 with a response rate of 53%, whilst when compared to 2016 this is an increase in sample of 20 responses. There was deterioration in the percentage response rate by 3% compared to 2016, but with a small deterioration in the amount of completed questionnaires received. The former CMFT response rate was 10% below the national response rate of 63%.

4.3 The former UHSM had an adjusted sample of 690 and a response rate of 60%, compared to 2016, this represents increase in the sample of 40 responses. There was deterioration in the percentage response rate by 6% and deterioration in the number of completed questionnaires received. The former UHSM response rate was 3% below the national response rate of 63%.

Table 1 shows the adjusted sample size and survey response rates for the former CMFT and former UHSM Trusts for 2017 compared to the 2016 and the national response rate for 2017.

[1] National Cancer Strategy – Achieving World Class Cancer Outcomes 2015. https://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf

	Former CMFT 2016	Former CMFT 2017	Former UHSM 2016	Former UHSM 2017	National 2017
Sample size	628	648	650	690	110,449
Completed	350	346	430	417	69,072
Response rate	56%	53% based on adjusted sample size of 648	66%	60% based on adjusted sample size of 690	63%

Table 1: Sample size and response rates for the former CMFT and former UHSM

4.4 The gender distribution for both the former CMFT and former UHSM differed, with more male respondents from the former CMFT and more female respondents from the former UHSM. This higher female response rate at the former UHSM is reflective of the delivery of Breast and Gynaecological Cancer Services at Wythenshawe Hospital, with the two services receiving 144 of the 417 total of responses. **Table 2** shows the gender profile of the 2017 survey sample.

Gender	Former CMFT	Former UHSM
Male	215 (62%)	152 (36.5%)
Female	131 (38%)	265 (63.5%)
Total	**346**	**417**

Table 2: Gender Profile of the Sample the former CMFT and former UHSM

4.5 **Table 3** shows the age profile of the 2017 survey sample with the single highest age range of respondents for both the former CMFT and the former UHSM identified as the 65-74 age range, with a total of 59% of respondents aged between 55-84 years for the former CMFT and 81% of respondents aged between 55-84 years for the former UHSM.

AGE	Former CMFT MALE	Former CMFT FEMALE	Former CMFT TOTAL	Former UHSM MALE	Former UHSM FEMALE	Former UHSM TOTAL	MFT TOTAL
16-24	0	1	1	0	0	0	1
25-34	4	3	7	0	1	1	8
35-44	9	3	12	2	6	8	20
45-54	19	17	36	7	41	48	84

55-64	43	26	69	21	67	88	157
65-74	91	46	137	65	105	170	307
75-84	41	27	68	46	34	80	148
85+	8	8	16	11	11	22	38
Total	**215**	**131**	**346**	**152**	**265**	**417**	**763**

Table 3: Age profile of the 2017 survey sample

4.6 The survey is structured into eleven thematic sections with an overall care score, as follows:

1. **Seeing your GP**
2. **Diagnostic Tests**
3. **Finding out what was wrong you**
4. **Deciding the best treatment for you**
5. **Clinical Nurse Specialist**
6. **Support for Cancer Patients**
7. **Operations**
8. **Hospital care as an inpatient**
9. **Hospital care as a day patient / outpatient**
10. **Home care and support**
11. **Care from general practice**
12. **Overall NHS Care**

4.7 The report presents both unadjusted and adjusted data. The survey guidance[2] explains that unadjusted data should be used to review the actual responses from patients relating to the Trust and case-mix adjusted data, together with expected ranges, should be used to understand whether the results are significantly higher or lower than national results.

4.8 Where tumour groups have 20 or less responses, no tumour-specific analysis has been provided. Responses for questions with 1-20 respondents are suppressed, to protect patient confidentiality and because uncertainty around the result is too great. For the former CMFT, responses continue to remain low for Lung, Sarcoma and Head & Neck cancer services, whilst Haematology patients continue to provide the largest cohort of responses, constituting 37% of the overall response rate. For the former UHSM, responses from Breast and Lung cancer patients constitute 71% of the overall response rate.

Table 4 shows the number of former CMFT and former UHSM patient responses by tumour group in the 2017 survey sample.

Tumour group	Number of responses former CMFT 2016	Number of responses former CMFT 2017	Number of responses former UHSM 2016	Number of responses former UHSM 2017

[2] National Cancer Patient Experience Survey (2017): National Results Summary. Available from: http://www.ncpes.co.uk/reports/2017-reports/national-reports-2/3579-cpes-2017-national-report/file

Brain & CNS	**0***	**0***	**0***	**1***
Breast	**0***	**0***	**113**	**138**
Haematology	**126**	**127**	**6**	**1**
Upper GI**	**35**	**30**	**10**	**4**
Gynaecology	**34**	**33**	**4**	**6**
Urology Other	**43**	**26**	**44**	**15**
Colorectal	**27**	**36**	**27**	**29**
Urology Prostate	**26**	**20**	**27**	**23**
Head& Neck	**16**	**14**	**13**	**16**
Sarcoma	**3**	**9**	**4**	**4**
Lung	**13**	**14**	**126**	**159**
Skin	**0***	**0***	**11**	**4**
Other	**25**	**37**	**45**	**17**

Table 4: Number of responses by Tumour Group for the former CMFT and former UHSM

***** The former CMFT and former UHSM do not treat Brain and CNS Cancers, nor does former CMFT treat patients with skin or breast cancer.
****** Upper GI includes patients diagnosed with liver, pancreatic or gall bladder cancer (HPB).

5. Results for the former CMFT and former UHSM

5.1 In line with previous surveys, patients were asked to rate their overall quality of care on a scale of 0 (very poor) to 10 (very good).

5.2 In comparison to the national benchmark score of 8.8 the overall score for the former CMFT was 8.9 (0.1 above the national benchmark) and overall score for UHSM was 8.8(in line with the national benchmark).

5.3 The overall quality experience scores for the Greater Manchester and East Cheshire Trusts ranged from 8.6 to 9.0, as demonstrated in **Chart 1**. The former CMFT score of 8.9 placed the Trust in joint 2nd position alongside the Christie NHS Foundation Trust, with the former UHSM score of 8.8 placing the Trust in 4th position.

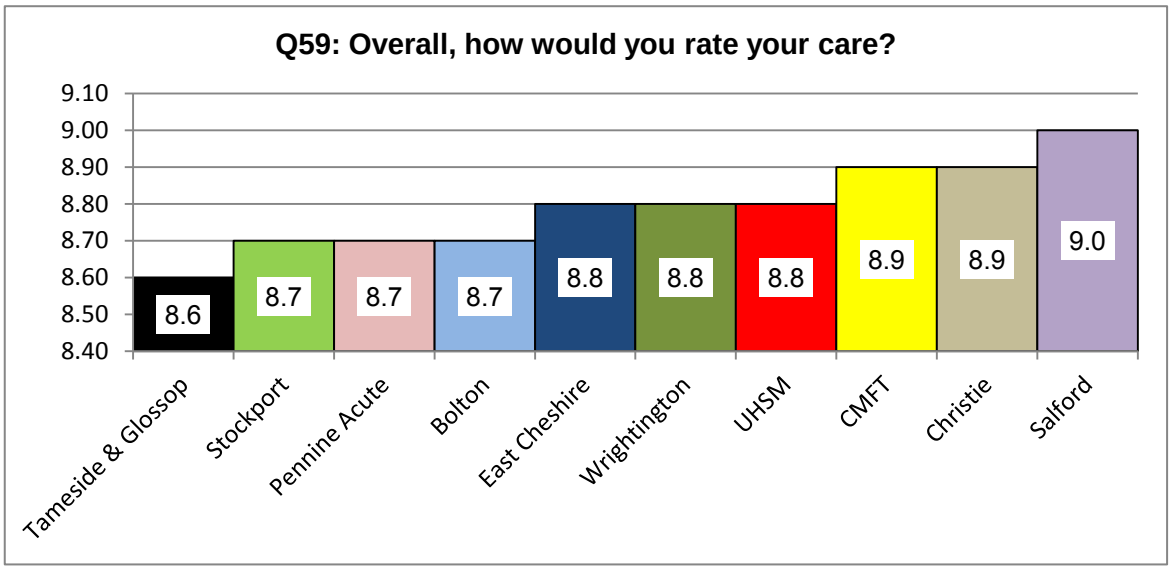


Chart 1: Greater Manchester/East Cheshire scores for overall quality of care

5.4 The overall quality experience scores for the Shelford Group Trusts also ranged between 8.6-9.0, as demonstrated in Chart 2. The former CMFT score of 8.9 placed the Trust in joint 3rd position, with the former UHSM score of 8.8 placing the Trust in joint 5th position. It is recognised that the former UHSM was not previously part of the 10 Shelford Group Trusts but has been included for completeness.

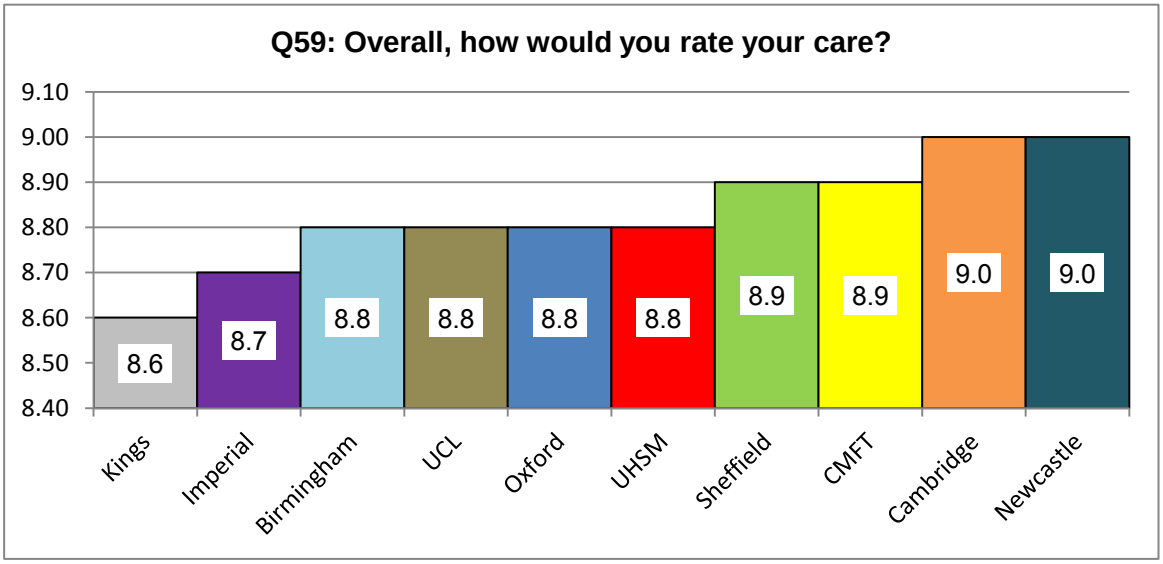


Chart 2: Shelford Group Trust scores for overall quality of care

5.5 The Cancer Dashboard[3], co-produced by NHS England and Public Health England, is designed as a tool to help clinical leaders, commissioners and providers to quickly and easily identify priority areas for improvement in their cancer services. There are six questions included in the NCPES (2017) from the Cancer Dashboard, with the questions reflecting what are considered four key patient experience domains:

- **Provision of information**
- **Involvement in decisions**
- **Care transition**
- **Interpersonal relations, respect and dignity**

5.6 The former CMFT performed higher than the national average in three questions and lower than the national average in the remaining three questions. The former UHSM performed higher than the national average in four questions and lower than the national average in the remaining two questions.

Table 5 provides detail of the former CMFT and former UHSM performance against the six National Dashboard questions.

Cancer Dashboard Questions	National Result 2017	Former CMFT Result 2017	Former UHSM Result 2017
% of respondents said that they were definitely involved as much as they wanted to be in decisions about their care and treatment	79%	81%	80%
% of respondents said that they were given the name of a Clinical Nurse Specialist who would support them through their treatment	91%	92%	93%
% of respondents said that it had been 'quite easy' or 'very easy' to contact their Clinical Nurse Specialist	86%	90%	87%
% of respondents said that, overall, they were always treated with dignity and respect while they were in hospital	89%	86%	87%
% of respondents said that hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital	94%	92%	92%
% of respondents said that they thought the GPs and nurses at their general practice definitely did everything they could to support them while they were having cancer treatment.	60%	57%	62%

Table 5: Former CMFT and former UHSM performance on Cancer Dashboard Questions

[3] National Cancer Dashboard. Available from: https://www.cancerdata.nhs.uk/dashboard#?tab=Overview

5.7 The comparison of the six Cancer Dashboard questions for the Shelford Group Trusts is provided at **Appendix 1.** Worthy of note as part of the Shelford Trust comparison the former CMFT secured 1st position and former UHSM 4th position in relationship to the question about the ease of contacting the Clinical Nurse Specialist (question 18), indicating that on the whole, patients know how to contact their key worker. The former CMFT registered as 8th and the former UHSM 9th in relationship to the question about knowing who to contact after leaving hospital (question 39).Specifically **high** scores (score above the national expected range) were received for one question for the former CMFT and two questions for the former UHSM, as detailed below:

Former CMFT:

Question	**National**	**CMFT**
Q51. Patient definitely given enough support from health or social services after treatment	45%	**56%**

Former UHSM:

Question	**National**	**UHSM**
Q9. Patient felt they were told sensitively that they had cancer	85%	**89%**
Q29. Patient had confidence and trust in all doctors treating them	85%	**90%**

In addition, for former CMFT, the question in the NCPES (2017) related to staff asking patients about their preferred name has shown continued improvement since 2015.

Question	**2015**	**2016**	**2017**
Q33. All staff asked patient what name they preferred to be called by	55%	67%	**70%**

Specifically **low** scores (score below the national expected range) were received for three questions for the former CMFT and two questions for the former UHSM, as detailed below:

Former CMFT:

Question	**National**	**CMFT**
Q31. Patient had confidence and trust in all ward nurses	76%	**67%**
Q38. Given clear written information about what should/should not do post discharge	86%	**80%**
Q52. GP given enough information about a patient's condition and treatment	95%	**92%**

Former UHSM:

Question	National	UHSM
Q23. Hospital staff told patient they could get free prescriptions	81%	**74%**
Q38. Given clear written information about what should/should not do post discharge	86%	**82%**

In addition, for former UHSM, whilst the score related to whether staff explained how the operation had gone in an understandable way has deteriorated the response score was 'within the expected range':

Question	2016	2017
Q26 Staff Explained how operation had gone in understandable way	86%	**76%**

6. Tumour Specific Analysis

6.1 Results for tumour-specific groups are provided where 21 or more patients have responded. For the NCPES (2017) the Trust's received non-adjusted tumour-specific scores for the following tumour groups (**Table 6).**

Former CMFT	Former UHSM
▪ Haematology ▪ Gynaecology ▪ Colorectal ▪ Upper GI (HPB) ▪ Urology ▪ Other	▪ Breast ▪ Lung ▪ Colorectal ▪ Prostate

Table 6: Tumour-specific groups with tumour-specific results

6.2 The available tumour-specific results for the former CMFT demonstrate that patients from the Haematology and Gynaecology services have reported a generally positive experience, with a number of scores above the national average. **In contrast** Colorectal, Upper GI (HPB) and Urology services, whilst areas of improvement are identifiable, the scores in a number of areas were below the national average.

6.3 The available tumour-specific results for the former UHSM demonstrate that patients from the Colorectal, Lung and Breast Services scored positively on many aspects of patient experience, with scores significantly higher for Colorectal and favourably for Lung and Breast, when compared to the national average (Lung and Breast).

6.4 Further detailed analysis of the tumour-specific group data will be undertaken by the clinical teams and action plans developed for improvement.

Image 1: The Macmillan Information and Support Team at former UHSM following their 'hero award' for supporting people affected by or living with cancer

7. Patient Comments

7.1 Alongside the questionnaire for the NCPES (2017) respondents were also given the opportunity to include any additional free text comments. **Appendix 2 and 3** provide a range of patient comments which highlight the positive aspects of the inpatient experience, as well as comments where care could have been improved. This information will be shared with clinical and ward teams for review.

The comment report is only available to MFT and is not available to the public.

8. Conclusion

8.1 Overall the results for the former CMFT and former UHSM are 'within the expected range' for Trusts of similar size.

8.2 Both the former CMFT and former UHSM have demonstrated the majority of results are 'within the expected range', however former CMFT scored above the National Average for Haematology and Gynaecology but below the National Average for Colorectal and Upper GI. The former UHSM scored above the National Average for Colorectal suggesting integration and joint work could result in improvements for MFT .The former UHSM also performed above the National Average for Lung and Breast which have been supported with investment to improve patient pathways as a result of Vanguard funding.

8.3 The results require further analysis by tumour-specific teams to both identify areas to celebrate success and identify areas for their improvement activity. The challenge remains for those tumour groups where less than twenty

responses were received to consider how they can encourage patients to respond to the future surveys.

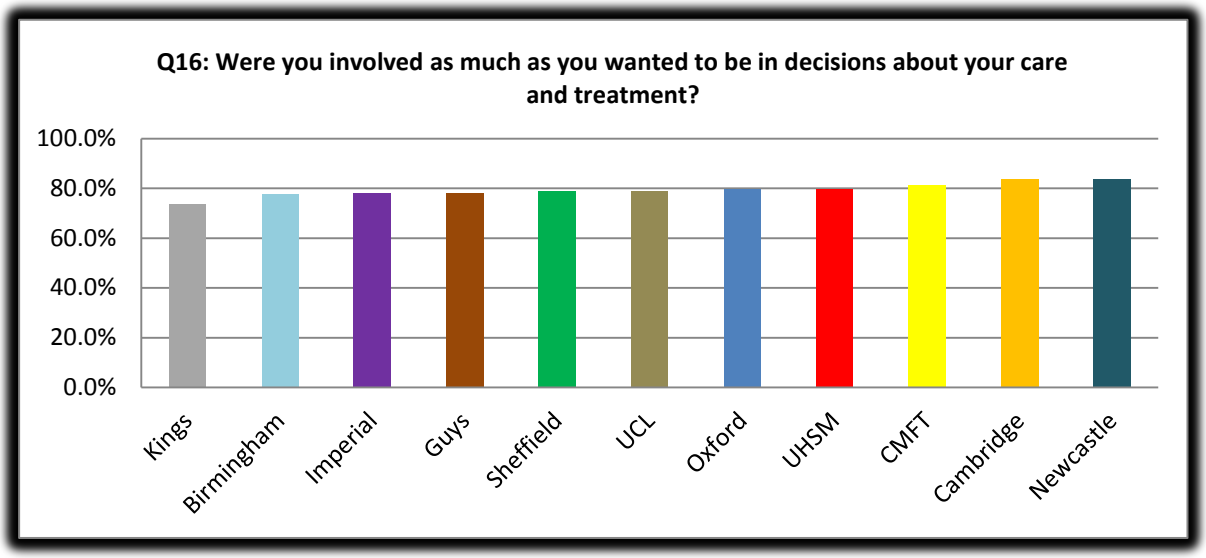
8.4 The ongoing development of ***What Matters to Me*** Patient Experience Programme across MFT will be fundamental in the delivery of improvements in cancer patient experience. Placing frontline leaders at the heart of driving the shift from average to excellent patient experience will be a focus for the delivery of a personalised patient experience for people with cancer***.***

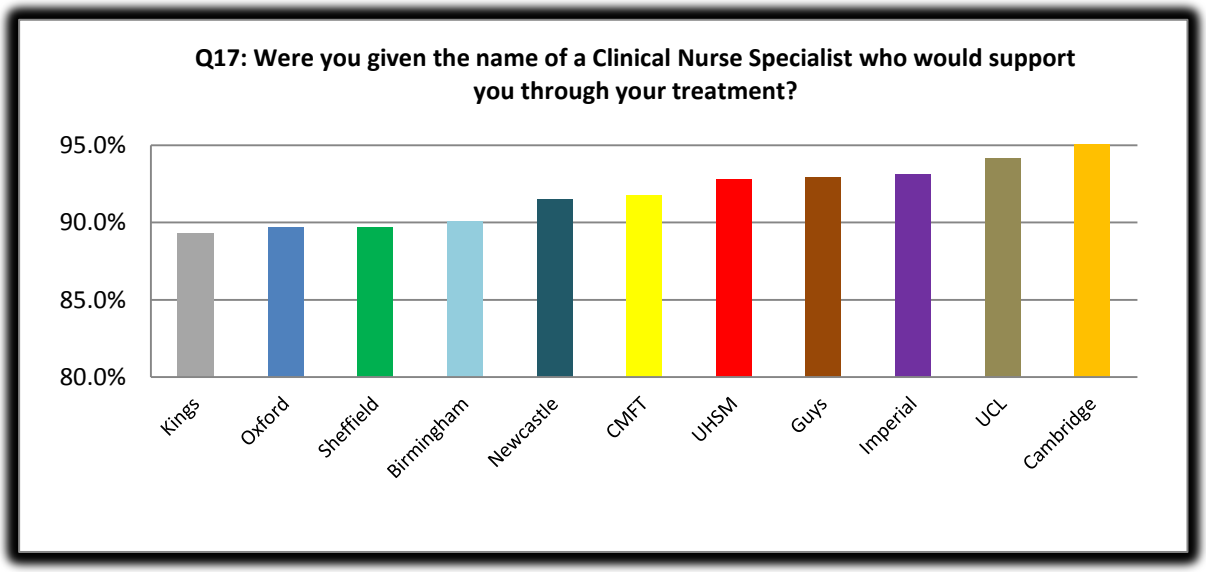
8.5 The report and the findings will be discussed at the Group Cancer Committee.

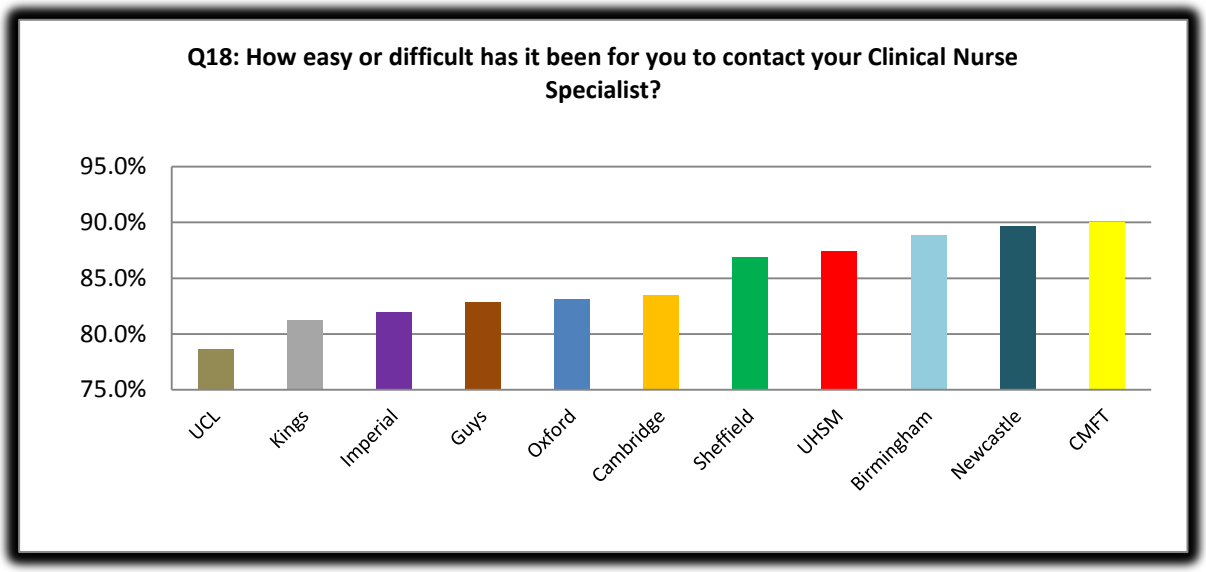
8.5 The Board of Directors is asked to note the feedback and the potential opportunities for improvements since the merger of the former organisations to create MFT.

Image 2: The Head & Neck Cancer Nursing and AHP team working with the Macmillan Centre staff to improve patient experience.

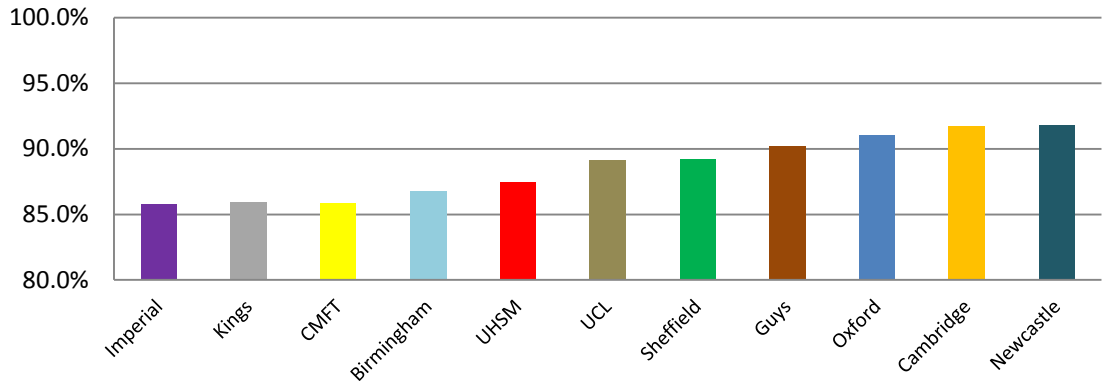
Appendix 1: Cancer Dashboard Performance: Shelford Group Comparison



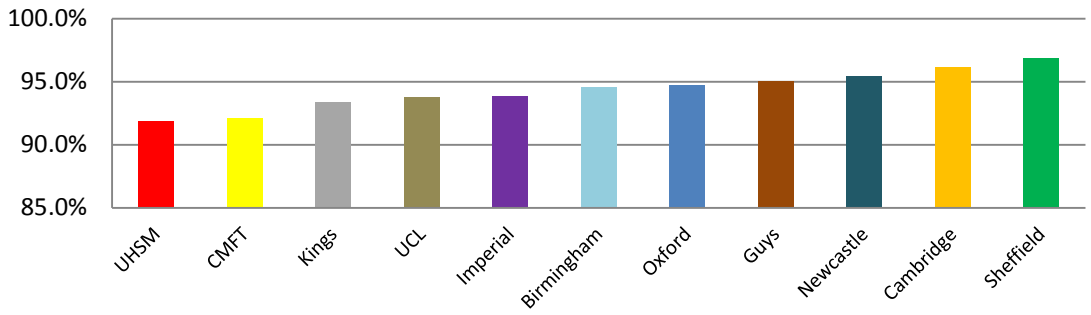




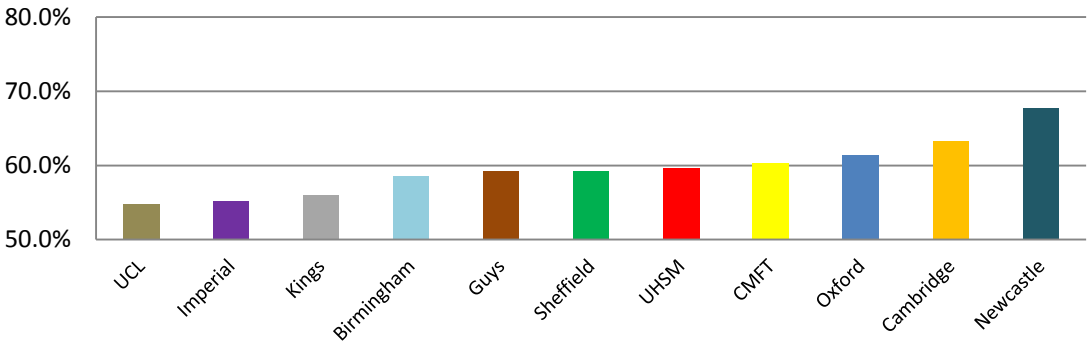
Q37: Overall, did you feel you were treated with respect and dignity while you were in the hospital?



Q39: Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?



Q54: Did the different people treating and caring for you (such as GP, hospital doctors, hospital nurses, specialist nurses, community nurses) work well together to give you the best possible care?



Appendix 2
Comments from survey respondents for the former CMFT NCPES (2017)

Former CMFT/ Tumour Group	What went Well	What could be improved
Colorectal	*Excellent dealings from all healthcare staff. Professor (consultant), (secretary) and 2 specialist colorectal nurses, in particular.*	*Time delays, especially obtaining results from endoscopy procedure*.
Urology	*My operation went well, everything on time and all the staff, surgeon and anaesthetist doctors were excellent.*	*Waiting for admittance at Manchester Royal Hospital (seven hours). Car park cost £15 due to wait. Follow-up appointments/treatment would be better done at local hospital, Fairfield*.
Head & Neck	*Excellent care. Lovely, clean hospital. Friendly staff.*	*Communication between specialists.* *Administration delays*
Lung	*All the hospital personnel where excellent.*	*better communication between the hospital regarding past illnesses at different hospitals,*
Haematology	*The facility and staffing at MRI for treating myeloma is world class.*	*Hospital food needs great improvement.*
Gynaecology oncology	*Specialist nurse at St Marys was exceptional and beyond, such a safety net. Everyone very attentive, made to feel normal.*	*Hospitals involved did not communicate enough at times*

Appendix 3
Comments from survey respondents for the former UHSM NCPES (2017)

Former UHSM/ Tumour Group	What Went Well	What Could Be Improved
Breast	*The care I was given at Wythenshawe is outstanding.* *Excellent care from specialist breast nurse at Nightingale Centre. Superb surgeon. Great results and wonderful communication.*	*Communication between Nightingales centre and Christie's needs to be improved. Not given correct information on what treatment I would be having* *I think if I had been better informed as to why treatment takes some time to start I may not have worried so much.*
Colorectal	*The level of contact with the practice throughout the process has been most supportive to me and the contact between the GPs and the hospital has been very quick and comprehensive.* *The treatment I have been receiving has been excellent and they staff has been excellent.*	*The aftercare after I was sent home left a lot to be desired. There was little or no communication between all services* *Much of the staffing seemed to be made up of nurses being drafted in from other wards or even, an agency, particularly at nights.*
Gynaecology-oncology	*Kindness and sensitivity of the consultant and Macmillan nurse.*	*More nursing staff*
Head and Neck	*I was a patient on ward F9 at Wythenshawe Hospital - from the doctors, right down to the cleaning staff, I received excellent care, with support from all.*	*As an inpatient on ward F9…both male and female were using the same toilets.*
Lung	*I was pleased and surprised at the speed in which the tests and final diagnosis then the operation took place. It happened so quickly which meant I didn't have time to dwell and worry about it.* *I cannot imagine how my treatment could have been better.*	*There seemed to be no confirmation sent to the referring department that the receiving department had received the referral.* *The administration of letters giving appointment times, also having got my address wrong on the computer system.*

	I was fortunate to meet such dedicated people.	

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Miss Toli Onon, Medical Director Professor J Eddleston, Medical Director
Paper prepared by:	Professor Bronwyn Kerr, Associate Medical Director Mrs S Corcoran, Director of Clinical Governance
Date of paper:	November 2018
Subject:	Learning from Deaths
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Resolution • Approval
Consideration of Risk against Key Priorities	To improve patient safety, clinical quality and outcomes
Recommendations	The Board of Directors is asked to note this report.
Contact:	Name: Mrs Sarah Corcoran Tel: 0161 276 8764

Introduction

This paper aims to provide assurance to the Board that the processes for Learning from Deaths across the organisation are in line with best practice as defined in the National Quality Board's (NQB) National Guidance on Learning from Deaths (LFD) (March 2017), and Guidance on Working with Bereaved Families and Carers (July 2018).

The Care Quality Commission (CQC) report '*Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England'* found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. In early March 2017, the National Quality Board released guidance for organisations intended to initiate a standardised approach to reviewing and learning from deaths.

Requirements of the guidance were;

- All Trusts to have a Mortality Policy in place by September 2017 on how organisations respond to and learn from deaths
- All mortality policies should include a clear process for engagement with bereaved families and carers including giving them an opportunity to raise questions or share concerns in relation to the quality of care received by their loved ones.
- From April 2017 - collection and publication of specified information on deaths through a paper and agenda item to a public board meeting in each quarter, to set out ~~in~~ the Trust's policy (by end Q2) and publication of the dashboard and learning points (by end Q3). The dashboard data would also need to be summarised in the Trust's Quality Account from June 2018.

Learning from Deaths Policy

In line with National recommendations, a Mortality Review Policy for the Group has been developed and ratified and is available on the publically available MFT web-site. This policy includes a clear process for engagement with bereaved families, and the relevant patient literature has been modified to support this. The policy is available on the staff intranet Learning from Deaths Policy. The policy is supported by a Group Mortality Strategy which is complete and awaiting EQIA.

Summary Information on Learning from Deaths

Also conforming to national guidance, a summary of mortality review activity, and the number of deaths deemed potentially avoidable is also available on the public MFT web-site. Going forward, this information will also be included in the Quality Accounts.

Oxford Road Campus and Trafford Hospital	**Deaths (excluding Patients with a Learning Disability)**			**Wythenshawe Hospital**	**Deaths (excluding Patients with a Learning Disability)**			**Deaths of Patients with a Learning Disability All Sites**		
Quarter	**Total**	**Reviewed**	**Avoidable (>50% likelihood)**	**Quarter**	**Total**	**Reviewed**	**Avoidable (>50% likelihood)**	**Total**	**Reviewed**	**Avoidable (> 50% likelihood)**
17/18 Quarter 3	458	105	0	17/18 Quarter 3	371	113	1	16	8	0
17/18 Quarter 4	498	79	1	17/18 Quarter 4	389	109	3	17	5	0
18/19 Quarter 1	443	56	0	18/19 Quarter 1	319	63	1	13	3	0
Total	**1,399**	**240**	**1**	**Total YTD**	**1079**	**285**	**5**	**46**	**16**	**0**

External Audit of Mortality Review in Legacy Organisations

An external audit of Mortality Review Processes in the legacy organisations was completed in January 2018 (Mersey Internal Audit Agency; Mortality Review Baseline Assessment). Significant assurance was obtained overall, with the majority of concerns having been addressed by the development of a unified Group Mortality Strategy and Policy as outlined above.

Issues that remain an active focus of work are assurance around mandatory review completion (on the Oxford Road Campus), directorate mortality review processes (on the WTWA Campus) and assurance on the process of sharing learning across the whole organisation.

Mortality Reviews

Mortality reviews are undertaken in cohorts of patients where a review is considered mandatory as defined in the Mortality Review Policy, and in addition in line with speciality best practice. For directorates with a large number of deaths, national guidance suggests a maximum of 50 reviews annually.

Across MFT, it is the intention that the Royal College of Physicians' Structured Judgement Review Tool will be used for all adult deaths, once the Informatics Work program permits the alteration to the electronic Portal. For neonatal review, the internal process has been adjusted to take account of new National Recommendations. For children, all deaths are reviewed; the RMCH process is being re- evaluated to avoid duplication between the Paediatric Intensive Care Unit (PICU) and RMCH processes.

Overall, mortality reviews were completed in 23.1% of deaths (July 2017 to June 2018).

For those deaths where an avoidable component may have been important, Hospitals and Managed Clinical Services (MCS) have been asked to present a summary to the Group Mortality Committee, in addition to their internal Mortality and Quality and Safety meeting. Correlation and dissemination of these cases will improve learning across the Group.

Patients with a Learning Disability

Within adult services within the former CMFT, completion of mortality reviews in patients with a learning disability has been low. Consequently, a new process has been instituted; all deaths in adult patients with a learning disability are to be reviewed by a multi-disciplinary group, chaired by the Director of Clinical Governance. This Learning Disability Mortality Scrutiny Group will be a subgroup of the Group Mortality Committee. All deaths in adult patients with a learning disability from 2018 on will be reviewed.

Introducing the Medical Examiner System

It is the intention of NHS England to introduce a Medical Examiner system for reviewing all deaths from April 2019. This approach, using sessional Medical Examiners and Medical Examiners Officers, has been trialled in a number of organisations. All deaths have a rapid review of the last 24 hours of care, and after a conversation with the family, a decision is taken as to whether or not to refer for mortality review ~~or not~~.

It is envisaged that the cost will be funded from cremation fees, with the only additional monies being for patients who are not cremated.

A working group, chaired by the Chief of Staff from the Medical Directors Office is being set up to oversee implementation. This will include any adjustment to the Mortality Review Strategy and Policy.

Involving Families

The learning from deaths process is now detailed in the Bereavement leaflet given to patients' families. A small number of reviews (4) have been requested in year and these have been undertaken and shared with families.

Mortality Indices Summary

Across the organisation, from April 2017 to September 2018, the crude mortality rate has remained at 0.4% for elective admissions and has seen a decrease for non-elective admissions from 1.5% to 1.4%.

Current figures for HSMR and SHMI are;

HSMR 86.1 (December 2017; 91.7)
SHMI 94.8 (December 2017; 100)

HSMR has fallen from January 2018 to June 2018 from 89.1 to 86.1. Figures for HSMR July 2017 to June 2018 are as below;

MRI	Wythenshawe	Trafford	RMCH	SMH
83.1	87.9	76.9	89.6	110.6

Both HSMR and SHMI compare well with Shelford Group peers;

HSMR for MFT sites compared to Shelford Group Jul-17 to Jun-18

Peer (Acute)	Observed	Expected	Relative Risk
Sheffield Teaching Hospitals NHS Foundation Trust	2,067	1,932	106.99
University Hospitals Birmingham NHS Foundation Trust	1,555	1,536	101.22
Oxford University Hospitals NHS Foundation Trust	2,019	2,179	92.65
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	1,487	1,617	91.95
Manchester University NHS Foundation Trust	**2,158**	**2,507**	**86.06**
King's College Hospital NHS Foundation Trust	1,941	2,273	85.41
University College London Hospitals NHS Foundation Trust	732	870	84.11
Cambridge University Hospitals NHS Foundation Trust	1,242	1,513	82.11
Guy's and St Thomas' NHS Foundation Trust	772	1,070	72.14
Imperial College Healthcare NHS Trust	1,340	1,994	67.19

MFT SHMI Score Compared to Shelford Group. Apr-17 to Mar-18

Peer (Acute)	Spells	Observed	Expected	SHMI
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	256,713	7,468	7,591	98.39
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	115,022	3,645	3,790	96.17
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	**173,890**	**3,486**	**3,678**	**94.78**

KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	110,748	3,235	3,432	94.26
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	100,773	2,596	2,774	93.59
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	115,220	3,205	3,483	92.02
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	75,061	2,355	2,711	86.87
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	108,220	2,233	3,012	74.13
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	70,535	1,167	1,586	73.57
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	90,683	1,441	2,060	69.94

Overall, co-morbidity coding remains low. Palliative care coding is now above peers, while the use of R codes (symptom coding on discharge) is now lower than peers and national value.

Learning from Deaths Scrutiny Group

The Learning from Deaths Scrutiny meetings are chaired by a Non-executive director and provide a forum where the processes of mortality review in each Hospital/MCS are subject to regular scrutiny. In addition, an informative case is presented, and key themes, challenges and action plans and dissemination are reviewed. Immediate feedback is to the Hospital/MCS Quality and Safety Committee.

Issues that have been identified where action plans have been developed include;

- Failure to recognise deterioration
- Poor communication between acute physicians and cardiology
- Poor antibiotic choice
- Line related sepsis
- Dislodged tracheostomy management
- Assessment of thrombosis risk
- Need for Urdu interpreter to support End of Life Management in childhood.

These meetings have proved extremely valuable in understanding the depth and extent of mortality review processes across the Group, and in highlighting differences in the issues identified in the quality of care that can be important across the organisation.

Improvements

Learning from deaths has generated a number of work programs and initiatives that are being generalised across the organisation where applicable. These include;
Specialist nurse led training in recognition of sepsis and Acute Kidney injury, expert analysis of all cardiac arrest calls and investigation through the Emergency Bleep Meeting when indicated.

Conclusions
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, ~~and~~ 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.

The creation of MFT has provided an opportunity to re-evaluate the approaches to learning from deaths in both organisations, and ~~to aspire~~ 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.

Recommendations

The Board of Directors is asked to receive the report and note the actions taken.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce and OD
Paper prepared by:	Trust Board Secretary – Alwyn Hughes
Date of paper:	31st October 2018
Subject:	MFT Board of Directors' Register of Interests (October 2018)
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Resolution • 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 (October 2018)
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

OCTOBER 2018

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 (October 2018).

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS

REGISTER OF DIRECTORS' INTERESTS

(October 2018)

BOARD OF DIRECTORS

REGISTER OF INTERESTS – October 2018

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) • Founding Member of Cheshire Community Foundation
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
Dr Ivan Benett	Group Non-Executive Director	• General Practitioner at The Range Medical Practice, Withington Road, Manchester • Standing member of a NICE Quality Standards Committee and Topic Specific Guideline Update Committee • Member of the Primary Care Cardiology Society

BOARD OF DIRECTORS

REGISTER OF INTERESTS – October 2018

NAME	POSITION	INTERESTS DECLARED
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
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 • 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

BOARD OF DIRECTORS

REGISTER OF INTERESTS – October 2018

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 – October 2018

NAME	POSITION	INTERESTS DECLARED
Sir Mike Deegan CBE	Group Chief Executive	Trustee, Nuffield Trust 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)
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
Margot Johnson	Group Executive Director of Workforce & OD	Sponsor Governor and Trust Board Chair of Manchester Health Academy
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	Director of Manchester Health Ventures – wholly owned subsidiary of MFT

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Margot Johnson , Executive Director of Workforce & OD
Paper prepared by:	Alwyn Hughes, Director of Corporate Services / Trust Secretary
Date of paper:	31st October 2018
Subject:	Refinement of the Board Assurance Framework (BAF) – Progress Report
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Approval
Consideration of Risk against Key Priorities:	**(Impact of report on key priorities and risks to give assurance to the Board that its decisions are effectively delivering the Trust's strategy in a risk aware manner)** In the absence of robust and comprehensive BAF, the opportunities for supporting and enhancing organisational governance by using a body of good practice outcomes and evidence will be diluted.
Recommendations:	The Board of Directors is asked to note progress in the continued refinement of the MFT BAF in response to the recommendations captured within the External, Independent Well Led Review (July 2018) and latest Internal Audit Review (September 2018).
Contact:	Name: Alwyn Hughes, Director of Corporate Services / Trust Secretary Tel: 0161 276 4841

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

THE BOARD ASSURANCE FRAMEWORK

(October 2018)

1. Background

Performance against the Board Assurance Framework (BAF) is reviewed at every formal Board of Directors via the Intelligent Board metrics. Significant risks to achieving the Trust's key priorities are reviewed and reported on at the Group Risk Management Committee (GRMC) and across other boards and, where necessary, appropriate committees dependent on the risk rating.

The Trust Scrutiny Committees, on behalf of the Board of Directors, utilise the BAF to inform and guide their key areas of scrutiny and especially targeted 'deep dives' into areas requiring further assurance. The full BAF is received and noted at least twice a year by the Board of Directors.

While a combined BAF was created shortly after the merger in October 2017, this is still in development, and the BAF's ease of use, accuracy and effectiveness is a key priority for the Board.

2. Development of the Board Assurance Framework

Ahead of the merger of the former University Hospital of South Manchester NHS Foundation Trust (UHSM) and former Central Manchester Hospitals NHS Foundation Trust (CMFT), a new Group Board Assurance Framework (BAF) was successfully created, which combined the content from the BAFs of both predecessor organisations.

At the time of the merger, there was an acknowledgement that there would need to take place an iterative process of refinement of the Group BAF, both in terms of its content and format, during the new Trust's first year of operation.

Following a developmental review of Leadership & Governance arrangements using the Well Led framework during the Summer (2018), one of the recommendations arising from the KPMG Reporting Accountant work concerned the further development of the Group Board Assurance Framework (BAF), and refinement of the process for updating and monitoring this, and of the continued role of the Board sub-committees and the Board itself in overseeing its development.

A Task & Finish Group (consisting of Group NEDs and Corporate Officers) was convened in September 2018 to further refine the format, content and operational effectiveness of the current BAF. In addition, an Internal Audit review was also commissioned and was broken down into two phases. The first phase, undertaken in September & October 2018, covered an initial review of the content and format of the BAF, with some limited coverage of how it is used as a basis for driving the agendas of the Trust Board and its sub-Committees. The second phase, to be completed by March 2019, will focus on the additional changes made to the BAF as a document and, importantly, how the BAF continues to be adopted as a 'live' document which evolves and informs the agendas of the Board and Committees. Under both phases of work, the Internal Audit Team will also reflect on the experience of good practice in Board Assurance Frameworks at other large NHS teaching hospitals, as well as large private sector companies and other organisations.

The conclusion of the first phase of the initial review undertaken by Internal Audit in September/October 2018 stated that:

> ***"Overall we found that the Trust's current Board Assurance Framework is a comprehensive document which captures risks to the strategic objectives of the Trust, controls in place to manage and mitigate those risks, and the assurances available in respect of those controls. The BAF is updated regularly to reflect progress against key actions and new assurances that emerge. We did identify a number of areas for further improvement and development of the BAF, which are summarised later in this Executive Summary. The majority of the areas for improvement result in low risk recommendations and are more akin to performance improvement observations rather than reflecting a weakness or breakdown in controls, or representing a risk to the Trust's achievement of its strategic objectives."***

The first phase of the Internal Audit Report highlighted a number of areas of 'good practice' adopted within the MFT BAF along with areas for further improvements. The Internal Auditors reported to the Trust's Audit Committee on 7th November 2018 that:

> *"Overall, we have graded the arrangements currently in place in relation to the Board Assurance Framework as providing you (the Trust) with* ***significant assurance with minor improvement opportunities.****"*

3. Next Steps

- The Task & Finish Group will now consider the areas for further refinement (and associated recommendations) as presented by the Internal Auditors to the Audit Committee on the 7th November 2018. Any changes to the existing BAF, based on the recommendations outlined, will be introduced (as required) during November & December 2018, and, early January 2019.

- There will be targeted training and awareness sessions with 'Principle Owners' of risks captured in the BAF. The focus will be on the introduction of any changes to the formulation, risk rating and moderation of the BAF in order to further strengthen consistency in approach and interpretation going forward.

- The updated BAF will be audited (Phase 2) by Internal Audit during second half of Q4 (2018/19)

- The refined BAF will be presented to the MFT Audit Committee on 6th February 2019 and Board of Directors meeting on 12th March 2018

- The Audit Committee will continue to focus on seeking assurance that the refined process outlined has been adhered to along with any gaps in control/assurances, and, consider whether any actions are clearly identified to mitigate and/or reduce the risk(s).

4. Recommendation

The Board of Directors is asked to note progress in the continued refinement of the MFT BAF in response to the recommendations captured within the External, Independent Well Led Review (July 2018) and latest Internal Audit Review (September 2018).

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Margot Johnson , Executive Director of Workforce & OD
Paper prepared by:	Mags Bradbury, Associate Director of Employee Wellbeing, Inclusion & Community
Date of paper:	31st October 2018
Subject:	**Update Report on the MFT Flu Vaccination Programme**
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Approval
Consideration of Risk against Key Priorities:	**(Impact of report on key priorities and risks to give assurance to the Board that its decisions are effectively delivering the Trust's strategy in a risk aware manner)** In the absence of a comprehensive Flu Vaccination Programme, for the MFT Workforce could increase absenteeism and have a significant adverse impact on the effective delivery of qualitative patient care and experience).
Recommendations:	The Board of Directors is asked to note the organisation's Flu vaccination Prorgramme in preparation for the Winter months.
Contact:	Name: Mags Bradbury, Associate Director of Employee Wellbeing, Inclusion & Community Tel: 0161 701 3516

Update Report on the MFT Flu Vaccination Programme 2018/19

1.0 Background

Manchester University (NHS) Foundation Trust (MFT) launched its 2018-19 Healthcare Workers Flu Vaccination Programme on the 1st October 2018. The programme plan is lead and managed by the Group Employee Health and Wellbeing (EHW) Service, working in partnership with Hospitals/Managed Clinical Services, Infection Control and communication teams to ensure successful delivery of the programme across MFT. The vaccination campaign has Executive leadership provided by both the Group Executive Director of Workforce and OD and the Group Chief Nurse.

The Department of Health has set a 75% target for all frontline healthcare workers to be vaccinated, although MFT offers the vaccine to all staff regardless of their role. A CQUIN target relating to achieving a 75% uptake rate is also in place.

To support the achievement of the target, this year's programme has been developed to incorporate lessons learnt from past flu vaccination programmes (from the former legacy organisations of CMFT and UHSM) and drawing on external good practice (NHS Employers). MFT is four weeks into its delivery plan which is focussing on achieving maximum engagement for all healthcare professionals. It should be noted that the flu vaccination is not a mandatory requirement and staff can therefore opt out.

2.0 NHS Employers and NHS Improvement Recommendations

On the 7 September 2108 a letter was sent to the all the Chief Executives of NHS Trusts and Foundation Trusts (Appendix 1) which was signed by National clinical and staff side professional leaders. The letter outlined the importance of the vaccination programme in relation to protecting the health and safety of both staff and patients. All Trusts were asked to ensure that every step was being taken to offer the vaccine to each healthcare worker within the organisation and collate information as to the reason staff opt out from the programme.

Trusts are expected to publish a self-assessment in Board of Directors papers before the end of 2018. MFT has reviewed the best practice management checklist, required to provide public assurance and has confirmed that the organisation is meeting each element of best practice.

The letter sets out a clear expectation that 100% of healthcare workers with direct patient contact will be vaccinated this year. It also strongly recommends that Medical Directors and Chief Nurses should undertake appropriate risk assessments and discuss with their staff and staff side colleagues how best to respond to situations where clinical staff in designated high risk areas decline the vaccination. In the high risk areas, it is suggested that staff should provide confirmation that they have been vaccinated and consideration should be given to the appropriate deployment of staff who have not been vaccinated.

Trusts have been asked to provide data relating to the reasons why staff declined to have the vaccine. The purpose of this is to try and target messages and to aim development of future programmes. At MFT the flu enrolment form has been adapted to capture the required data in readiness for submission and to provide further organisational insight into staff perceptions. In addition the form will capture if an employee has been vaccinated elsewhere e.g. at their GP. This data will be included in MFT's uptake rate submission.

3.0 MFT's Approach to the NHS Employers and NHS Improvement Recommendations

The flu vaccine is not a mandatory requirement for healthcare workers so employees are within their rights to decline. Careful consideration was given to the suggested approach of deploying staff who have declined the vaccine away from the high risk areas viz a viz the risk associated with the operational impact and the ability to maintain safe staffing levels. Last year's data shows a 47% non-compliance rate across MFT high risk areas equating to circa 979 non-vaccinated staff. On this basis MFT has taken the decision to adopt a different approach based on a strong engagement and activity plan across the Group, reinforced with a reporting process throughout the programme to provide assurance on compliance rates.

4.0 Delivery & Engagement Activity

Planning for this year's campaign commenced prior to the summer. A key component on the plan was to make the vaccination programme as accessible as possible and engaging to all staff across the Trust. A Group communication plan was developed utilising all available media channels. The programme was launched by the Chief Nurse on the 1st October. Twenty One training sessions were delivered with 150 flu champions recruited and trained. Hospital/Managed Clinical Services were allocated dedicated support for flu clinics on their sites. All hospitals have delivered pop up clinics which are promoted locally and in group wide communications; this work has been supported by the EHW team out on the hospital sites. In addition clinics were used at key events for example the Nursing, Midwifery and Allied Health Professionals Conference, Chief executive engagement sessions and staff induction.

5.0 Reporting

Working with key stakeholders the EHW team have developed a comprehensive and robust flu programme which is based on accepted and proven best practice. Considerable improvements have been made to the data collection process to ensure that MFT has accurate and timely reporting. This will enable each hospital to have clear insight as to the engagement of their staff with the programme and enable them to be responsive in terms of targeted activities.

The EHW service has produced weekly uptake reports, including a breakdown by Hospitals, Divisions, Departments and staff groups. MFT will use the data to target 'hot spot' areas or specific staff groups to increase engagement and uptake with the flu programme. The table sets out below the number of Flu vaccinations given in the first five weeks of the programme:

	Number of Vaccinations Forms Returned
Week 1	3,560
Week 2	2,848
Week 3	1,622
Week 4	1,127
Week 5	505
Total	**9,662**

45.7% of frontline staff have taken the opportunity to have a flu vaccine offered through the MFT staff wellbeing service, equating to 61% of the 75% target. Hospitals have now been issued with local reports so that specific targetted action can be taken to build on these numbers. Staff who have received a flu vaccine via alternative routes (eg from their GP surgery) are not included in these numbers.

6.0 Summary

This report provides an update of the first five weeks of MFT's flu campaign. The Trust has focused communication and activity around the clear message that the flu vaccination is about patient safety. Whilst the Trust has made significant progress towards the 75% target set, the Trust needs to maintain momentum over the next few months.

Recommendations: The Board of Directors is asked to note the progress made on deliverying the Flu Vaccination Programme.