NHS
Manchester University
NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS' MEETING

Meeting Date: 8th July 2019

(Held in Public)

100/19 Apologies for Absence

Apologies were received from Professor Dame Sue Bailey and Miss Toli Onon.

101/19 Declarations of Interest

There were no declarations of interest received for this meeting.

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

102/19 Patient Story – 'What Matters to Me'

The Group Chief Nurse introduced a DVD highlighting the extraordinary work of the MFT Volunteer Service. 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

103/19 Minutes of the Board of Directors Meeting held on 13th May 2019

The minutes of the meeting held on the 13th May 2019 were agreed as a correct record.

104/19 Matters Arising

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

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

105/19 Group Chairman's Report

i). The Group Chairman reported that the 10th annual Young People's Open Day took place on 25th June 2019 and was a great success with around 570 young people attending including students from 24 different schools/colleges across the Greater Manchester area. It was noted that stands covered a wide range of MFT's services including Nursing, Medical Illustration, Laboratories, Orthopaedics, Specialised Play Services and Mental Health Services.

The Group Chairman explained that visitors had the chance to complete a questionnaire to help inform the MFT Forward Plan with nearly 100 being completed, and MFT Governors, as part of the Trust's Membership Stand, worked really hard to talk and engage with young people about their work as Governors, what membership is and finding out attendees' views about what health priorities were important to them.

ii). The Group Chairman congratulated the MFT Charity Team for their recent success in winning the *'National Charity of the Year'* at the prestigious Institute of Fundraising National Charity Awards down in London.

iii). The Board noted that the *Lord Philip Hunt* had visited Trafford Hospital on 11th June 2019 in his capacity as President of the Health Care Supply Association. It was reported that Lord Hunt had the opportunity to view the 70th anniversary plaque at Trafford before having a tour of the hospital and specifically the Finance and Procurement Business Unit.

iv). The Group Chairman reported that the Trust had been celebrating the 10th Birthday of the *New Hospitals Development* on the Oxford Road Campus during June and July with celebrations taking place across each of the hospitals who relocated to their new accommodations in 2009.

v). The Group Chairman congratulated Ms Emily May Robertson, Ward Manager at MRI, after being awarded the British Empire Medal (BEM) for services to Nursing at the recent Queen's Birthday Honours.

vi). The Group Chairman was pleased to report that the Trust held two events during 'Volunteers Week' in June (at Wythenshawe and the Oxford Road Campus), to thank our Volunteers for everything they do to support patients, their families and friends.

vii). The Board noted that over 650 staff took part in 'Team MFT' on 19th May 2019 as part of the Great Manchester Run.

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

106/19 Group Chief Executive's Report

i). The Group Chief Executive was pleased to report that work had begun on constructing the new helipad on top of Grafton Street car park, funded by £3.9m raised by the MFT Charity.

ii). The Group Chief Executive reported that *Health Innovation Manchester* and global partner *Qiagen* had launched a new company called *'APIS Assay Technologies'* to develop new tests for the prediction, prevention, and diagnosis of disease**.** It was noted that the new company would be dedicated to developing novel techniques (called biomarkers) for diagnosing disease and pinpointing the treatments which are right for each individual patients.

iii). The Board noted the commencement of 'all age' CAR-T Therapy.

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

107/19 Operational Performance

Board Assurance Report

The Joint Group Medical Director reported that MFT's 'Never Events' performance was stable with no reported events since March 2019 (more detailed report on NEs later on the agenda). It was also confirmed that the organisation had not experienced an 'avoidable death' in the last two quarters of 2018/19 which was reflected in the data presented in the Board Assurance Report. In response to observations from Dr Benett, the Joint Group Medical Director also confirmed that the Trust's SMR, Crude Mortality, SHMI remained stable.

The Group Chief Nurse reported that the information presented in the Board Assurance Report in relation to the Trust's performance against the % of Complaints Resolved within the agreed timeframe was a rolling 12 months average and that there had been particularly good progress within this area since April 2019 (59.3%), May (64.3%) and June (70.5%) which should positively impact on the rolling average going forward.

The Group Chief Operating Officer reported that MFT's final Q1 (2019/20) position in relation to the emergency access 4-hour wait performance was 84.27% compared to GM's position of 82.9%. The Board noted the comprehensive range of actions undertaken across all MFT sites to improve the current levels of performance (with particular attention on performance 'overnight', 'patient streaming' and 'long lengths of stay'). It was also confirmed that this area of performance was closely monitored against a number of Patient Safety & Patient Experience indicators alongside ensuring staff feel 'safe' at the front-end of the departments providing the services across the sites.

The Board was also advised that the organisation continued to have no patients waiting more than 52 weeks for their initial treatment and the Trust remained below its Waiting List trajectory (a positive position) with the new RTT Compliance IT System being introduced in September 2019. It was also noted that the Trust's Cancer Performance was 77.4% at the end of Q4 (2018/19) against a target of 85%. It was acknowledged that this was not a positive position and that a number of actions and concentration of efforts was on improving timely access to diagnostics (for cancer patients) throughout each of the key cancer facilities. The Group Chief Operating Officer confirmed that whilst the MRI's cancer performance had particularly improved from 70% to 80% with the drive now to reach 85%, the Wythenshawe performance had experienced some short-term challenges with the 'lung cancer pathway' and additional demand in support of the Stockport Breast Service.

The Group Chief Operating Officer also reminded the Board that there are 14 sites currently 'testing' the new National Operational Standards and the Trust was currently waiting for the outcome of the pilot sites (focused on patient outcomes). She confirmed that the Board would be kept regularly sighted on any developments.

In response to observations and questions from Mr Trevor Rees, discussion also centred on whether there was any adverse impact on performance in response to the current issues around NHS Pensions. It was confirmed that the Trust was currently closely monitoring the national position and supporting staff equitably across the organisation (clinical & non clinical).

The Group Executive Director of Workforce & Corporate Business provided an overview of performance against the Workforce Performance Indicators; paying particular attention to 'Attendance'. He confirmed that there was a great deal of focused activity in this area including Health & Wellbeing and the management of short and long term sickness. It was also confirmed that the Deputy CEO was supporting the oversight of the Attendance Absence Management System across the sites (with details of the roll-out programme noted).

The Group Executive Director of Workforce & Corporate Business also highlighted the focus on improving Appraisal performance and highlighted key areas of work closely monitored by the HR Scrutiny Committee.

In response to observations and comments by Professor Georghiou, Mr Nic Gower and Mr John Amaechi, it was also agreed that a bespoke awareness (development) session on the new Attendance Absence Management System would be organised for the Group Non-Executive Directors.

The Board Assurance Report was noted.

Decision:	Report Noted Bespoke awareness (development) session on the new Attendance Absence Management System for the Group Non-Executive Directors	**Action by:** Executive Director of Workforce & Corporate Business	**Date:** October 2019

Transforming Care For the Future Q1 (2019/20) Report

The Chief Operating Officer provided an overview of the 2019/20 'Transforming Care for the Future' Q1 position under the key headlines of 'Q1 Objectives'; ''Delivery of MFT Operational Excellence Standards'; 'Integrated Care & Pathways to Deliver Clinical Benefits'; 'Creating the Culture and build capability for continuous improvement for change'; and, 'Looking ahead to Q2'.

It was noted that the Transformation Team had delivered against the objectives set out for Q1 with the key deliverables during the quarter identified as 'review of Trafford theatres'; 'support to the MRI in developing centralised booking'; 'sustained performance against the Manchester Agreement Metrics for Gynaecology and Lithotripsy services along with good performance on the Stroke KPIs which went live on the 1st April'; 'launch of the 19/20 curriculum for building capability and implementation of a single improvement hub on the new intranet site'; and, 'well received GIRFT visits across Renal, breast surgery and Cardiology. It was also noted that the launch of community and secondary integration projects in respiratory had been deferred.

The Chief Operating Officer also confirmed that Ms Veronica Devlin had recently started in post as MFT's new Chief Transformation Officer following Mrs Vanessa Gardener's appointment as Chief Executive of the MRI.

The Board noted the Q1 Report.

Decision:	2019/20 'Transforming Care for the Future' - Q1 (2019/20) Transformation Report noted	**Action by:** n/a	**Date:** n/a

Group Chief Finance Officer's Report

The Group Chief Finance Officer presented a summary overview of the financial performance for May 2019 which was a bottom line deficit (on a control total basis excluding Provider Sustainability Fund) of £8.8m (3.2% of operating income).

It was particularly noted that the operating financial performance has continued to worsen in-month, with performance against operational income & expenditure budgets in April and May now over £5.6m worse than the approved Hospital / MCS Control Totals. It was reported that specific additional recovery and delivery actions had been agreed with each Hospitals/MCS leadership team during the second week of June 2019, to secure stronger, more consistent delivery of the required operating financial performance through the immediate upcoming months.

The Board noted that more in-depth focus and challenge would be facilitated at the Finance Scrutiny Committee scheduled later in the week (11th July 2019) during which the Month 3 position would be available for scrutiny.

The Chief Finance Officer's Month 2 Report (2019/20) was noted.

Decision:	Month 2 (2019/120) Report Noted	**Action by:** n/a	**Date:** n/a

108/19 Strategic Review

Update on Key Strategic Developments

The Group Executive Director of Strategy provided an update to the Board of Directors in relation to strategic issues of relevance to MFT.

Attention was drawn to several national issues including the NHS Long Term Plan which was published in January 2019. It was noted that an implementation framework would be published shortly and would mandate the format and content of local implementation plans. It was confirmed that GM would respond to this in the second five-year plan, due to be published in Autumn 2019. The Board also noted the continued alignment of NHS England and NHS Improvement (including recent appointments along with the key role of the Regional Office).

The Group Executive Director of Strategy also confirmed that at a GM-wide level, paediatric medicine would now be regarded as an in-scope specialty for the Improving Specialist Care programme. It was also reported that having been named by NHS England as the preferred supplier through phase 2 of the national procurement of PET-CT, MFT and The Christie were now finalising contractual arrangements for the delivery of the PET-CT service for Greater Manchester.

At a more local level, it was noted that the overarching Group Service Strategy (originally approved November 2018) had now been updated based on the feedback received from the Council of Governors and key external stakeholders along with findings from the development of the individual clinical services. (See separate agenda item below).

The Group Executive Director of Strategy provided a progress report on Clinical Service Strategies (Waves 1, 2 & 3) and confirmed that the development phase of the programme was now complete. It was noted that the next steps included wider engagement, business case development (for those proposals contained within the strategies that had resource implications) and implementation planning.

The Board was particularly reminded that the proposals outlined in all of the strategies represented MFT's preferred option at this point. However, it was also recognised that they were at a formative stage only and a decision to make or implement any material service changes would not be taken until after the Trust and/or Commissioners had taken appropriate steps. It was recognised this could (as required) include public involvement, consultation with the relevant Health Overview Scrutiny Committee(s) and the completion of an equality impact assessment.

The Group Executive Director of Strategy confirmed that in relation to the Trafford Community Services, due diligence on the proposed transfer of community services from Pennine Care NHS FT to MFT was underway with a target date for transfer agreed as 1st October 2019.

The Board noted the updates under each of the key headlines as presented.

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

The MFT Annual Plan (2019/20)

The Group Executive Director of Strategy reminded the Board of the background and purpose of an Annual Plan which is to set out what the organisation intends to do in the coming year in order to achieve its short-term targets (such as performance and financial targets) as well as making progress towards its longer-term vision and strategic aims. The Board was also reminded that the MFT Operational Plan was developed from January to March 2019 and reviewed by the Council of Governors and approved by the Board prior to submission to NHE E/I on 3rd April 2019.

The Board recalled that the MFT vision and strategic aims were established as part of the Single Hospital Service Programme and, as such were designed to be relevant for the duration of the programme. The Group Executive Director of Strategy explained that since the SHS programme was still in train, it was agreed that the existing vision and strategic aims would be retained for 2019/20 (noted in the accompanying appendices to the report). The Board noted that each Hospital / MCS within the Group had developed their own business plan and decided what their priorities for the coming year should be.

The Board was advised that the MFT Annual Plan (noted as an attachment to the report presented) brought together, at a summary level, the Hospital / MCS business plans and the plans of the Group-wide departments such as HR, Transformation. The Board also underlined that as a Foundation Trust, the organisation must 'have regard to the views of the Council of Governors' who should in turn represent the views of their constituents and the process to facilitate/support this was highlighted and noted. The Board was particularly advised that each Hospital / MCSs had presented their proposed key priorities and plans to the Council of Governors in December 2018 and Governors had the opportunity to comment and provide feedback on the proposals directly.

The Group Executive Director of Strategy also highlighted the links between the MFT Annual Plan and the development of the Clinical Service Strategy and that year 1-2 initiatives highlighted in the Strategy would be reflected in the annual plans for 2019/20 and 2020/21.

In response to observations and questions from Mr Nic Gower and Professor Luke Georghiou, the Board also noted how the objectives described in the Annual Plan would be monitored in various ways; some through the Board Assurance Report and AOF, others through less formal mechanisms. It was also recognised that further work was to be undertaken to map how progress for each initiative would be monitored and reported.

In conclusion, the Board **a**pproved the MFT Annual Plan 2019/20 and noted that further work would be brought back to the Board to show how progress will be monitored.

Decision:	MFT Annual Plan 2019/20 approved Update Report on how progress with the MFT Annual Plan (2019/20) will be monitored	**Action by:** Group Executive Director of Strategy	**Date:** November 2019

Update Report on the Manchester Local Care Organisation (MLCO)

The Chief Executive of the MLCO presented a summary overview of a report which provided a more detailed update from the MLCO under the key headlines of 'System resilience and escalation'; 'Integrated neighbourhood working'; 'Communications and engagement'; 'Phase II and business case development'; 'Business Plan and MLCO 2019/20 priorities'; 'Adult social care improvement programme'; and, 'Trafford'.

Particular attention was drawn to the MLCO's continued work with MFT and partners such as Manchester City Council and Greater Manchester Mental Health NHS Foundation Trust to support the alleviation of current acute flow pressures. It was noted that the work became one of MLCO's key delivery priorities for 2018/19 and had now been identified as one of MLCO's key priorities for 2019/20.

The Chief Executive of the MLCO explained that alongside its partners, the MLCO had now commenced winter planning for 2019/20 and the MLCO response to supporting the alleviation of winter pressures and wider system flow had been identified as one of the five key priorities for 2019/20.

In response to questions from Mr Barry Clare, the Chief Executive of the MLCO confirmed that seven of the twelve Integrated Neighbourhoods were now co-located (compared to two out of twelve at the start of the programme).

The Board noted the content of the MLCO update report.

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

109/19 Governance

Update Report on Workforce Race Equality and Workforce Disability Equality Standards

The Group Executive Director of Workforce & Corporate Business provided an overview of the Trust's review of the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) 2018/19 data against prescribed indicators along with an action plan to reduce the gaps in the workplace for Black and Minority Ethnic (BME) staff and disabled staff.

The Board was reminded that the WRES and the WDES were included in the NHS Standard Contract and the WRES had been a requirement of NHS Commissioners and NHS healthcare providers, including independent organisations, since July 2015 and the WDES since April 2019. It was further noted that all NHS Trusts were required to produce and publish their WRES and WDES reports on an annual basis by the 31st July and 31st August respectively.

The Board noted the data presented within the WRES under each of the main indicator headings, namely, the workforce Profile; Recruitment; Disciplinary Process; Training; Staff Experience; and, Board Representation. Particular attention was drawn to the actions undertaken by the Trust in three key WRES priority areas, namely, increasing the representation of BME staff within Senior Leadership Teams; tackling poor behaviour and the experience of harassment, bullying and abuse; and, understanding the variation in disciplinary outcomes.

It was further noted that in addition to these key areas of focus, the Trust would improve the monitoring of ethnicity in relation to Non-Mandatory Training over the coming year; continue to promote ESR self-recording of protected characteristics, including ethnicity, by sharing information on how to access and use ESR; celebrate the diversity of the Trust with events and activities such as Equality, Diversity and Human Rights Week and Black History Month; continue to support and develop the BME Staff Network as part of the Trusts wider Staff Diversity Networks; and, deliver an Equality, Diversity and Human Rights Strategy.

The Group Executive Director of Workforce & Corporate Business also provided a summary overview of the WDES data which had been captured within the Trust in 2018/19 under the same key indicator headings as the WRES. The Board noted the actions identified to address the WDES key priority areas and particularly noted that overall, the Trust had seen an increase of representation of disabled staff rising from 2.6% to 2.84% between 2017-2018 and 2018-2019. However, it was further noted that disabled staff were under-represented in all clusters compared to the population of Manchester with a disability (17.8%). It was reported that disabled staff were also under-represented in bands 8a upwards in comparison to the overall Trust average of 2.84%. It was also noted that a key issue with the data presented was that at present, 28% of disability status was not known.

The Group Executive Director of Workforce & Corporate Business described the areas of priority for the Trust including addressing variation in the under representation of the Trust's workforce to reflect the population; building on the recruitment and selection process at MFT to ensure the transparency and inclusiveness of applicants; understanding the variation in the outcomes of the capability process; introducing a new Absence Management policy; continued support from the Trust's Employee Health and Wellbeing Service for new and existing staff and their managers to identify reasonable adjustment; and, develop an equality and diversity learning and development programme which would include disability employment training and unconscious bias training.

Discussion also centred on the role of the Freedom-to-Speak-Up framework within the organisation and the performance of the NHS against other major employers within the public & private settings.

The Group Executive Director of Workforce & Corporate Business confirmed that the Trust was committed to reducing the gap in representation and experience. He explained that the development of the Removing Barriers Programme aimed at increasing representation of BME staff was a key programme to delivering change. He also explained that whilst it was the first year of the WDES for the NHS and the data had identified gaps, MFT had already built a programme that supported young people with disabilities, supported internships, and was the largest provider of this type of access to work schemes. However, it was also acknowledged that more work was being undertaken to understand and address the areas for improvement identified in the new disability standard. It was agreed that a report on progress in delivering the key actions aligned to the challenges outlined in the WRES & WDES priority areas would be presented to the Board in November 2019.

In conclusion, the Board approved the report as the basis for publication of the data and submission to NHS England by 31st July 2019. It also noted the key areas of focus and work underway to make improvements against both the WRES and WDES Standards. It was also agreed to delegate responsibility to the HR Scrutiny Committee, on behalf of the Board of Directors, for monitoring overall performance of WRES and WDES actions going forward with a further progress report to be presented to the Board of Directors in November 2019.

Decision:	Approved the report as the basis for publication of the data and submission to NHS England by 31st July 2019 Delegated responsibility to the HR Scrutiny Committee for monitoring overall performance of WRES and WDES actions going forward. Report on progress in delivering the key actions aligned to the challenges outlined in the WRES & WDES priority areas.	**Action by:** Group Executive Director of Workforce & Corporate Business	**Date:** November 2019

Clinical Research Network; Greater Manchester Annual Report (2018/19), and, the CRN:GM Annual Plan (2019/20)

The Joint Group Medical Director presented a summary overview of the Clinical Research Network; Greater Manchester Annual Report (2018/19) paying particular attention to the key areas of success across CRN:GM coupled with developments across the GM Business Intelligence System which had transformed the day to day activities of all key stakeholders within GM.

The Group Chairman and Group Chief Executive stated that the report served to capture the excellent, first class work undertaken within CRN:GM which clearly demonstrated the translation of research into direct benefits for the citizens of Manchester and beyond.

The Board of Directors also received an overview of the CRN:GM Annual Plan for 2019/20. It was noted that the CRN Coordinating Centre had developed the CRN Performance Operating Framework (POF) for 2019/20 which set out the organisational requirements and the national performance objectives, measures and targets for the NIHR CRN which would be used to measure the success of the LCRN. The Joint Group Medical Director confirmed that the CRN:GM Annual Plan for 2019/20 had been developed with close reference to, and in line with this POF and now set out the strategic direction for CRN GM within this reporting year.

The Board noted the new CRN High Level Objectives (HLOs) which were attached with the submission presented in the report together with the new harmonised specialty objectives. In accordance with the HLOs, it was noted that the CRN:GM had to set 3 specific recruitment targets for 2019/20 (which were also noted). A number of other documents were also noted with the CRN:GM Annual Plan along with a number of appendices which supported the annual plan submission.

Discussion also centred on key activities within the CRN:GM and the inclusion of Community Services & Primary Care going forward.

In conclusion, the Board of Directors received and approve both the CRN:GM Annual Report (2018/19) and CRN:GM Annual Plan (2019/20).

Decision:	CRN:GM Annual Report (2018/19) and CRN:GM Annual Plan (2019/20) approved.	**Action by:** n/a	**Date:** n/a

Update Report on the Management of 'Never Events' (including Action Plan)

The Joint Group Medical Director reminded the Board that in January 2019, a report was presented on the number and type of 'Never Events' (NE) which had occurred in MFT during the previous 12 months along with an Action Plan in response.

The Board noted that the Update Report presented not only provided an overview of MFT's current performance and actions in response to NE's, but also summarised two national documents published in December 2018 *(CQC's 'Opening the door to change: NHS safety culture and the need for transformation', and, NHSI's consultation document 'Developing a patient safety strategy for the NHS')* and set-out recommendations in response to the possible changes ahead.

The Joint Group Medical Director highlighted several key messages captured within the two national reports and it was confirmed that the NHSI consultation document had been reviewed within the organisation and a response submitted to NHSI (overseen by the Joint Group Medical Director, Miss TS Onon, on 14th February 2019).

The Board was advised that up to 14th June 2019, the Trust had experienced 5 NEs (the details of which were duly noted) in a 12 month period and the risk was currently rated at a Level 16. It was also noted that a range of actions had been implemented, or, were 'in progress' as a result of incidents including a new MFT Safe Procedure Policy; updated training programmes for NG tube position checking; implementation of a time out before insertion of implants; and, review of covers on air outlets.

The Joint Group Medical Director confirmed that a clinical 'away session' had also been held to review practice in respect of safety checklists and this had informed an improvement project which was now underway within the MRI; the results of this would inform improvement work across the Group. It was also confirmed that all Hospitals had undertaken work on assessing all invasive procedures and were focused on developing and implementing local safety standards for the highest risk areas.

The Board was advised that a Group Management Board Seminar was held on 29th April 2019 where a detailed discussion on culture was undertaken and this work was now being used to inform the Quality and Safety Strategy and next steps. The Board particularly noted that the Clinical Governance Team had undertaken a gap analysis based on the report and the likely outcome of the consultation and this was detailed in the appendices presented.

The Board of Directors noted the Update Report.

Decision:	Updated report noted	**Action by:** n/a	**Date:** n/a

Follow-up Report on the Response to the Gosport Inquiry Report

The Group Chief Nurse reminded the Board of Directors that an update report was last received on the Trust's response to the findings of the Gosport Independent Panel in January 2019. She explained that the report now presented in July 2019 provided an update on progress with actions pursued by each Hospital/MCS since the beginning of the year along with Group-wide action(s).

The Board particularly noted the development of the Freedom to Speak Up Champions network which was now becoming embedded across all Hospitals and MCS. The Deputy Chairman Fundraising Board & FTSU Guardian confirmed that the MFT Freedom-to-Speak-Up Annual Report would be presented to the Board of Directors at the next meeting in September 2019

The Group Chief Nurse explained that whilst it was not possible to be fully assured that an individual would not seek to harm patients, it was essential that the Board was assured that the systems and processes in place would mitigate any such risk and protect patients from any systematic harm over time that was evident at the Gosport Memorial Hospital. The

The Board accepted the existing Assurance sources presented in the report against the four themes identified and it was concluded that all outstanding actions had been reviewed and aligned with existing work plans and action plans throughout the organisation**.** The Group Chief Nurse confirmed that the Quality Strategy, Executive Work Plans and the CQC Action Plan all addressed any of the outstanding issues for completion. It was noted these actions related to standardisation of mortality review processes; availability of site level data for some outcomes and specialty SHMI; and, improvements to Pharmacy audit process.

In conclusion, the Board of Directors noted and approve sources of assurance presented in the report and supported the continuation of this work through 'business as usual' processes.

Decision:	Progress Report noted and approved the sources of assurance as presented MFT Freedom-to-Speak-Up Annual Report to be presented to the Board of Directors at the next meeting in September 2019	**Action by:** Deputy CEO & FTSU Guardian	**Date:** 9th September 2019

Report on 'Learning from Deaths'

The Joint Group Medical Director provided an overview of a report aimed at providing assurance to the Board that the processes for 'Learning from Deaths' across the organisation were 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 Board noted that a summary of mortality review activity, and the number of deaths deemed potentially avoidable, was available on the public MFT web-site (and was also included in the MFT Quality Report 2018/19).

The Joint Group Medical Director highlighted some of the key information captured within the Group Level SHMI data and paid particular attention to the positive findings identified during 2018/19 which included a conclusion that 'very few deaths of the total reviews undertaken were defined as potentially avoidable'; 'improvements to sepsis management'; 'good end of life care'; 'good management of complex surgery'; 'good input from palliative care team'; 'improvement in palliative care coding'; and, 'ore rapid response to possibility of sepsis'.

The Board also noted the actions undertaken throughout the organisation in response to learning withy examples highlighted within the report presented. The Joint Group Medical Director also described the Mortality Review processes adopted across the Trust (in line with the MFT Mortality Review Policy). It was particularly noted that MFT Hospitals and Managed Clinical Services (MCS) presented a summary of their Mortality Review work to the Group Learning From Deaths Committee, in addition to their internal Mortality and Quality and Safety meeting. It was also noted that correlation and dissemination of these cases was improving learning across the Group.

The Joint Group Medical Director also confirmed that a consistent review process for all deaths of people with a Learning Disability on the Oxford Road Campus was established in January 2019. It was also noted that Wythenshawe, Trafford, Withington and Altrincham (WTWA) had already developed a learning disability mortality review process utilising a checklist which considered additional issues relating to the care and treatment of someone with a learning disability. Key areas of focus going forward based upon the key themes identified from the completed reviews when considering the learning disability aspects of care were noted along with the continuing work to embed a consistent approach to the review of deaths of patients with an identified learning disability.

The Board noted activities captured within the report under the main headlines of 'Introducing the Medical Examiner System'; 'involving Families'; 'Mortality Indices Summary'; and, 'Learning from deaths Scrutiny Meetings'.

In conclusion, the Joint Group Medical Director explained that since the inception of MFT in October 2017, a considerable amount had been achieved in developing a coherent and uniform approach to Learning from Deaths to improve the quality and safety of care. She emphasised that there would now be pace applied to the implementation of the structured judgement review as the tool for the review of all adult deaths.

It was particularly noted that overall, mortality metrics suggest that the work programs of 2018/2019 to address coding issues continued to deliver improvement, but that co-morbidity coding still required further work. The Joint Group Medical Director confimred that going forward, the focus would be less on process and more on the learning from deaths, and dissemination of the resulting changes and developments in practice across the organisation

The Board of Directors receive the report and noted the actions taken.

Decision:	Report received and actions taken noted.	**Action by:** n/a	**Date:** n/a

The MFT Complaints Annual Report (2018/19)

The Group Chief Nurse confirmed that the Trust adhered to the Statutory Instruments No. 309, which required NHS bodies to provide an annual report on the Trust's complaints handling, which must be made available to the public under the NHS Complaint Regulations (2009). She explained that the MFT Complaints Annual Report reflected all complaints and concerns made by (or on behalf of) patients of the current and legacy Trusts, received between 1st April 2018 and 31st March 2019.

The Board was reminded that extensive work had been undertaken during 2018/19 to develop the complaints systems and processes for the newly formed MFT. The Group Chief Nurse explained that the report celebrated some of those achievements and improvements, whilst acknowledging there were further improvements still to be realised in the newly established Trust as Hospitals/ Managed Clinical Services (MCSs) and the Manchester Local Care Organisation (MLCO) developed and refined their processes for complaints handling.

The Board noted that throughout the report, the term 'Complaints' was used to describe formal complaints requiring a response from the Chief Executive and the term 'Concerns' was used to describe informal contacts with the Patient Advice and Liaison Service (PALS), which required a faster resolution to issues that may be resolved in real time.

The Group Chief Nurse explained that the report detailed examples of learning and change as a direct result of feedback received through complaints and concerns. It was particularly noted there had been a demonstrable improvement in the timeliness of complaint acknowledgement, a more timely response to PALS concerns and formal complaints coupled with a reduction in the number of unresolved complaints over 41 days.

The Board was advised that the Complaints / PALS processes would continue to be reviewed and developed in 2019/20 in order to ensure that the Trust continued to be responsive to feedback received in the form of complaints or PALS concerns. The Group Chief Nurse pointed out that it was anticipated that improvement of the complaint response would lead to a reduction in the number of re-opened cases.

Both the Group Chief Nurse and Group Chairman expressed their gratitude to those patients and families who had taken the time to raise concerns and acknowledged their contribution to improving services, patient experience and patient safety within MFT.

In conclusion, the Board of Directors noted the content of the comprehensive report, the work undertaken by the corporate and Hospitals/ MCSs and MLCO teams to improve the patient's experience of raising complaints and concerns and, in line with statutory requirements, provided approval for the report to be published on the Trust's website.

Decision:	Annual report noted and approval received for the document to be published on the Trust's Website.	**Action by:** n/a	**Date:** n/a

The MFT Safeguarding Annual Report (2018/19)

The Group Chief Nurse presented the MFT Safeguarding Annual Report which reflected the safeguarding work undertaken throughout the Trust and outlined some of the key safeguarding priorities across the city of Manchester during 2018/19.

The Board noted that the aim of the Annual Report was to provide assurance that the Trust was fulfilling its statutory safeguarding responsibilities as outlined in Section 11 of the Children Act 2004 and in the Care Act 2014. It was noted that it also aimed at providing assurance that systems were in place that supported MFT service users to be kept safe whilst in the care of the Trust's Hospitals, Managed Clinical Services (MCS) and the Manchester Local Care Organisation (MLCO), and ensured they were protected from neglect or harm. It also ensured that patients, service users and families had a voice, ensuring that they were actively involved in any decision-making regarding their safety and protection; that they felt safe and were protected from harm or neglect.

The Group Chief Nurse described some of the internal and external safeguarding activity undertaken in 2018-2019 and outlined key priority areas for 2019-2020. She explained that the previous 12 months had been an extremely busy year for safeguarding with challenges, changes and opportunities in safeguarding within the Trust and across Manchester and GM. It was noted that changes to legislation, national policy and guidance continued to influence the safeguarding agenda and the establishment and embedding of MFT and the MLCO had enabled safeguarding to be considered at a whole system level across the organisation and beyond.

The Board acknowledged that the 2018-2019 Annual Report demonstrated the complexity of the safeguarding work undertaken within the Trust by the Safeguarding Team and wider workforce whilst ensuring that patients and staff were safe.

In response to observations from Mrs Chris McLoughlin on the benefits of the merger since October 2017, it was also recognised that in the coming year, the Safeguarding Team would consolidate delivery of safeguarding services under the Single Hospital Services and would ensure that the support of staff and the protection of patients remained central in any organisational change.

In conclusion, the Board of Directors noted the activity undertaken within the Trust and across the multi-agency partnership to support MFT staff and services to be responsive to the safeguarding needs of patients and service users. The Trust's on-going focus on safety supports safeguarding to remain a key organisational Priority was also noted.

The Chairman on behalf of the Board of Directors noted the work undertaken by the safeguarding team in keeping vulnerable people safe.

Decision:	Annual report noted	**Action by:** n/a	**Date:** n/a

Committee meetings which had taken place:

- Group Risk Management Committee held on 8th May 2019
- Audit Committee held on 22nd May 2019
- Quality & Performance Scrutiny Committee held on 4th June 2019
- MLCO Scrutiny Committee held on 7th May 2019
- HR Scrutiny Committee held on 25th June 2019

110/19 Date and Time of Next Meeting

The next meeting of the Board of Directors held in public will be on **Monday 9th September 2019** at **2pm** in the **Main Boardroom**

111/19 Any Other Business

There was no other business.

Present:	Mr J Amaechi	-	Group Non-Executive Director
	Mr D Banks	-	Group Director of Strategy
	Dr I Benett	-	Group Non-Executive Director
	Mr P Blythin	-	Group Director of Workforce & Corporate Business
	Mrs J Bridgewater	-	Group Chief Operating Officer
	Mrs K Cowell (Chair)	-	Group Chairman
	Mr B Clare	-	Group Deputy Chairman
	Sir M Deegan	-	Group Chief Executive
	Professor J Eddleston	-	Joint Group Medical Director
	Professor L Georghiou	-	Group Non-Executive Director
	Mr N Gower	-	Group Non-Executive Director
	Mrs G Heaton	-	Group Deputy CEO
	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 D Cain	-	Deputy Chairman Fundraising Board
	Mr A W Hughes	-	Director of Corporate Services / Trust Board Secretary
	Mr M McCourt	-	Chief Executive, MLCO
Apologies:	Professor Dame S Bailey	-	Group Non-Executive Director
	Miss T Onon	-	Joint Group Medical Director

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING (Public)

ACTION TRACKER

Board Meeting Date: 11th March 2019			
Action	Responsibility	Timescale	Comments
Nursing & Midwifery Safer Staffing Report (inc progress on the retention programme work streams) to be presented to the Board of Directors	Group Chief Nurse	September 2019	*Scheduled for September 2019*
Priority areas for action from the 2018 National Staff Survey to receive a mid-year review of progress against agreed actions by the HR Scrutiny Committee.	Group Executive Director of Workforce & Corporate Business	October 2019	*Scheduled for October 2019*

Board Meeting Date: 8th July 2019			
Action	Responsibility	Timescale	Comments
Update Report on how progress with the MFT Annual Plan (2019/20) will be monitored	Group Executive Director of Strategy	November 2019	*Scheduled for November 2019*
Bespoke awareness (development) session on the new Attendance Absence Management System for the Group Non-Executive Directors	Executive Director of Workforce & Corporate Business	October 2019	*Scheduled for October 2019*
MFT Freedom-to-Speak-Up Annual Report to be presented to the Board of Directors at the next meeting in September 2019	Deputy CEO & FTSU Guardian	September 2019	*Schedule for September 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:	September 2019
Subject:	**Board Assurance Report – July 2019**
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration of Risk against Key Priorities:	The Board Assurance Report is produced on a monthly basis to inform the Board of compliance against key local and national indicators as well as 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)

Safety
R.Pearson\T.Onon

Core Priorities	✓	◇	×	No Threshold
	3	1	1	0

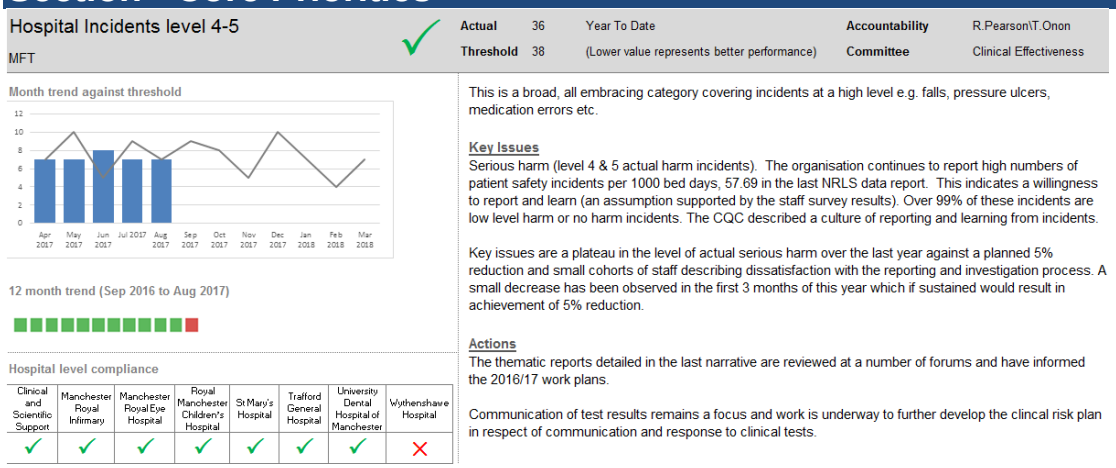
The bar at the very top of each page identifies the domain and accountability. To the right of the top bar is a summary of the core priority indicators associated with the domain. For the example of Patient Safety:

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

Headline Narrative

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

Section - Core Priorities



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.

> Board Assurance

July-19

Safety

J.Eddleston\T.Onon

Core Priorities	✓	◇	×	No Threshold
	5	0	1	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.
In response to this the following actions are underway and will be included in a review of the group risk (Never Events - 3228).

- New MFT Policy in place for Safe procedures and being implemented
- Group wide work is being undertaken on Safe Surgery/Procedure Checklists
- Work has been undertaken with the National Health Safety Investigation Branch (HSIB) on learning
- Work is being undertaken with the Shelford Safety leads to ascertain if there is further learning and action that can be shared
- A further Safety Alert has been circulated to all Hospital sites with required actions
-All Hospital Sites / MCS are undertaking risk assessment for each Never Event type including identifying controls in place and actions required and adding to the Risk Register
The Quality and Safety Committee will be overseeing this work and the aim continues to be to eradicate these events.

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

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

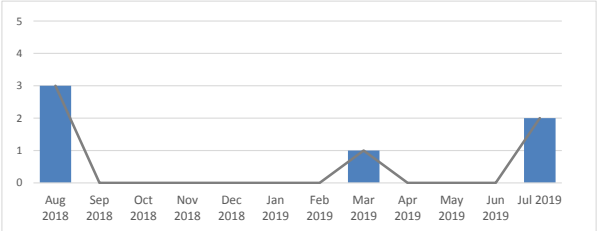
Safety - Core Priorities

Never Events

✗

Actual 2 Year To Date **Accountability** J.Eddleston\T.Onon
Threshold 0 (Lower value represents better performance) **Committee** Clinical Effectiveness

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✗	✓	✗	✓	✓
0	0	1	0	1	0	0

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

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

In the last 12 months there have been 6 Never Events 2 misplaced NG Tubes, 1 wrong site surgery, 1 wrong implant, 1 retained item and 1 connection to air instead of oxygen. Investigations for all of these are complete or underway with a range of actions being implemented.

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 or are underway to identify learning with associated action plans in place.

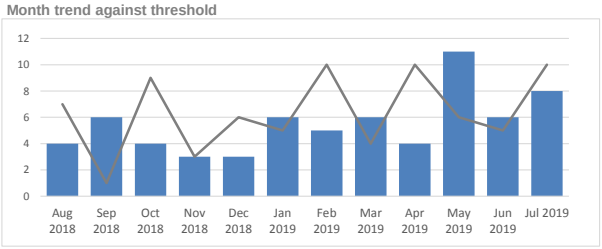
A new MFT Safe Procedure Policy is now in place. Further work is now being undertaken Group wide on safer surgery/ procedure checklists and item counts, with a focused pilot in MRI bearing completion and a plan to rollout across teh group from the autumn. This work will be reported to the Quality and Safety Committee.

Hospital Incidents level 4-5

✓

Actual 29 Year To Date **Accountability** J.Eddleston\T.Onon
Threshold 31 (Lower value represents better performance) **Committee** Clinical Effectiveness

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✗	✓	✓	✗	✓	✗
2	9	2	2	2	0	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, 53.03 in the last NRLS data report. This indicates a willingness to report and learn (an assumption supported by the staff survey results). Over 99% of these incidents are low level harm or no harm incidents.

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

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

Thematic reports are reviewed at a number of forums and will inform the 19/20 work plans.

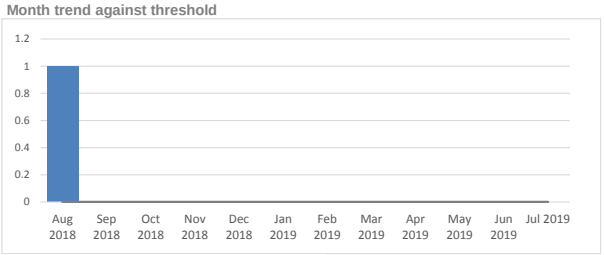
> Board Assurance

July-19

Mortality Reviews - Grade 3+ (Review Date)

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

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✓	✓	✓	✓	✓
0	0	0	0	0	0	0

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

Key Issues

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

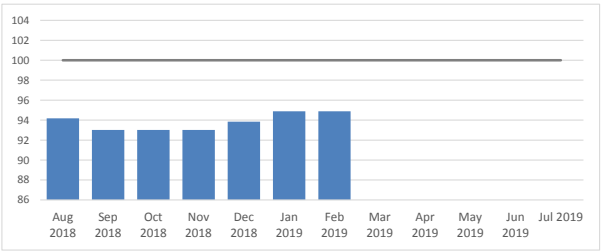
The role of the Group Mortality Review Group in supporting dissemination of good practice, lessons and action plans is being developed. Mortality review processes are generally robust, but will be altered by the introduction of a Medical Examiner system. A deficiency in mortality review for patients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

Actions

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

SHMI (Rolling 12m)

Actual	94.9	Latest Period	**Accountability**	J.Eddleston\T.Onon
Threshold	100	(Lower value represents better performance)	**Committee**	Clinical Effectiveness



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✓	NA	NA	NA	NA	✓
NA	96.0	NA	NA	NA	NA	92.4

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. The Chief Medical Examiner role is now being appointed to.

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 and adults with a Learning Disability undergo a detailed mortality review.

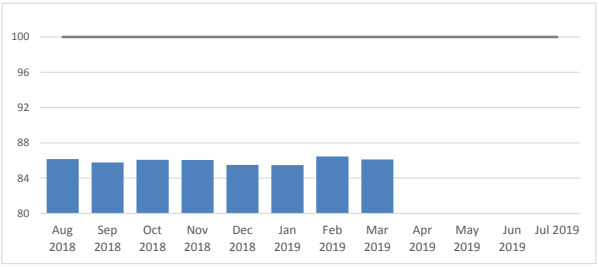
Performance is well within the expected range.

> Board Assurance

July-19

HSMR (Rolling 12m)

Actual	86.1	Latest Period	**Accountability**	J.Eddleston\T.Onon
Threshold	100	(Lower value represents better performance)	**Committee**	Clinical Effectiveness



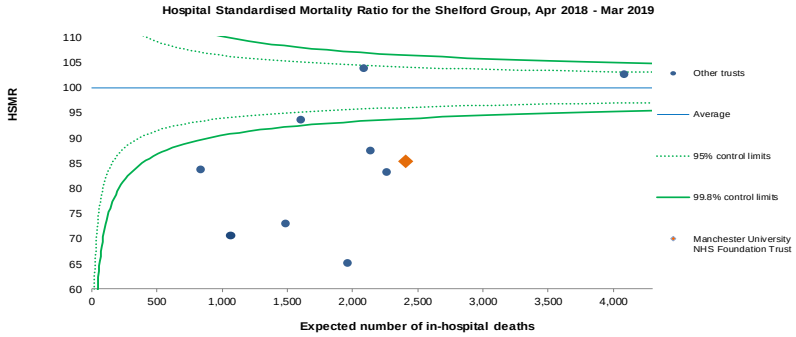
HSMR monitors a Trust's actual mortality rate when compared to the expected mortality rate. It specifically focuses on 56 diagnosis codes that represent 85% of national admissions.

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.

Progress

The Group HSMR is within expected levels.



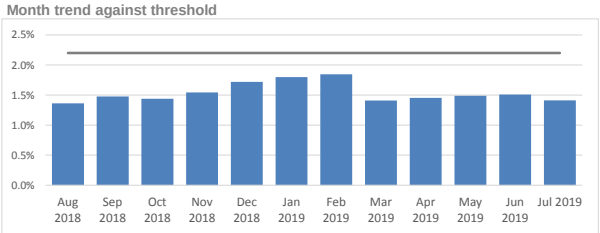
Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✓	NA	NA	NA	NA	✓
NA	80.8	NA	NA	NA	NA	86.0

Crude Mortality

Actual	1.46%	Year To Date	**Accountability**	J.Eddleston\T.Onon
Threshold	2.20%	(Lower value represents better performance)	**Committee**	Audit Committee

Month trend against threshold



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

Key Issues

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

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

Progress

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✓	✓	✓	✓	✓	◇
NA	1.7%	0.2%	0.3%	0.0%	0.0%	2.3%

Patient Experience

C.Lenney

Core Priorities	✓	◇	✕	No Threshold
	5	1	1	2

Headline Narrative

In relation to the volume of complaints, over 41days and the resolution of complaints within timescale demonstrates an improving picture.The number of new formal complaints received across the Trust during June 2019 was 114 which is a decrease compared to 127 in May 2019 and 120 in April 2019. Performance is monitored and managed through the Accountability Oversight Framework (AOF). There is a reduction of cases over 41 days in June 2019 when compared to May and April 2019. The closure of complaints within the agreed timescales across MFT in June 2019 was 70.3%,demonstrating an increase in the number of complaints resolved within the timeframe agreed with the complainant.

The Friends and Family Test (FFT) score is unchanged with an overall score of 94% of respondents 'Extremely Likely' or 'Likely' to recommend the service they received to their Friends and Family

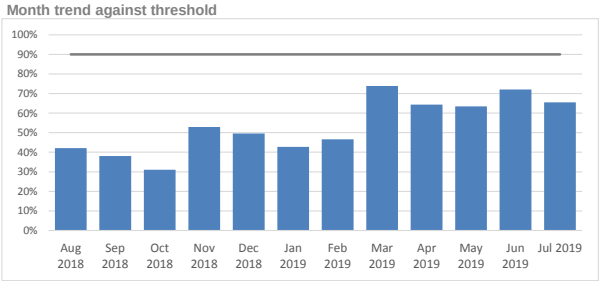
Infection prevention and control remains a priority for the Trust. Trust performance for the current financial year (until the end of June 2019) is below trajectory for CDI but above trajectory for MRSA due to one case being reported in May 2019 (against a threshold of zero).

Patient Experience - Core Priorities

Percentage of complaints resolved within the agreed timeframe

Actual	66.4%	Year To Date	**Accountability**	C.Lenney
Threshold	90.0%	(Higher value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
◇	✕	✕	◇	✓	✕	◇
89.7%	41.0%	48.5%	86.2%	90.9%	61.5%	87.4%

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

Progress

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

The overall MFT performance continues to demonstrate improvement since March 2019 with performance in July 2019 at 65.5% .

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.

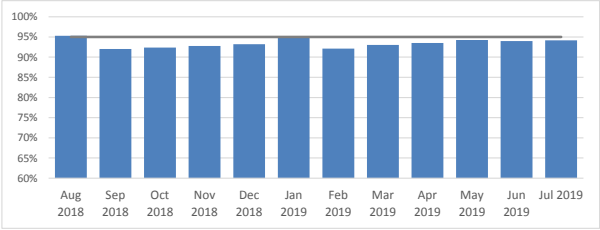
Actions

Performance is monitored and managed through the Accountability Oversight Framework (AOF).

FFT: All Areas: % Extremely Likely and Likely

Actual	94.0%	Year To Date	**Accountability**	C.Lenney
Threshold	95.0%	(Higher value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
◇	◇	◇	✓	◇	✓	◇
94.9%	92.6%	90.9%	97.6%	94.2%	97.3%	94.2%

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

Actions

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

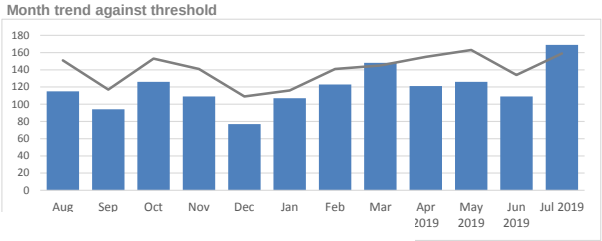
Progress

The response rate for Inpatients in July 2019 improved by 4.3% to 26.5%.
The Emergency Departments response rates in July 2019 was 11.7%, this was a decrease of 0.4% compared to May 2019 .
The implementation of SMS text messaging for the FFT for the Paediatric Emergency Department, RMCH is in its final stages of being developed and is anticipated to improve response rates.

Complaint Volumes

Actual	525	Year To Date	**Accountability**	C.Lenney
Threshold	611	(Lower value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✗	✓	✓	✓	✓
30	141	69	51	20	15	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 July 2019 was 169 which is a significant increase of 60 cases.
WTWA received the highest number of formal complaints in July 2019, receiving 57 complaints (33.72% of total). This is a significant increase in number of complaints for WTWA compared to the previous three months. Of the 57 complaints received there were no specific themes or clinical locations identified.
MRI received the second highest number of formal complaints in July 2019, receiving 37 complaints (21.89% of total).
At the end of July 2019 there was a total of 32 cases over 41 days old, this is comparable to the previous three months.
The Hospital/MCS with the highest number of cases over 41 days at the end of July 2019 was WTWA with 10 (5.91% of total) cases at 41 days old. This number is higher than the number of WTWA cases at over 41 days old at the end of June 2019 (7) and May 2019 (7).
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 (AOF).

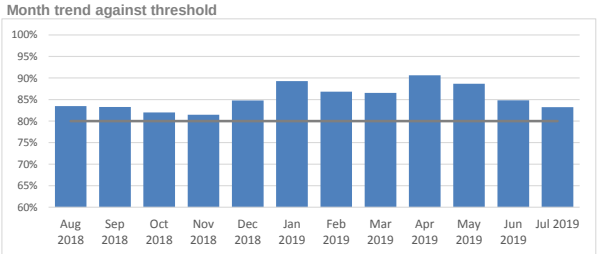
Progress

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

Nursing Workforce – Plan v Actual Compliance for RN

Actual	83.2%	Latest Period	**Accountability**	C.Lenney
Threshold	80.0%	(Higher value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✓	✗	✓	✓	NA	✓
NA	83.6%	78.1%	81.2%	90.4%	NA	85.4%

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 July 2019 there were 13 (14%) inpatient wards across the Group that had a registered nurse vacancy factor above 25%. The nurse fill rate continues to reach the 80% target with a fill rate of 83.2% which is a slight reduction to June when the fill rate was 84.8%. It is anticipated that the fill rate will increase when the next group of newly qualified nurses commence in post from September 2019.

Established escalation and monitoring processes are in place to ensure delivery of safe and effective staffing levels to meet the acuity and dependency of the patient group. Daily senior nurse staffing huddles are in place across the Hospitals.

Actions

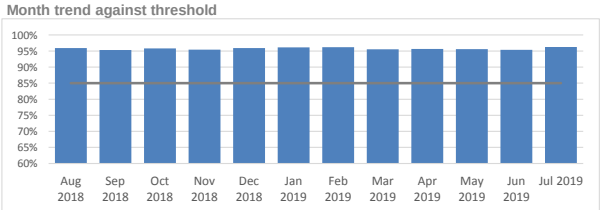
Where shortfalls in nurse staffing levels occur and this cannot be resolved, staff are redeployed from other areas following a risk assessment and professional judgement based on the acuity and dependency of patients in each area. Nursing assistant levels are increased in some areas to support such a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

Acuity and dependency data is captured through the Allocate SafeCare system which supports daily deployment of nursing staff. The Safer Care Nursing Tool (SNCT) has been introduced to support establishment reviews. The hospitals completed a 2nd data census in June to determine the acuity and dependancy of patients on their wards. This data will support annual establishment reviews to ensure wards are staffed safely based on patients needs.

Food and Nutrition

Actual	95.7%	Year To Date	**Accountability**	C.Lenney
Threshold	85.0%	(Higher value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✓	✓	✓	✗	✓
98.4%	95.5%	90.7%	97.2%	98.1%	80.8%	96.8%

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 in response to the low score achieved by the Trust within the National Impatient Survey. Patient Dining Forums are established for ORC and WTWA. The Oxford Road Campus Improvement Programme 'Good to Great' is now led by the Head of Nursing (Quality and Patient Expereince) the Improvement Programme has been rolled out to WTWA, led by the Deputy Director of Nursing.

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

The Hospital/ MCS progress related to delivering the commitments withing the Nutrition and Hydration Strategy is monitored through the Trust Patient Experience and Quality Forum.

> Board Assurance

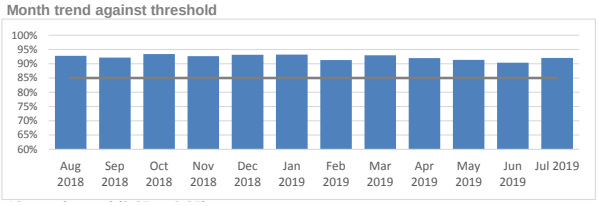
July-19

Pain Management

✓

Actual	91.4%	Year To Date	**Accountability**	C.Lenney
Threshold	85.0%	(Higher value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✓	✓	✓	✓	✓
96.9%	86.7%	85.2%	94.8%	98.5%	100.0%	92.7%

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

Progress

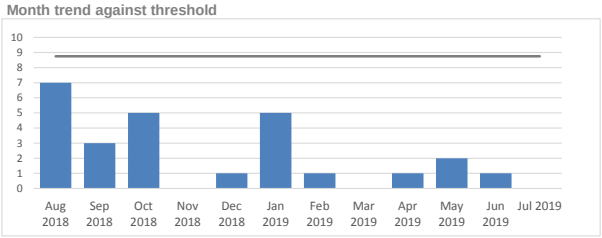
Work continues across the Trust to drive improvements in pain assessment and management.
The oversight for this work is now provided by the Deputy Director of Nursing, CSS who continues to lead work to establish a future work programme. Performance against this KPI is monitored through the Trust Harm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

Clostridium Difficile – Lapse of Care

✓

Actual	4	Year To Date	**Accountability**	C.Lenney
Threshold	26	(Lower value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✓	✓	✓	✓	✓
0	2	0	0	0	0	2

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. Recent changes to the national apportioning algorithm mean that trust attributable cases now also include cases that have been an inpatient at the reporting trust within the previous 28 days. Accordingly, the new maximum threshold for the Group for 2019/2020 is 173 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

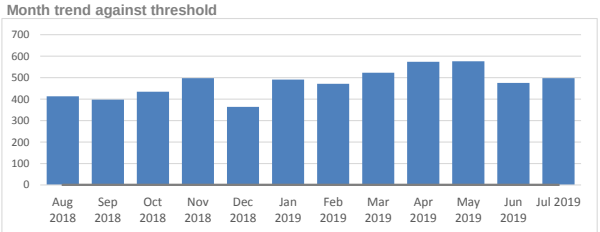
There have been a total of 70 cases of Clostridium difficile infection reported since April 2019: 48 (68.5%) of which were trust-attributable against a trajectory of 68. Following CCG review, there have been four lapses in care identified: two lapses in care identified at MRI (HPB and Ward 10) and two lapses in care identified at Wythenshawe Hospital (Ward A4 and Ward A1), with 17 cases pending review (awaiting ribotyping results/details of further investigation etc.).

PALS – Concerns

-

Actual	2122	Year To Date	**Accountability**	C.Lenney
Threshold	None	(Lower value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
-	-	-	-	-	-	-
116	511	244	179	132	74	714

The number of PALS concerns received by the Trust is within the limits of normal variation.

Key Issues

A total of 497 PALS concerns were received by MFT during July 2019 compared to 475 PALS concerns in June 2019.

The Hospital / MCS level performance against this indicator for year to date is detailed in the Hospital/ MCS Level Compliance Chart and volumes of PALs are monitored via the AOF.

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.

> Board Assurance

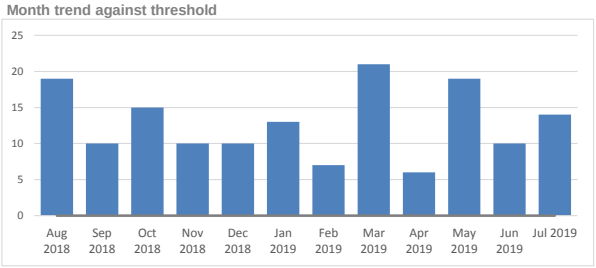
July-19

All Attributable Bacteraemia

-

Actual	49	Year To Date	**Accountability**	C.Lenney
Threshold	None	(Lower value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
-	-	-	-	-	-	-
5	22	3	4	0	0	7

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 25% reduction in healthcare associated GNBSIs by April 2022, and a 50% reduction by April 2024. There are currently no sanctions applied to this objective

Progress

There have been 190 incidents of E. coli bacteraemia reported since April 2019. Of these, 42 (22%) cases were determined to be hospital-onset, against a trajectory of 33.

There have been two trust-attributable MRSA bacteraemias reported since April 2019 (AICU and the Burns Unit, both at Wythenshawe Hospital), with two non-trust-attributable MRSA bacteraemia reported (AMU at Wythenshawe Hospital and A&E at MRI).

Operational Excellence

J.Bridgewater

Core Priorities	✓	◇	✕	No Threshold
	4	0	7	0

Headline Narrative

• **Diagnostic standard -** MFT has delivered outstanding performance with delivery of the national standard in July reporting 0.89% against the 1% national standard. While Wythenshawe Hospital has performed well against this target pre and post merger, historically Oxford Road Campus has been challenged, and this is the first time MFT as an integrated organisation has achieved the target. This is exceptional performance by Hospitals and CSS against a backdrop of +10.8% increase in demand, and national pressures reporting performance of 3.8% for June. As a Trust, providing shorter waiting times for diagnostics will invariably improve the patient experience and support the positive transformation of cancer pathways.

• **A&E 4 hours** - MFT performance in July remains challenged, underachieving against the 90% trajectory. As a result a rapid recovery trajectory and actions are in place across the Hospitals / MCS and MLCO to support recovery in the remainder of Q2. Patient safety remains a key priority with strong performance for ambulance handover and no 12 hour trolley waits. Areas of focus align to the national priorities including: improving overnight performance, increasing streaming and same day emergency care, improving flow within the hospitals and timely discharge, and working with system partners on reducing demand and long length of stay and Delayed Transfers of Care.

• **RTT** - The waiting list size trajectory has been delivered across Q1, due to increases in elective activity and improvements in data quality. Performance is reported as 83%, which is below MFT performance for June and the National profile. The performance was expected to reduce in line with actions being taken via the Trust RTT Recovery Task Force. Progress updates have continued to be provided to the Trust Quality and Safety and Quality and Performance Scrutiny Committees outlining the factors and ongoing actions, with oversight maintained through the RTT Task Force and close working with Commissioners.

• **+52 week Waits** - The Trust continues to deliver its commitment to eliminate all 52 week waits with zero reported in July.

• **Cancer 62 Day** - As expected in line with action taken to treat a number of the longest wait patients and improve the size of the cancer patient tracking lists performance in Q4 reduced to 77.4%, which was in line with the national trend and performance. Performance is challenged across the MRI, SMH and WTWA. A cancer excellence programme is in place to support quality improvements for the benefit of patient access and experience, and is focused on: implemnting best practice, improvement of pathways and capacity, training and eductaion.

• **Cancelled operations >28 days** - There were 0 reported in July.

Operational Excellence - Core Priorities

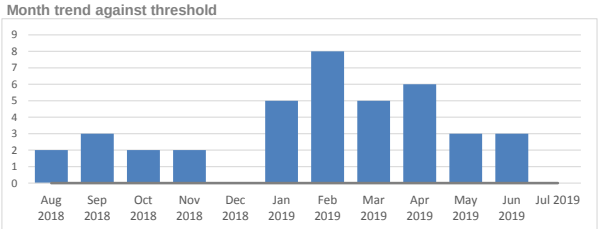
Cancelled operations - rescheduled <= 28 days

✕

Actual 12 Year To Date **Accountability** J.Bridgewater

Threshold 0 (Lower value represents better performance) **Committee** Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✕	✕	✓	✓	✓	✓	✕
1	4	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.
Capacity and Demand plans are in place to support Trust bed requirements which is a factor in cancellations.

Progress

• In July there were 0 reported breaches.
• MFT continues to perform strongly against this target, and remains within the top three acute Trusts in GM.
• MFT typically performs better than the national position against this standard.

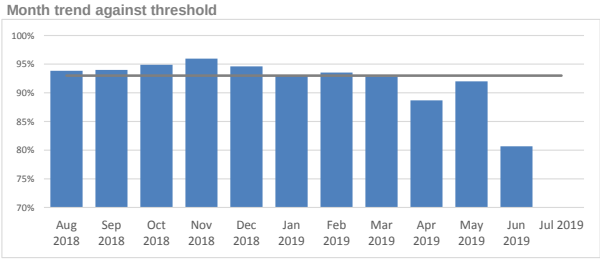
Cancer Urgent 2 Week Wait Referrals

✕

Actual 87.4% Quarterly **Accountability** J.Bridgewater

Threshold 93.0% (Higher value represents better performance) **Committee** Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✕	✓	✕	NA	NA	✕
NA	90.5%	98.3%	72.1%	NA	NA	88.0%

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, creating capacity pressures, in particular this is a key pressure within the Gynaecology service on the Oxford Road Campus.
• Aid to the Stockport Breast service has exceeded capacity and is having significant impact on performance.

Actions

• Collaborative actions taken with speciality teams to strengthen performance and increase the volume of patients seen within 7 days, within the workforce available.
• SMH have reviewed the Gynaecology pathway and have an action plan in place, additional support has been put in place in Q1 / Q2 as this is currently the area of greatest risk to the standard.
• GM have recognised the increase in demand is significant across the region and are reviewing the demand profile.
• An action plan is in place for the WTWA Breast pathway working collaboratively with Stockport and Commissioners to sustain provision of Breast services for patients in GM.
• Actions being taken to support the 62 Day standard will also support 2ww delivery.

Progress

• High numbers of breaches in Breast as expected in line with providing aid to Stockport service, plans are in place to increase capacity and improve access times.
• Gynaecology delivery service reflective of GM pressures, although in July and August there is emerging improving performance.
• MRI improving with progress in LGI.

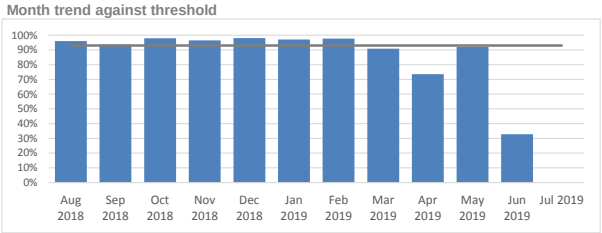
> Board Assurance

July-19

Cancer 2 Week Wait - Breast

Actual	64.4%	Quarterly	**Accountability**	J.Bridgewater
Threshold	93.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	NA	NA	NA	NA	NA	✗
NA	NA	NA	NA	NA	NA	64.4%

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, with a strong track record of performance.Support to Stockport has placed considerable pressure on service delivery, with June reporting performance of 33%.

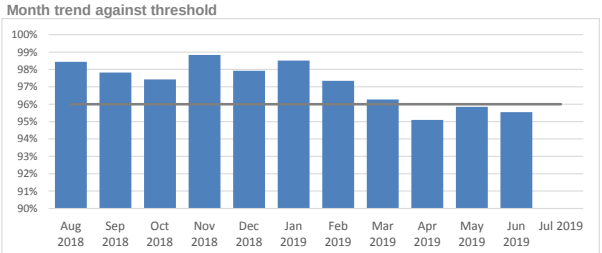
Actions
Actions taken as per the 62 day standard.

Progress
The Trust is underachieving against the standard, performance is being monitored and escalated by Manchester Commissioners.

Cancer 31 Days First Treatment

Actual	95.5%	Quarterly	**Accountability**	J.Bridgewater
Threshold	96.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✗	✓	✓	NA	NA	✓
NA	91.8%	100.0%	100.0%	NA	NA	96.4%

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
MRI failed Q4 with a signifcant number of breaches in Urology. A back log was cleared within this time and some surgery has now moved to Christie and WTWA.

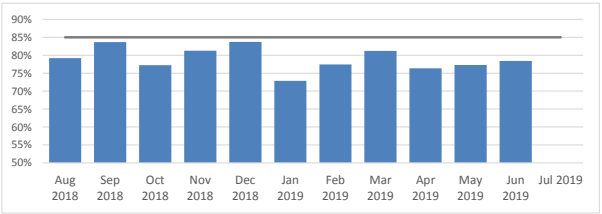
Progress

Typically the Trust performs well against this standard. However, MRI urology and Wythenshawe Lung pressures have contributed to lower performance.

Cancer 62 Days RTT

Actual	77.4%	Quarterly	**Accountability**	J.Bridgewater
Threshold	85.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✗	NA	✗	NA	NA	✗
NA	80.7%	NA	61.5%	NA	NA	77.3%

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

Key Issues
• The Trust continues to experience a significant increase in the demand for cancer services in excess of the national and regional profile, circa 20%.
• Capacity pressures across high demand services.

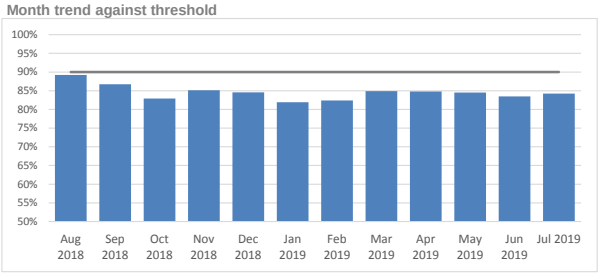
Actions
• Oversight and Monitoring by Hospital Cancer Boards.
• Assurance and challenge through AOF
• Group Cancer Excellence Improvement Programme - 6 Key Elements based on NHSI and national best practice, presented to MFT Cancer Committee in August 19.
• Working with NHSI to access external expertise and assurance, focused on utilisation of demand and capacity tools, strengthening training for teams.
Key Hospital/MCS Actions:
• Senior Hospital monitoring and escalation of delays in patient pathway on cancer PTL
• Speciality level recruitment of workforce to match demand.
• Pathway developments i.e. Lung, LGI
• SMH increasing 2ww and diagnostic capacity
• CSS increasing diagnostic scan and reporting capacity

Progress
•The Trust is underperforming against the 62 day standard,
• Q4 performance reduced to 77.4% in line with actions to improve the patient tracking list size and increase the number of treatments undertaken. MFT was inline with the national trend for the same period with a 5% reduction in performance in Q4.
• The GM region is experiencing increased pressure with demand growth, which is impacting on performance across a number of providers and underperformance of the 62 day standard.
• MRI has maintained continued improvement, albeit with pressures remaining in Urology and LGI.
• Wythenshawe has experienced pressure in lung, with Hospital Executive oversight in place.
• SMH experiencing significant pressure in Gynaecology, reflective of GM demands on this service.
• Shared learning - NHSI enhanced training attended by Cancer Manager to explore further improvement opportunities across networks.

A&E - 4 Hours Arrival to Departure

Actual	84.21%	Quarterly	**Accountability**	J.Bridgewater
Threshold	90.00%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✗	◇	✓	✓	✓	✗
NA	76.2%	89.9%	93.8%	100.0%	100.0%	85.2%

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

- Mutual aid to other GM providers is a risk of increased pressure on A&E and out of area admissions.
- Greatest challenge for Hospitals include: Overnight pressures in A&E, Stranded patients and DTOC.
- Increased demand seen in Q4/Q1 has continued into Q2.
- Community capacity as alternative to A&E, Primary care capacity to facilitate increased streaming.
- Reduction/changes in community/care home capacity across GM.
- Age profile of presentations to Wythenshawe weighted with older, frail patients.
- RMCH has seen a change in demand profile with an increase in acuity and patients requiring critical care.
- Mental Health bed capacity and increasing DTOC.

Actions

- Internal oversight arrangements are in place with twice weekly meetings between the Group COO and Hospital Chief Executives.
- Hospitals have a number of plans in place that are being progressed to support resilience including:
  - 2019/20 Capacity Plans
  - Transformation plans and patient flow improvement boards
- Working with system partners and the LCO to reduce long length of stay and improve discharge, with a trajectory in place for 19/20.
- Joint working with GM Mental Health, task force established, working to improve ambulatory pathways and timely assessment of patients.
- Capital upgrade to Wythenshawe, MRI, and PED.
- Treat and Transfer pathways RMCH
- Working with system partners to seek external expertise and assurance in relation to: long length of stay patients and corridor care.
- Supported GM deep dive review of Same Day Emergency Care in conjunction with NHS Elect.
- Additional actions are being taken to support improvement in performance, overseen by the Group COO, and supported by additional regional discussions. These are aligned to national priorities of: Streaming, Same Day Emergency care, Flow, Timely Discharge and reducing long length of stay. In addition, all 3 main ED departments will be working with ECIST over the next 3 months to support implementation of local actions.

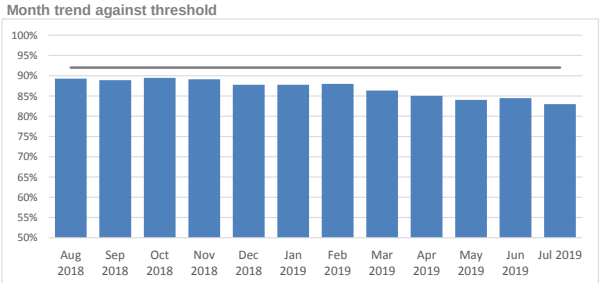
Progress

- MFT reported performance of 84.21% for July which circa -2% below national levels.
- Pressures overnight remain a challenge at MRI and Wythenshawe Hospitals.
- Revised trajectories in place to supporting intensive recovery plans with oversight of Group COO.
- MLCO and partners attending weekly LOS meetings to improve timely discharge for patients.
- Senior leadership working with external partners, ECIST based onsite to support opportunities for improvement.
- National weekly LLOS reporting and ECIST workshops now completed by the Trust which stratifies reasons for >21 day los from CUR.
- Secured plans to reinstigate GP streaming, and revise supporting model to optimise access to ENP and ANP at Wythenshawe Hospital.
- Focus on safety and reducing risk, performance against type 1 included in oversight meeting with Hospital Executives.

RTT - 18 Weeks (Incomplete Pathways)

Actual	83.0%	Latest Period	**Accountability**	J.Bridgewater
Threshold	92.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✗	✗	✗	✗	✗	✗
92.2%	85.1%	80.7%	79.9%	83.9%	81.1%	83.7%

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, with an increase in referrals across Q1 of 19/20
- Capacity and workforce pressures.
- Urgent Care pressures.
- Work to upgrade the PAS across the Oxford Road Campus and 18 week reporting systems is a key risk to growth of the waiting list.

Actions

RTT Taskforce in place, chaired by the Chief Operating Officer and Chief Information Officer

- RTT Recovery programme in place, with continued delivery across 6 work streams including 52+ week waits, data quality, PAS upgrade, training and education and outpatient transformation.
- RTT PMO in place to ensure delivery and support to hospitals.
- 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.
- Commencement of middle manager elective care education programme, in conjunction with NHS Improvement
- Working with Commissioners in relation to demand management, particularly for specialist hospitals, to support stability of the waiting list.
- Additional independent sector capacity across SMH in June 2019, and corporate performance team capacity to support validation and reduction in the waiting lists.
- Working with NHSI to access external expertise and assurance, focused on utilisation of demand and capacity sustainability tools, strengthening training, knowledge and expertise for hospital teams.

Progress

- Trust RTT performance in July is 83% which is below the National profile of (86.3% latest June 19)
- Trust's RTT waiting list size has been delivered better than trajectory for July 19 and across all of quarter 1 19/20. This has been due to improvements in the timely treatment of patients and data quality validation of the waiting list.
- The Trust has had no 52 week breaches in Quarter 1 of 19/20, in line with trajectory.
- High risk area for 52+ weeks is Gynaecology Services, on the Oxford Road Campus. Actions taken include: daily tracking of long wait patients, preparation and implementation plan for e- referrals, and minimum data set for referrals into the service.

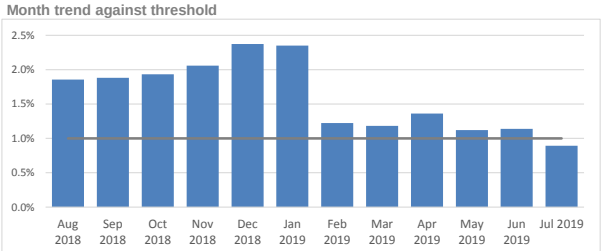
> Board Assurance

July-19

Diagnostic Performance

Actual	0.9%	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	Wythenshawe, Trafford, Withington & Altrincham
✓	◇	◇	✗	NA	NA	✓
0.8%	1.2%	4.6%	32.3%	NA	NA	0.4%

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

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

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

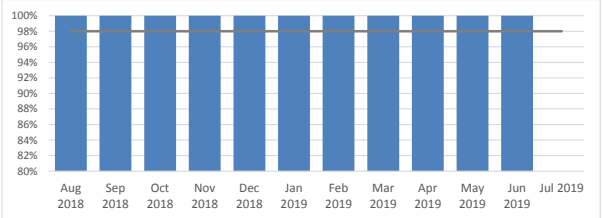
Actions
- Monitoring sustainability through AOF process.
- Implementation of the business case for the 3rd MRI scanner.
- Additional recurrent radiology sessions.
- Monthly forecasting in place, risks escalated to Hospital Directors.

Progress
- The Trust has achieved better than the 1% target, reporting 0.89% for the first time since 2014. This outstanding achievement has been against backdrop of a 10.8% increase in referrals.
- SMH and RMCH are reporting amber compliance, with small waiting lists and less than 8 breaches on each site.

Cancer 31 Days Sub Chemo Treatment

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

Month trend against threshold



Hospital level compliance

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

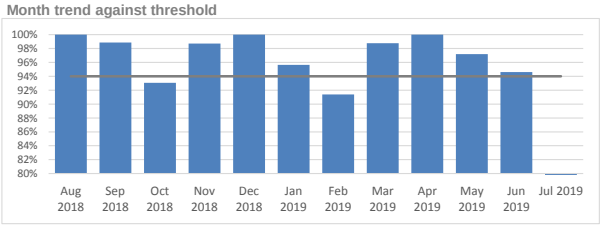
Progress
The Trust continued to achieve the standard.

Actions
Actions taken as per the 62 day standard.

Cancer 31 Days Sub Surgical Treatment

Actual	97.1%	Quarterly	**Accountability**	J.Bridgewater
Threshold	94.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✓	NA	✗	NA	NA	✓
NA	95.1%	NA	90.9%	NA	NA	97.5%

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.

Actions
Service pressures in SMH- Monitored through AOF.

Progress
The Trust achieved the target.

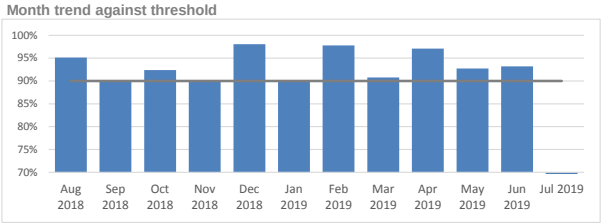
> Board Assurance

July-19

Cancer 62 Days Screening

Actual	94.6%	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	Wythenshawe, Trafford, Withington & Altrincham
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. There was 1 breach in MRI.

Workforce and Leadership

P. Blythin

Core Priorities	✓	◇	✕	No Threshold
	6	0	5	3

Headline Narrative

The MRI state of readiness development centre part 2 was completed in July.

The Quarter 2 Pulse Check will be launched in August.

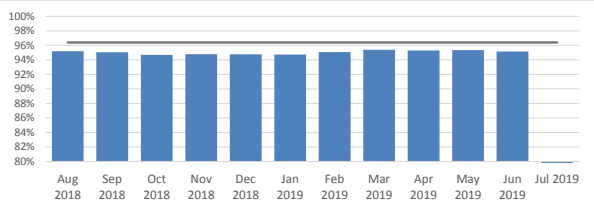
Workforce and Leadership - Core Priorities

Attendance

Actual 95.1% Latest Period **Accountability** P. Blythin

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

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✕	✕	✕	✕	◇	✕
96.4%	94.8%	95.2%	95.3%	93.3%	96.3%	94.1%

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 Group's attendance rate for June is lower at 95.1% compared to the previous month's figure (95.3%).

The attendance rate was slightly higher at the same point last year (June 2018) at 95.6%.

Meanwhile the latest figures released by NHS Digital show that for February 2019 the monthly NHS staff sickness absence for the whole of the North West HEE region was 5.2% (these figures include all provider organisations and commissioners). MFT's performance for the same period was 4.9%.

Actions

Work is underway to ensure Health and Wellbeing initiatives are focussed in areas where the biggest improvements can be made. The MFT HWB Framework is currently in development and will be ready for application by November 2019. Attendance is one of the key metrics which is closely monitored through the Accountability Oversight Framework (AOF). Focussed discussion with the HR Directors of each Hospital/Managed Clinical Service (MCS) also features prominently in the actions to improve performance. Corporate performance is addressed though the Corporate Directors' Group.

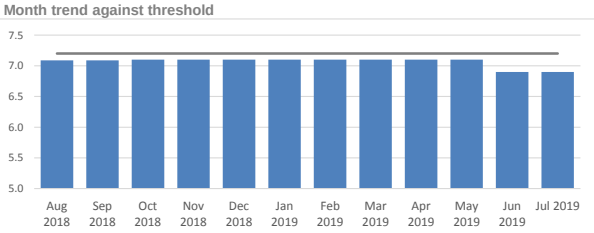
A programme to implement Absence Manager across all Hospitals/MCS sites has been launched and is sponsored by Group Deputy Chief Executive, Gill Heaton to oversee implementation. Cohort 1 is expected to go live in September 2019 and is on track for implementation. Each Hospital/MCS has developed a trajectory and action plan to increase attendance.

Engagement Score (quarterly)

Actual 6.90 Latest Period **Accountability** P. Blythin

Threshold 7.20 (Higher value represents better performance) **Committee** HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✕	✕	✓	✕	✕	✕	✕
6.8	6.8	7.2	6.8	7.0	7.1	7.0

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

Key Issues

The 2019-20 Quarter 1 Pulse Survey was conducted between 3rd and 23rd June. The Group staff engagement score from this survey was 6.9 (7.1. in Q4 2018-19).

Actions

The Quarter 2 Pulse Survey will run from 19th August until 8th September, with the results available two weeks later. The Staff Engagement Task and Finish Group is now established and will be meeting monthly, to help shape our future approach to staff engagement and surveys. Hospitals/MCS continue to develop their staff engagement action plans in response to feedback from the Q1 survey and the 2018 Staff Survey. Preparation for the 2019 Staff Survey have begun and are progressing as per the national timetable.

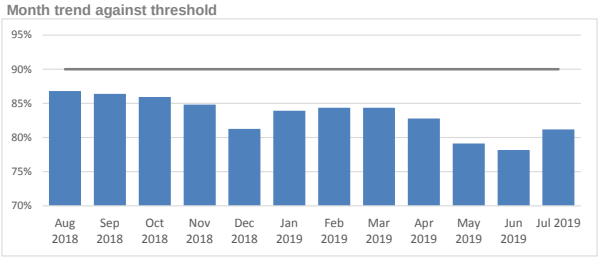
> Board Assurance

July-19

Appraisal- non-medical

Actual 81.2% Latest Period **Accountability** P. Blythin
Threshold 90.0% (Higher value represents better performance) **Committee** HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
◇	✗	✗	◇	✓	✓	✗
86.9%	66.5%	85.1%	88.8%	95.5%	92.9%	85.3%

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

Key Issues

Compliance in July increased by 3% to 81.2%. This increase was due primarily to a 10.9% increase in compliance across MRI although all other Hospitals/MCS, except one, also increased compliance in July.

Actions

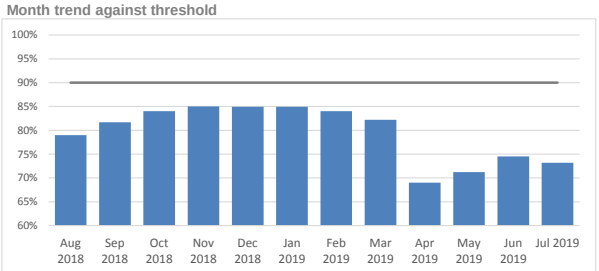
All Hospitals/MCS have plans in place to improve compliance. Progress against these plans will be reviewed as part of the month AOF process and adjustments will be made to ensure compliance improves.

HRDs also have regular ongoing discussions within their Hospital/MCS management teams to monitor progress and compliance against plans that are developed.

Level 2 & 3 CSTF Mandatory Training

Actual 73.2% Latest Period **Accountability** P. Blythin
Threshold 90.0% (Higher value represents better performance) **Committee** HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✗	✗	✗	✗	✗	✗	✗
75.8%	66.8%	68.2%	77.7%	78.8%	73.0%	80.0%

This indicator measures the % of staff who are compliant at the point the report is run. Staff are compliant if they have undertaken Level 2 & 3 CSTF Mandatory training within the previous 12 months.

Key Issues

A new Clinical Mandatory Training Programme became effective across the Group from the start of the financial year. Some of these subjects have previously not been reported as part of mandatory training. In view of this it was agreed at EDT that Hospitals/MCS ensure 90% compliance by October 1st and the trend has been reset to April 2019. Plans are now in place and improvements are monitored through the AOF. The aggregate compliance against all 9 of the Level 2 and Level 3 Core Clinical subjects is being reported from July, whereas previously the aggregate compliance was for 6 subjects only. The aggregate compliance for July was 73.2% which is 1.3% lower than the aggregate compliance reported in June.

Actions

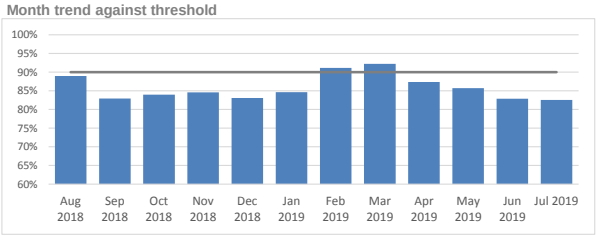
A widespread communication plan has been delivered to ensure that all staff understand the changes to the new programme.

The OD Team is supporting the Hospital/MCS in the resolution of initial issues emerging as a result of the new programme implementation. Ongoing discussions at the AOF are a priority to ensure effective implementation, understanding and compliance against plan. Close scrutiny via the AOF will continue to monitor and mange any deviation from plan effectively. Compliance data for all 9 Core Clinical subjects will be made available to the Hospital/MCS to allow them to apply the required management focus to ensure target compliance is achieved by October.

Appraisal- medical

Actual 82.5% Latest Period **Accountability** P. Blythin
Threshold 90.0% (Higher value represents better performance) **Committee** HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
◇	✗	✗	◇	✗	◇	✗
85.3%	82.4%	75.5%	88.2%	75.7%	86.8%	83.3%

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

Key Issues

Compliance fell by 0.4% in July to 82.5% and no Hospital / MCS is achieving target compliance.

Actions

All Hospitals/MSC continue to deliver against plans that were developed to increase compliance. Monitoring also takes place through the monthly AOF reviews where Hospitals/MCS present the trajectories and action plans in place to achieve compliance.

A communication was sent to the Hospitals/MCS leadership teams in July requesting that revalidation new starter forms are completed and returned for new starters (this should be included in the medical recruitment packs); previous UK based appraisals and ARCPs can be added to SARD and will show the doctor as compliant for 12 months. New starters who have had no previous appraisal should be appraised within the first three months; a PDP setting exercise and summary will be sufficient.

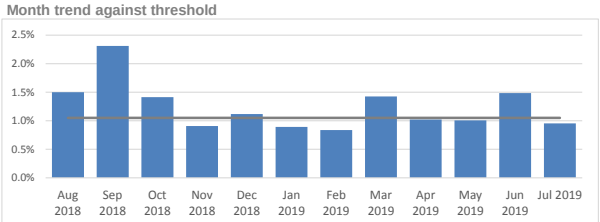
> Board Assurance

July-19

B5 Nursing and Midwifery Turnover (in month)

Actual	0.95%	Latest Period	**Accountability**	P. Blythin
Threshold	1.05%	(Lower value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✗	✓	✓	✗	✓	NA	✓
1.41%	0.83%	0.96%	1.21%	0.00%	NA	0.78%

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 July 2019 is 0.95% against a monthly target of 1.05%. This is a decrease in turnover from June 2019 at which the turnover was 1.48%.

Actions

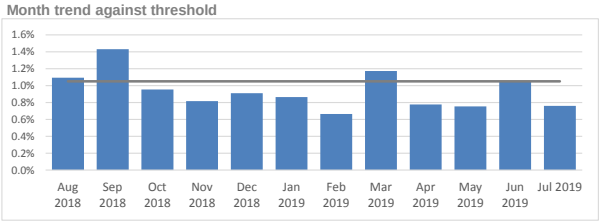
Retention of Nurses and Midwives remains a key focus for the Trust with each Hospital/MCS establishing a retention strategy that include:-

- Internal transfer process for band 5 Staff Nurses and Nursing Associates
- Development of an apprenticeship strategy to support nursing careers
- Opportunities for Nurses and Midwives to retire and return flexible
- Expansion of rotational programmes
- Staff engagement events
- Pastoral support for new starters

Turnover (in month)

Actual	0.76%	Latest Period	**Accountability**	P. Blythin
Threshold	1.05%	(Lower value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✓	✓	✓	◇	✓
0.74%	0.77%	1.00%	0.78%	0.13%	1.04%	0.81%

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 decreased and now stands at 0.76% compared to 1.1% for the previous month.

The turnover rate was higher at the same point last year (July 2018) at 1.1%.

Actions

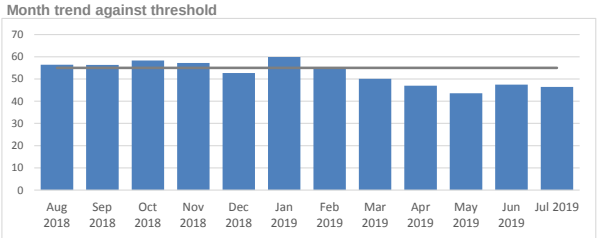
The Hospitals/MCS continue to focus on staff turnover with regular staff engagement sessions, facilitating internal moves to prevent staff leaving the organisation.

The RMCH HR team have started to meet with managers of hotspot turnover areas to understand what is driving turnover in their departments and agree appropriate action to improve retention. The Hospital has setup two new working groups for August 2019 to support retention; a Retention & Quality of Care Group and a Health & Wellbeing Group.

Time to Fill Vacancy

Actual	46.4	Latest Period	**Accountability**	P. Blythin
Threshold	55.0	(Lower value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	◇	✓	✓	✗	✓	✓
45.5	55.2	46.4	39.2	81.0	40.3	43.9

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. The metric does not include Staff Nurses as there is a separate metric for this provision.

Key Issues

Group wide, the Time to Fill figure has decreased from 47.4 days and now stands at 46.4 days for July.

Actions

The Trust 'Time to Hire' for July 2019 (without Band 5 Nursing starts) is 46.4 working days, which has decreased from last month's figure but is still 8.5 working days under the target of 55 working days. The Trust does expect to see an increase in the next 2 months as Student Nurses are waiting on exam results. There is still further work to do around streamlining processes and there has been a strong emphasis on the medical workforce as their overall time to hire is higher at 72.6 working days.

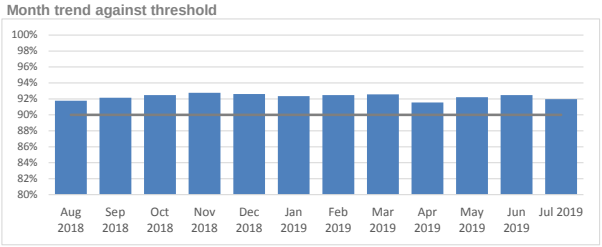
> Board Assurance

July-19

Level 1 CSTF Mandatory Training

Actual	92.0%	Latest Period		**Accountability**	P. Blythin
Threshold	90.0%	(Higher value represents better performance)		**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✗	✓	✓	✓	✓	✓
93.0%	89.1%	90.0%	96.2%	92.6%	91.3%	91.3%

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

Following the successful integration of Core Level 1 training in the 2018/19 financial year, compliance is now being monitored against the aggregate of all 11 Core Level 1 subjects. In July the aggregate compliance decreased by 0.5% to 92.0%.

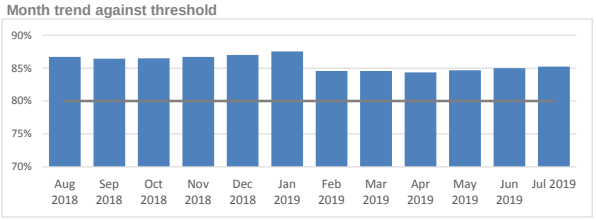
Actions

Monthly compliance reports continue to be made available via the electronic Workforce Intelligence Portal (eWIP). Ongoing review of target compliance will continue with non compliant Hospitals/MCS being monitored by the AOF process. Monthly review of target compliance for Corporate functions is monitored through the Corporate Directors' Group.

Nurse Retention

Actual	85.2%	Latest Period		**Accountability**	P. Blythin
Threshold	80.0%	(Higher value represents better performance)		**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✓	✓	✓	NA	✓
84.9%	84.6%	87.0%	85.9%	88.1%	NA	85.1%

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

Key Issues

In July 2019, Nursing and Midwifery retention stands at 85.2% which is a slight increase from June 2019 at which the retention rate was 85.0%. This rate remains above the threshold of 80%.

Actions

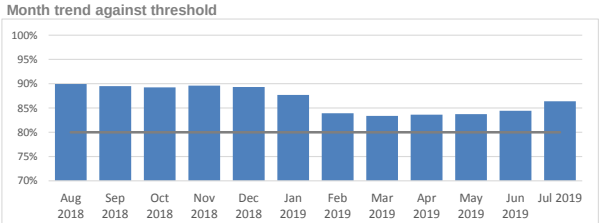
The retention threshold target for nursing and midwifery staff provides a strong indication of whether we are able to retain staff across the Trust and whether our polices, procedures and practices are supportive of the Trust being seen as a good place to work. The overall retention rate is good at 85.2%.

Actions are detailed in the above metric for Nursing and Midwifery Turnover and are a result of the retention plan developed in January 2019 which continues to progress and be monitored.

BME Staff Retention

Actual	86.4%	Latest Period		**Accountability**	P. Blythin
Threshold	80.0%	(Higher value represents better performance)		**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✓	✓	✓	✓	✓
87.6%	86.3%	83.3%	89.0%	89.9%	83.3%	84.5%

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 as they are employed by the lead employer St Helens & Knowsley Trust. The rate is shown as a rolling 12 month position.

Key Issues

In July 2019, there was no significant difference between the BME and White staff retention rates. The BME retention rate remains consistently above the Trust's threshold of 80% month on month.

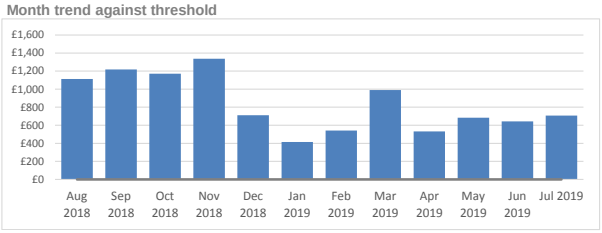
Action

Hospital/MCS are tracking this within their AOF and developing plans to address where negative gaps are being identified. The Trust is developing a Removing the Barriers Programme aimed at increasing the representation of BME colleagues in leadership roles across the Trust. This programme was embedded as part of the new ED&I Strategy approved by Group Management Board in July.

Medical Agency Spend

Actual £706.8 Latest Period **Accountability** P. Blythin
Threshold None (Lower value represents better performance) **Committee** HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
-	-	-	-	-	-	-
£20.6	£363.6	£20.8	£2.2	£80.4	£7.3	£211.9

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

Key Issues
For July 2019 the total value of Medical and Dental agency staffing was £706.8 compared to £642.8 in June 2019.

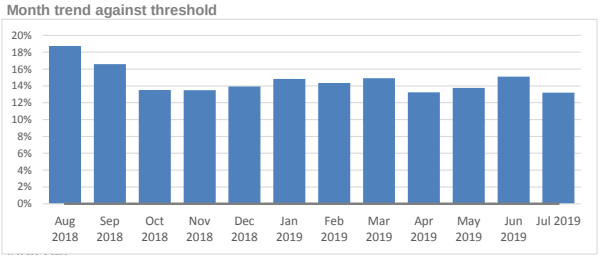
Actions
Hospital/MCS are continuing to make improvements to their agency spend position, with weekly review meetings taking place. These meetings have led to greater understanding of the spend, and therefore greater grip and control, on future spend.

Tiered framework for agency suppliers launched. Corporate teams are working closely with the tier 1 agencies to establish relationships and work on plans to increase fill rates and reduce rates of pay and agency commission.

Qualified Nursing and Midwifery Vacancies B5 Against Establishment

Actual 13.2% Latest Period **Accountability** P. Blythin
Threshold None (Lower value represents better performance) **Committee** HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
-	-	-	-	-	-	-
8.4%	13.7%	10.9%	10.1%	2.5%	NA	16.5%

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 within Nursing and Midwifery are within the staff nurse (band 5) role. At the end of July 2019 there were 518.8 wte (13.2%) staff nurse/midwife/ODP (band 5) vacancies across the Trust. This is a decrease from June 2019 when there was 567.1 wte vacancies.

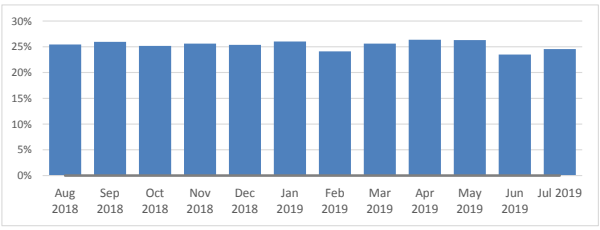
Actions
There are 368 nurses and midwives expected to start before the end of September 2019 upon graduation and registration with the NMC with a further 89 nurses with conditional job offers who are currently going through the recruitment process. The trust continues to recruit nurses from overseas. There are 60 international nurses expected to start in September 2019 with cohorts of approximately 25 nurses expected to arrive every 6 weeks for the rest of the financial year.

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

% BME Appointments of Total Appointments

Actual 24.6% Latest Period **Accountability** P. Blythin
Threshold None (Higher value represents better performance) **Committee** HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
-	-	-	-	-	-	-
27.8%	28.0%	18.6%	18.0%	45.2%	40.0%	25.0%

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

Key Issues
One in four appointments is of black and minority ethnic origin (24.6%), which is generally consistent month on month. The performance of all of the Trust' hospitals and managed clinical services reflects the greater Manchester black and minority ethnic population of around 17%. Hospitals/MCS whose performance is below the Trust average are RMCH (18.6%), Corporate Services (20.5%), MLCO (19.1%) and SMH (18.0%).

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

Finance

A.Roberts

Core Priorities	✓	◇	✕	No Threshold
	0	1	1	0

Headline Narrative

- Please see agenda item 5.2

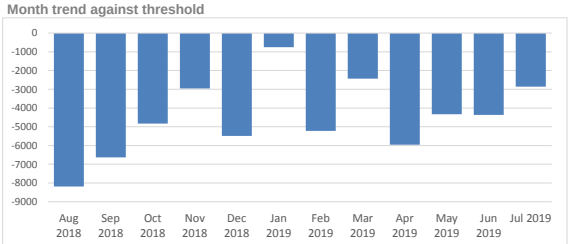
Finance - Core Priorities

Operational Financial Performance

Actual -£17,510 Year To Date **Accountability** A.Roberts

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

Month trend against threshold



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

Please see the Chief Finance Officer's report for more detail.

Hospital level compliance

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

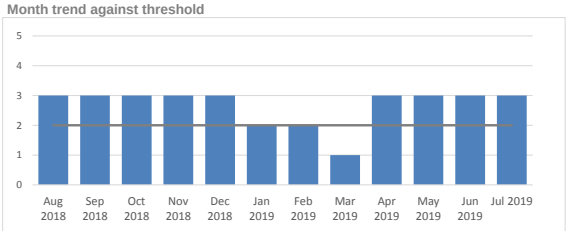
Followin
g these

Regulatory Finance Rating

Actual 3 Latest Period **Accountability** A.Roberts

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

Month trend against threshold



The regulatory finance rating identifies the level of risk to the ongoing availability of key services. A rating of 4 indicates the most serious risk and 1 the least risk. This rating forms part of NHSI's single oversight framework, incorporating five metrics:

- Capital service capacity
- Liquidity
- Income and expenditure margin
- Distance from financial plan
- Agency spend

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Adrian Roberts, Chief Finance Officer
Paper prepared by:	Ursula Denton, Group Director of Finance
Date of paper:	13th August 2019
Subject:	**Financial Performance for 2019/20**
Purpose of Report:	Indicate which by ✓ • Information to Note • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration of Risk against Key Priorities:	Maintaining financial stability for both the short and medium term
Recommendations:	Operating financial performance has been consistently worse than plan, with performance against operational income & expenditure budgets up to the end of month 4 now over £8.3m worse than the approved Hospital/MCS Control Totals. Robust delivery of the signed-off operational and financial plans needs to be demonstrated month-on-month to assure the Trust's continuing financial sustainability.
Contact:	Name: Adrian Roberts, Chief Finance Officer Tel: 0161 276 6692

Executive Summary

1.1	**Delivery of financial Control Total**	The financial performance for the first four months of the year was **a bottom line deficit** on a control total basis (excluding Provider Sustainability Fund) **of £8.1m** (1.4**%** of operating income). Operating financial performance up to the end of month 4 has reached £8.3m worse than the approved Hospital/MCS Control Totals. Current progress with delivery is still inconsistent with the financial plans put into place across Hospitals. Successful delivery of the overall 2019/20 plan approved by the Board demands further significant improvements to be embedded and sustained over the months ahead.
1.2	**Run Rate**	Whilst July's in-month performance indicates some progress with improved delivery, these have as yet been too patchy to stabilise the month-on-month run-rate. Robust delivery of the signed-off operational and financial plans needs to be demonstrated month-on-month to assure the Trust's continuing financial sustainability.
1.3	**Remedial action to manage risk**	Specific additional recovery and delivery actions were agreed with each Hospital/MCS leadership team during the second week of June, to secure stronger, more consistent delivery of the required operating financial performance through the immediate upcoming months. Follow up discussions will continue to be held fortnightly between the Group CFO, Group COO and Hospital CEOs and leadership teams to ensure that progress is maximised and any delay factors are systematically tackled and removed.
1.4	**Cash & Liquidity**	As at 31st July 2019 the Trust had a cash balance of £161.2m.
1.5	**Capital Expenditure**	In July, a revised capital plan was submitted to NHS Improvement for 2019/20 totalling £72.4m. Against a planned spend to July of £19.2m, the actual spend was £20.5m.

Financial Performance

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

	Year to date - Month 4					
	Annual Plan	Year to date budget	Variance from budget	Variance as % of budget	Variance to month 3	Year to date Actual
	£'000	£'000	£'000	%	£'000	£'000
INCOME						
Income from Patient Care Activities						
A and E	53,712	18,181	94		89	18,275
Non-Elective (includes XBD's)	304,268	101,134	468		-751	101,602
Elective (includes Day Case & XBD's)	229,764	76,526	-2,572		-2,767	73,954
Out-Patients (includes First & Follow up)	188,113	62,595	-1,067		-632	61,528
Other NHS Clinical Income	448,019	149,441	-2,925		-1,724	146,516
Community Services (includes LCO)	106,822	35,608	-17		-1	35,591
Passthrough drugs and devices	146,417	48,804	1,012		-39	49,816
Sub -total Income from Patient Care Activities	**1,477,115**	**492,289**	**-5,008**	**-1.0%**	**-5,825**	**487,281**
Private Patients/RTA/Overseas(NCP)	10,964	3,376	-650		-728	2,726
Total Income from Patient Care Activities	**1,488,079**	**495,665**	**-5,658**	**-1.1%**	**-6,553**	**490,007**
Training & Education	62,438	20,812	622		92	21,434
Research & Development	58,061	19,354	452		322	19,806
Misc. Other Operating Income	110,272	36,732	-4,775		-3,912	31,957
Other Income	**230,771**	**76,898**	**-3,701**	**-4.8%**	**-3,498**	**73,197**
Total Income	**1,718,850**	**572,563**	**-9,358**	**-1.6%**	**-10,051**	**563,205**
EXPENDITURE						
Pay	-1,010,287	-339,175	2,763	0.8%	2,768	-336,412
Non pay	-650,218	-217,664	5,781	2.7%	6,533	-211,883
Total Expenditure	**-1,660,505**	**-556,839**	**8,544**	**1.5%**	**9,301**	**-548,295**
EBITDA Margin (excluding PSF)	**58,345**	**15,724**	**-814**	**2.6%**	**-750**	**14,910**
Interest, Dividends and Depreciation						
Depreciation	-27,927	-9,409	622		468	-8,787
Interest Receivable	444	148	195		152	343
Interest Payable	-40,848	-13,629	-38		-31	-13,667
Dividend	-3,261	-1,087	231		174	-856
Surplus/(Deficit) on a control total basis	**-13,247**	**-8,253**	**196**	**2.4%**	**13**	**-8,057**
Surplus/(Deficit) as % of turnover						**-1.4%**
PSF Income	**27,020**					**6,286**
Additional PSF from 18/19						**917**
Non operating Income						**441**
Depreciation - donated / granted assets						**-240**
Impairment						**-11,333**
	13,773					**-11,985**

Operating Unit Performance against breakeven measures

Income	Pay	Non Pay	Trading Gap	Hospital / MCS	Variance to breakeven budgets - (adverse) / positive		Prior months distance from Control Total	Variance to Control Total		I&E Annual Turnover
Year to date variance					Year to date (to month 4)			Control Total (YTD)	Variance to control total	
£000s					£000s	%	£000s	£000s	£000s	£000s
1,366	-235	-196	-433	Clinical & Scientific Support	502	0.6%	9	500	2	238,575
265	2,073	-519	-681	Facilities, Research & Corporate	1,138	1.1%	624	0	1,138	298,301
-66	943	-46	-358	Manchester LCO	473	1.4%	-38	467	6	100,058
-2,819	-1,211	-677	-8,255	MRI	-12,961	-10.3%	-4,518	-7,733	-5,228	377,443
-155	369	-125	-855	REH / UDH	-766	-2.8%	-92	-400	-366	83,471
-62	-521	-9	0	RMCH	-592	-0.7%	-1,139	316	-908	248,120
-506	29	456	-834	Saint Mary's Hospital	-855	-1.5%	-740	-270	-585	175,080
-1,836	577	402	-3,592	WTWA	-4,449	-3.2%	-1,812	-2,035	-2,414	419,096
-3,813	**2,025**	**-714**	**-15,008**	**Trust position**	**-17,510**	**-2.7%**	**-7,706**	**-9,156**	**-8,354**	**1,940,145**

Key Run Rate Areas

1. 2019/20 Trading Gap challenge

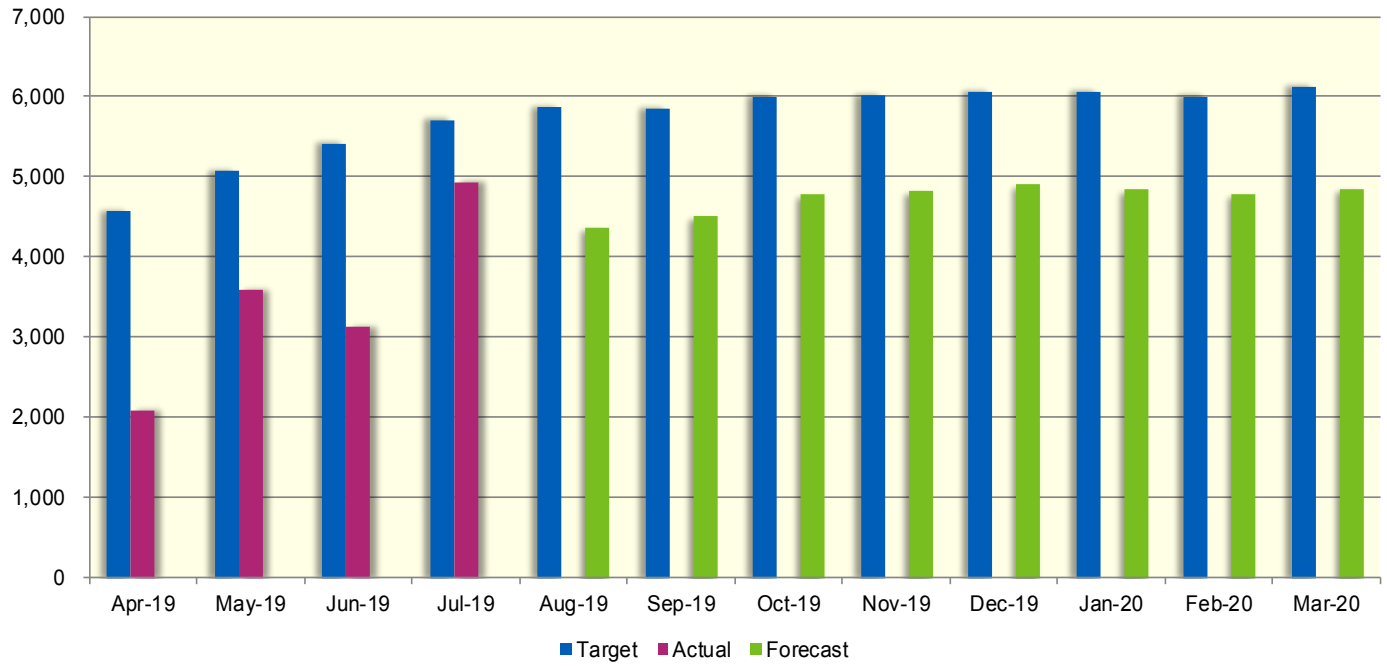
Theme Breakdown	Savings to date Target £'000	Achieved £'000	Variance £'000	Financial RAG	Forecast to year-end Target £'000	Forecast £'000	Variance £'000	Financial Forecast
Hospital Initiative	1,056	1,049	(7)	99%	2,367	2,821	454	119%
Contracting & income	7,387	6,620	(768)	90%	22,733	21,154	(1,579)	93%
Procurement	1,935	1,968	33	102%	7,391	8,050	658	109%
Pharmacy and medicines management	547	291	(256)	53%	2,650	2,322	(328)	88%
Length of stay	1,158	728	(430)	63%	4,338	3,894	(443)	90%
Outpatients	205	220	15	107%	902	929	26	103%
Theatres	378	136	(242)	36%	1,972	1,386	(585)	70%
Workforce - medical	790	666	(124)	84%	3,376	3,090	(287)	92%
Workforce - nursing	676	377	(299)	56%	2,670	2,220	(450)	83%
Admin and clerical	509	479	(30)	94%	1,589	1,456	(134)	92%
Workforce - other	1,246	1,113	(134)	89%	4,010	3,888	(122)	97%
Blood Management	0	0	0		0	0	0	
Budget Review	158	115	(42)	73%	557	453	(104)	81%
Integration	0	0	0		0	0	0	
Total identified (at or above level 3)	**16,047**	**13,761**	**(2,285)**		**54,556**	**51,661**	**(2,894)**	
Total identified (below level 3)	737	0	(737)		5,359	4,622	(737)	
Unidentified	4,993	0	(4,993)		8,837	0	(8,837)	
Grand Total	**21,777**	**13,761**	**(8,015)**	**63%**	**68,752**	**56,283**	**(12,469)**	**82%**

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%

Trading Gap Target and Achievement /Forecast by Month



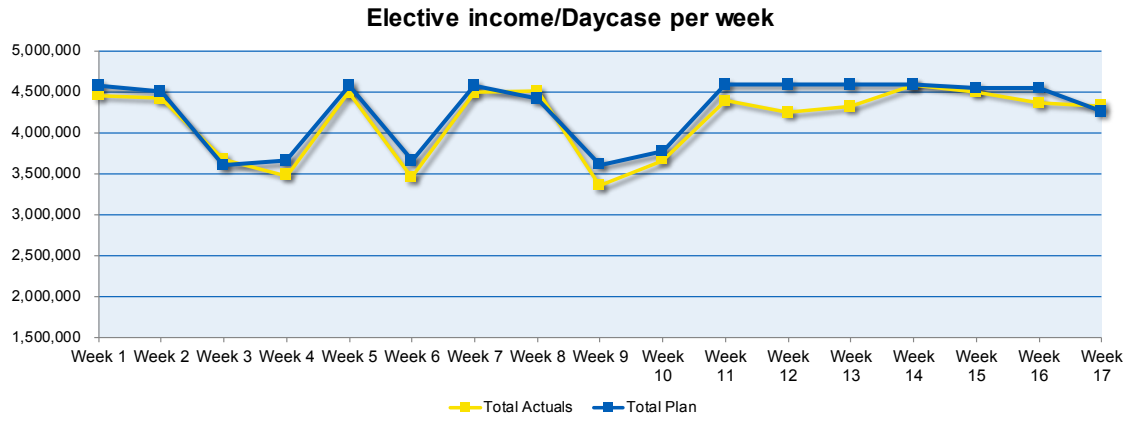
2. Agency spend by Staff Group and Hospital / MCS

Staff Group	Average M1-6 (18/19) £000's	Average M7-9 (18/19) £000's	Average M10-12 (18/19) £000's	Average M1-3 (19/20) £000's	M4 (19/20) £000's
Consultant	-452	-438	-258	-284	-323
Career Grade Doctor	-48	-52	-38	-89	-17
Trainee Grade Doctors	-685	-571	-352	-247	-366
Registered Nursing Midwifery	-772	-637	-601	-574	-578
Support to Nursing	-137	-150	-117	-48	-62
Allied Health Professionals	-177	-93	-103	-83	-38
Other Scientific and Theraputic	-177	-206	-135	-141	-103
Healthcare Scientists	-164	-81	-105	-8	-84
Support to STT / HCS	-89	-106	-41	-32	-27
Infrastructure Support	-85	-90	-113	-101	-53
Grand Total	**-2,786**	**-2,424**	**-1,863**	**-1,607**	**-1,651**

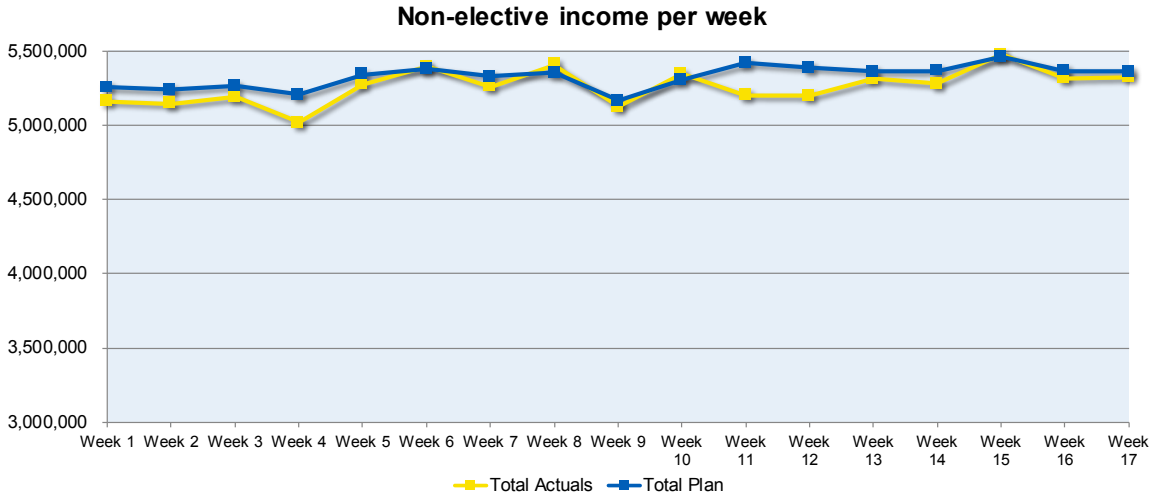
Hospitals	Average M1-6 (18/19) £000's	Average M7-9 (18/19) £000's	Average M10-12 (18/19) £000's	Average M1-3 (19/20) £000's	M4 (19/20) £000's
Clinical & Scientific Support	-444	-301	-271	-191	-208
Manchester LCO	-47	-44	-61	-44	-43
MRI	-924	-859	-524	-680	-654
REH / UDH	-111	-117	-89	-82	-91
RMCH	-144	-157	-142	-78	-71
Saint Mary's Hospital	-36	-30	-38	-24	-26
WTWA	-899	-697	-632	-412	-464
Corporate	-164	-179	-101	-99	-73
Research	-17	-40	-5	2	-21
Total	**-2,786**	**-2,424**	**-1,863**	**-1,607**	**-1,651**

Trust Total	Agency spend - YTD	Agency ceiling - YTD	Difference (£000)	% Above / (below) ceiling
	6,472	8,776	-2,304	(26.3%)

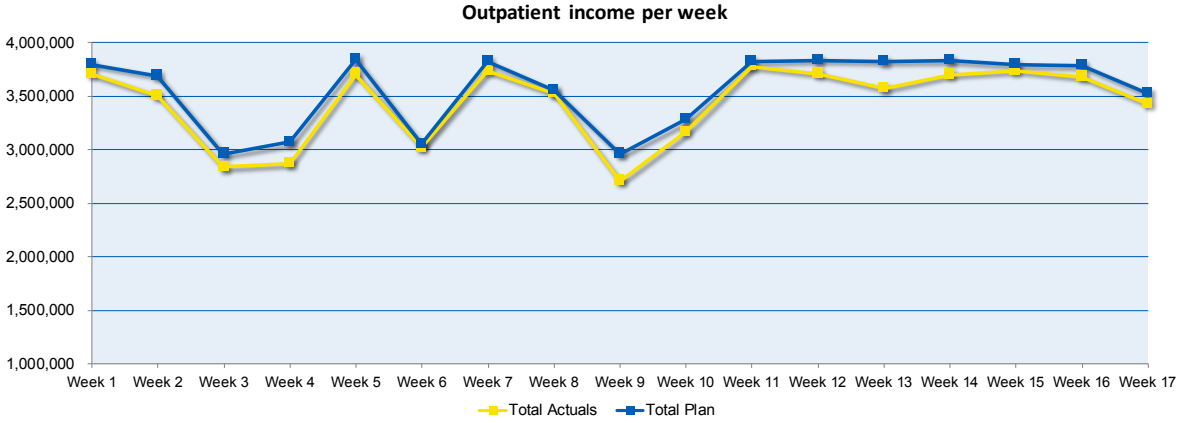
3. Elective / Daycase income: July 2019



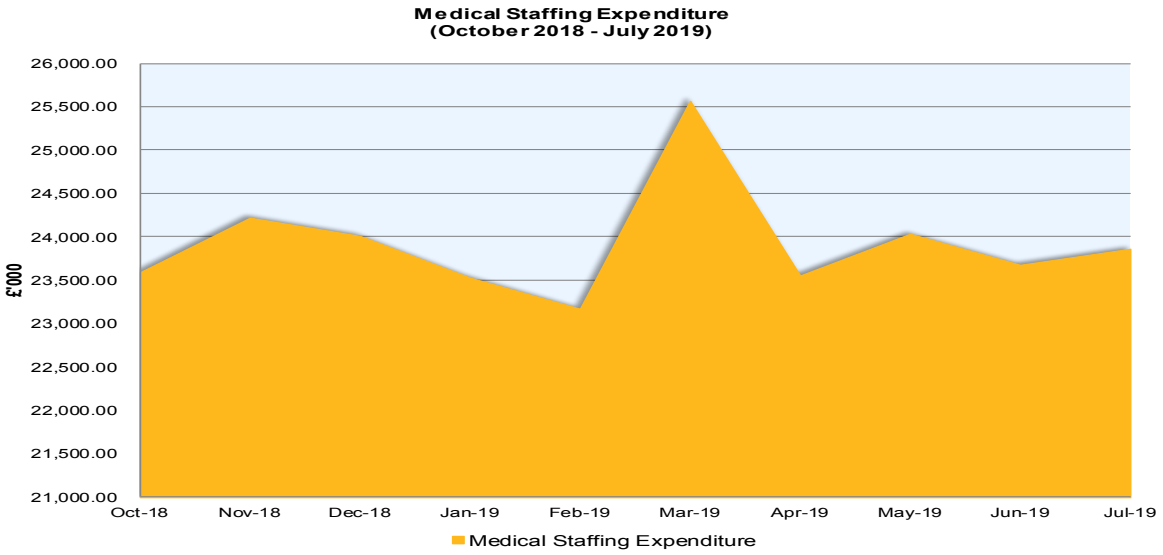
4. Non-Elective income: July 2019



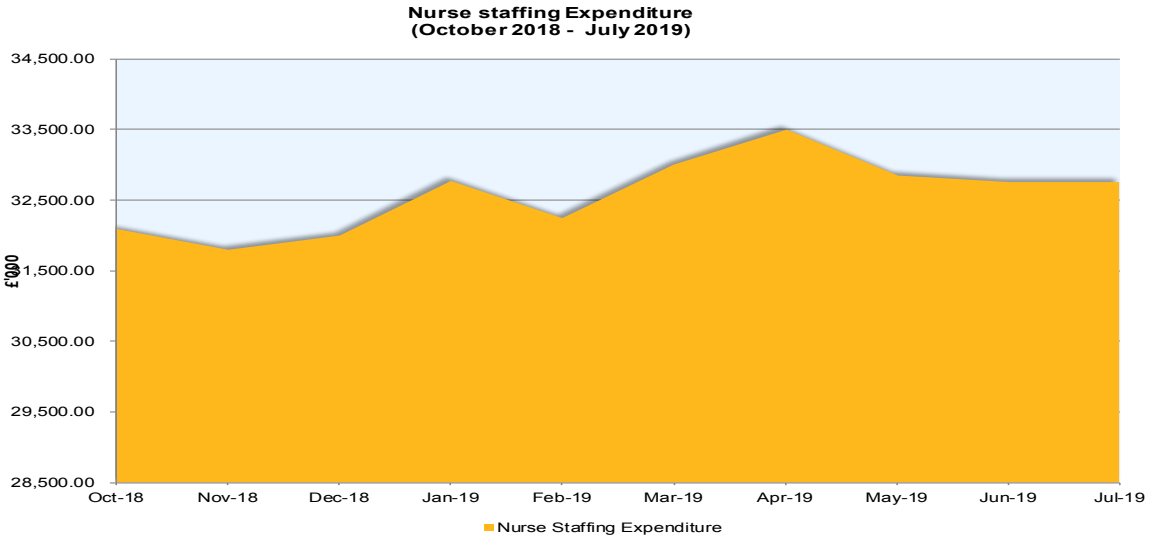
5. Outpatient income: July 2019



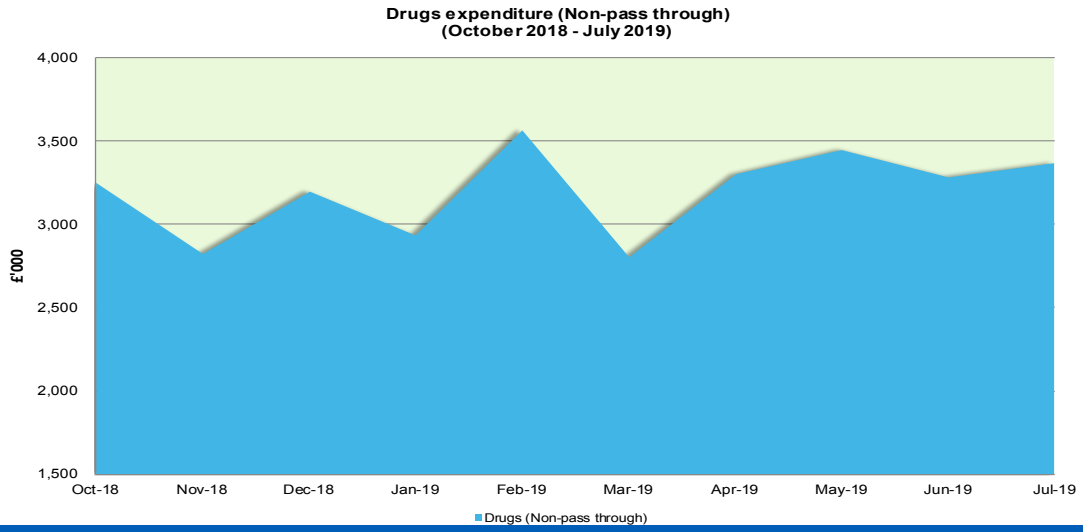
6. Medical Staffing: July 2019



7. Nurse staffing: July 2019



8. Prescribing: July 2019



NHS Improvement's KPIs

	Plan YTD		Actual YTD	
	Metric	Level	Metric	Level
Liquidity ratio	1.8	1	8.5	1
Capital servicing capacity	1.0	4	1.1	4
I&E Margin	(0.3%)	3	(0.3%)	3
I&E margin: Distance to financial plan	0.0%	1	0.0%	1
Agency spend Metric - above / (below) the agency ceiling	(6.4%)	1	(26.3%)	1
Use of Resource (UOR) metrics - Level 1 being highest		**3**		**3**

	Annual Plan (full year)		Forecast 19/20	
	Metric	Level	Metric	Level
Liquidity ratio	(3.2)	2	(3.2)	2
Capital Servicing Capacity	1.4	3	1.4	3
I&E Margin	0.8%	2	0.8%	2
I&E margin: Distance to financial plan	0.0%	1	0.0%	1
Agency spend Metric - above / (below) the agency ceiling	(9.1%)	1	(9.1%)	1
Use of Resource (UOR) metrics - Level 1 being highest		**2**		**2**

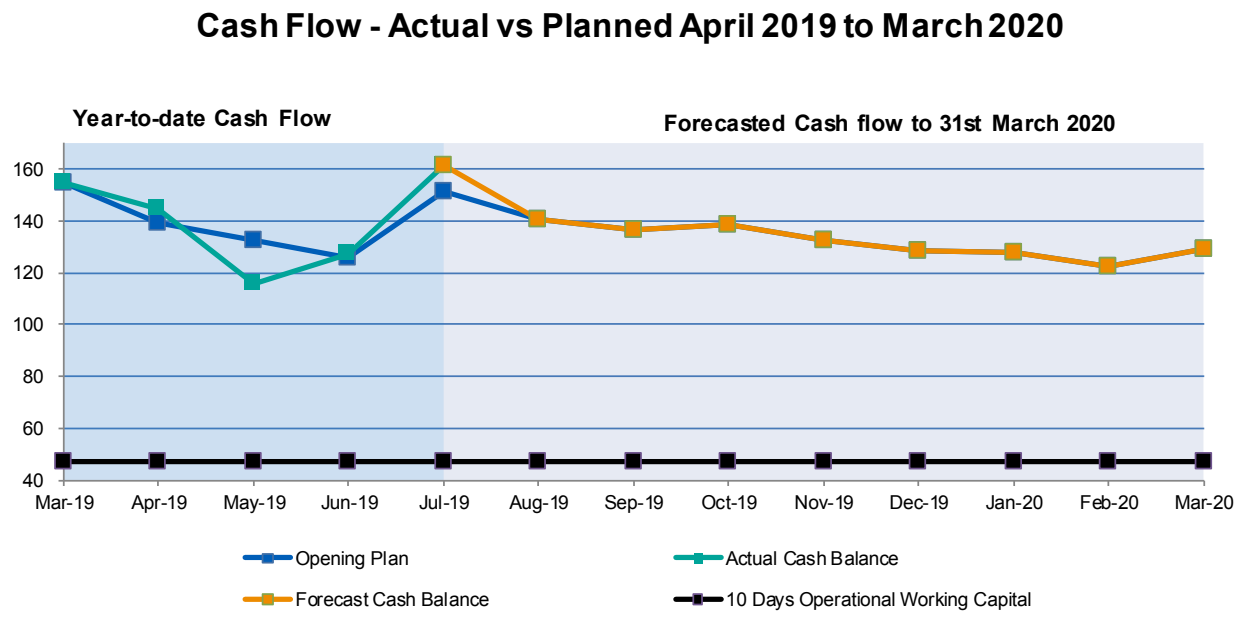
Narrative:

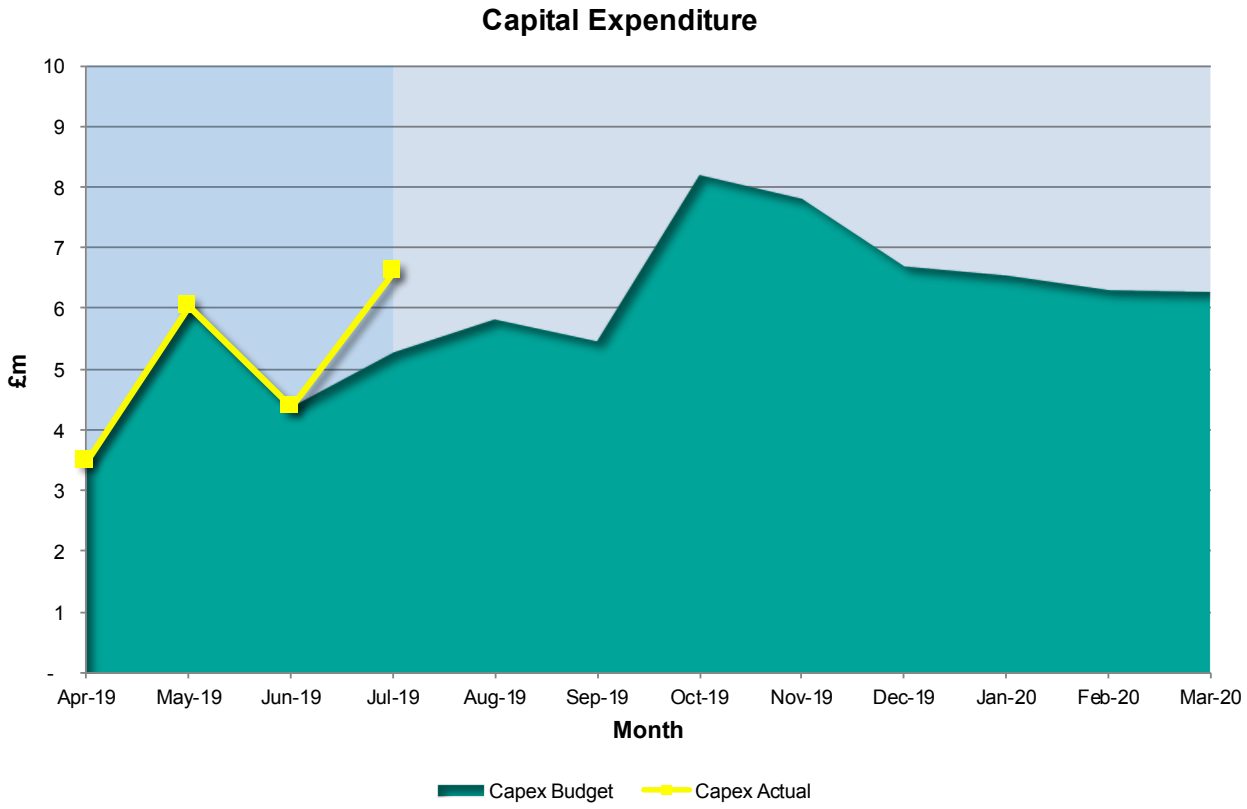
The Trust's financial risk rating scores at month 4 are consistent with the planned metrics submitted to NHSI Improvement.

Balance Sheet

	Opening Balance 01/04/2019 £000	Actual Year to Date 31/07/2019 £000	Movement in Year to Date £000
Non-Current Assets			
Intangible Assets	4,120	3,811	(309)
Property, Plant and Equipment	594,723	595,213	490
Investments	2,513	2,513	0
Trade and Other Receivables	4,969	4,791	(178)
Total Non-Current Assets	**606,325**	**606,328**	**3**
Current Assets			
Inventories	16,462	17,286	824
NHS Trade and Other Receivables	83,118	82,375	(743)
Non-NHS Trade and Other Receivables	45,816	36,654	(9,162)
Non-Current Assets Held for Sale	210	210	0
Cash and Cash Equivalents	154,563	161,211	6,648
Total Current Assets	**300,169**	**297,737**	**(2,432)**
Current Liabilities			
Trade and Other Payables: Capital	(4,242)	(5,975)	(1,733)
Trade and Other Payables: Non-capital	(171,403)	(181,547)	(10,144)
Borrowings	(19,780)	(19,453)	327
Provisions	(15,858)	(15,602)	256
Other liabilities: Deferred Income	(20,400)	(19,302)	1,098
Total Current Liabilities	**(231,683)**	**(241,879)**	**(10,196)**
Net Current Assets	**68,486**	**55,858**	**(12,628)**
Total Assets Less Current Liabilities	**674,811**	**662,186**	**(12,625)**
Non-Current Liabilities			
Trade and Other Payables	(2,600)	(4,180)	(1,580)
Borrowings	(407,793)	(403,734)	4,059
Provisions	(8,815)	(8,095)	720
Other Liabilities: Deferred Income	-	(2,559)	(2,559)
Total Non-Current Liabilities	**(419,208)**	**(418,568)**	**640**
Total Assets Employed	**255,603**	**243,618**	**(11,985)**
Taxpayers' Equity			
Public Dividend Capital	204,780	204,780	0
Revaluation Reserve	45,408	45,408	0
Income and Expenditure Reserve	5,415	(6,570)	(11,985)
Total Taxpayers' Equity	**255,603**	**243,618**	**(11,985)**
Total Funds Employed	**255,603**	**243,618**	**(11,985)**

Cash flow and capital expenditure





Scheme	Full Year Plan £'000	Plan YTD at 31st July 2019 £'000	Spend YTD at 31st July 2019 £'000	Spend in future months £'000	Forecast Year End £'000
Property and Estates schemes					
Cardiac MR Scanner	850	35	26	824	850
Diabetes Centre	1,649	6	26	1,623	1,649
Helipad	4,746	723	375	4,371	4,746
Other Charity Funded Projects	496	50	42	454	496
Property & Estates Schemes - backlog maintenance	23,751	4,916	6,395	17,356	23,751
MRI ED redevelopment	1,000	342	344	656	1,000
RMCH ED redevelopment	885	0	0	885	885
RMCH Atrium	200	16	5	195	200
3rd MRI scanner	1,692	1,261	1,230	462	1,692
BMT	3,000	302	32	2,968	3,000
Property & Estates - sub-total	**38,269**	**7,651**	**8,475**	**29,794**	**38,269**
IM&T schemes	**17,625**	**7,154**	**7,964**	**9,661**	**17,625**
Equipment rolling replacement programme	**6,734**	**1,244**	**966**	**5,768**	**6,734**
Healthier Together	**0**	**0**	**0**	**0**	**0**
PFI Lifecycle	**9,813**	**3,165**	**3,133**	**6,680**	**9,813**
Total expenditure	**72,441**	**19,214**	**20,538**	**51,903**	**72,441**

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Julia, Bridgewater, Group Chief Operating Officer
Paper prepared by:	Rachel Bayley, Director of Performance and EPRR
Date of paper:	August 2019
Subject:	**EU Exit Update**
Purpose of Report:	Indicate which by ✓ • Information to Note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration of Risk against Key Priorities:	To achieve high standards of patient safety and clinical quality across the Trust demonstrated through performance outcome measures
Recommendations:	To note the contents of the report
Contact:	Name: Rachel Bayley Tel: 0161 276 6718

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EU Exit

August 2019

Julia Bridgewater
Chief Operating Officer

Governance Arrangements

- **EU Exit Operational Readiness Guidance -** published 21 December 2019 – Focus on 7 areas:

- **Senior Responsible Officer** – Chief Operating Officer, Julia Bridgewater
- **MFT EU Exit Contingencies Group** - in place since January 2019, with representatives covering the above 7 areas
- **Risk Register –** Composite risk added to the MFT risk register since January 2019
- **National / Regional Workshops –** attendance by MFT to support EU Exit planning
- **GM Partnership Coordination** - of regional response and collaborative working across providers via the Local Health Resilience Partnership forum.
- **MFT Business Continuity** – Robust MFT process in place for Business Continuity Planning across all hospitals and Managed Clinical Services, places MFT in the best possible position.
- **MFT EPRR Governance structure**

Current Position

- National Team increasing intensity of preparations and communications through August – September
- National Situation Reporting will recommence in September to provide assurance of planning and identify areas of risk.
- A number of national subgroups in place underpinning the 7 areas of EU Exit Operational Readiness - working directly with subject experts across providers.
- EU Exit workshops relating to operational readiness, communications and data protection taking place through August – September.
- EU Exit Operational Readiness Areas:

Pharmacy	• MFT compliant with the national guidance that local Trusts must not stockpile, NHSE working to ensure there is an additional 6 weeks of stock to mitigate any short term delays.
Procurement	• NHS Supply Chain retained and replenished centralised stock holdings. • Routine stock reviews undertaken across wards. • Work undertaken by MFT procurement team with specific areas of higher risk to standardise and strengthen stock management processes.

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Current Position

- EU Exit Operational Readiness Areas:

Workforce	• Settled status –choice of individuals to opt for 'settled status', current no change to the requirements for evidence of right to work. • Communications and support to Trust EU staff • MFT Risk Register - identify any concentrated workforce risks across services.
Reciprocal Healthcare	• Emergency and GP services will remain exempt from charges. • Visitors from the EU, Norway, Iceland, Liechtenstein or Switzerland will **not** be covered for healthcare in the same way they are now if there is a no-deal EU Exit. • Citizens from these countries living lawfully in the UK on or before exit day will still be eligible for free NHS care. • MFT processes in place to manage the changes to reciprocal healthcare.
Research	• No new guidance at this point.
Data Sharing	• Workshops taking place in September.

KEY MESSAGE:

Robust planning based on available information and guidance from the national team has been undertaken to date, with supporting governance and business as usual arrangements in place. There will be an intensity of national planning from August – October and MFT will continue to respond to new guidance accordingly, ongoing reporting / escalation to the Executive Team and Risk Committee.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Darren Banks, Group Executive Director of Strategy
Paper prepared by:	Caroline Davidson, Director of Strategy
Date of paper:	August 2019
Subject:	**Strategic Development Update**
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration of Risk against Key Priorities:	All individual strategic developments are risk assessed and monitored through the Board Assurance and Risk Management processes.
Recommendations:	The Board of Directors is asked to note the updates in relation to: National level ▪ NHS Long Term Plan ▪ North West Genomics Laboratory Hub Greater Manchester level ▪ Improving Specialist Care Programme Local level ▪ MFT Clinical Service Strategy Development ▪ RMCH and Alder Hey
Contact:	Name: Darren Banks, Group Executive Director of Strategy Tel: 0161 276 5676

1. Introduction

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

2. National Issues

NHS Long Term Plan

The NHS Long Term Plan was published in January 2019 with an Implementation Framework published in June 2019. This requests each Sustainability & Transformation Partnership /Integrated Care System to create a five-year strategic plan by November 2019 covering the period 2019/20 to 2023/24. System plans will be aggregated and combined with additional national activity information and published as part of a national implementation plan by the end of the year. This will be used as the cornerstone of the mandate and planning guidance for the NHS for the next 5 years.

The GM Health and Social Care Partnership team has set out its approach to the development of an implementation plan for Greater Manchester, which also incorporates the implementation of the Health & Social Care Prospectus. Draft plans are required from CCGs and thematic leads by early September.

The priority areas set out in the framework that are of particular relevance to MFT are:

- The need to develop digitally- enabled outpatient care and remove the need for a third of face to face outpatient visits – systems must decide priority areas
- The need to achieve shorter waiting times for planned care
- Engagement with the system in relation to maternity and children's services, cancer, CHD, respiratory and diabetes in order to ensure any predicted changes to activity are accounted for and enable programme implementation.

North West Genomics Laboratory Hub

Staff from Liverpool Women's NHS Foundation Trust joined the genomics department as part of the North West Genomic Laboratory Hub (NW GLH). The NW GLH, alongside another six GLHs from across the country, make up the new national Genomic Medicine Service. This Service builds on the legacy of the successful 100,000 Genomes Project and will make available in routine clinical care the benefits of whole genome sequencing for both rare disease and cancer patients.

3. Greater Manchester Issues

Improving Specialist Care Programme

It has been agreed that paediatric medicine will be an in-scope specialty for the Improving Specialist Care programme which will be supported by the Transformation Unit with MFT as the Provider Transformation Lead.

4. MFT Issues

MFT Clinical Service Strategy Development

Overarching Group Service Strategy

The overarching Group Service Strategy was approved by the Board of Directors in July 2019 following feedback from key stakeholders and input of any issues that arose during the development of the individual clinical service strategies.

Clinical Service Strategies

Waves 1, 2 and 3 cover the services spanning WTWA and MRI. The wave 1 Clinical Service Strategies were approved by the Board in February 2019, wave 2 specialties in March 2019 and wave 3 in July 2019.

The Clinical Service Strategies for Manchester Royal Eye Hospital and University Dental Hospital were approved in May and Saint Mary's and RMCH in July 2019.

This will mark the end of the development phase of the clinical service strategy programme. One of the key next steps is a programme of engagement with patients, their families and the wider public which we are undertaking in partnership with our commissioners.

It is important to note that the proposals outlined in all of the strategies represent our preferred option at this point. However, they are at a formative stage only. 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 Scientific Services Strategy

Following completion of Waves 1-3 and the MCS Clinical Service Strategies, work has begun to develop the supporting strategies for Clinical and Scientific Services. An overarching strategy for the MCS is being developed which will be followed by a strategy for each of the divisions – Imaging, Laboratory Medicine; Anaesthesia, Critical Care and Peri-operative Medicine; Pharmacy; Allied Health Professionals. All strategies will be completed by the end of the financial year.

Communications

To communicate the key messages about the Group Service Strategy, a series of articles were included in MFT iNews and across the Intranet featuring each of the five pillars of the Strategy. Work is now underway to develop an animation to tell the story of how the Group Service Strategy and the individual Clinical Service Strategies were developed.

<u>RMCH and Alder Hey</u>

RMCH has signed a memorandum of understanding with Alder Hey Children's Hospital which sets out how we will collaborate on the delivery of specific specialist and tertiary paediatric services in the North West, to deliver safe, high quality and equitable care for children and young people.

5. Actions / Recommendations

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

National level
- NHS Long Term Plan
- North West Genomics Laboratory Hub

Greater Manchester level
- Improving Specialist Care Programme

Local level
- MFT Clinical Service Strategy Development
- RMCH and Alder Hey.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Michael McCourt, Chief Executive, Manchester Local Care Organisation
Paper prepared by:	Tim Griffiths, Assistant Director - Corporate Affairs, Manchester Local Care Organisation
Date of paper:	August 2019
Subject:	**Manchester Local Care Organisation Update**
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration of Risk against Key Priorities:	Leading on the development and implementation of integrated care.
Recommendations:	The Board of Directors is asked to Note the contents of this paper.
Contact:	Name: Tim Griffiths Tel: 07985448165

1. Introduction

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

- System resilience and escalation;
- Integrated neighbourhood working;
- Phase II and business case development;
- Trafford; and,
- New care models.

2. System resilience and escalation

a. As per previous updates to Board, MLCO continues to work closely with MFT and its principal hospital sites to support the alleviation of current acute flow pressures.

2.2 At the request of MFT, in July 2019, MLCO mobilised their response to the increasing number of DTOCs in the Manchester system. The re-mobilisation of this intensive MLCO led response follows the work that MLCO led from August 2018 to March 2019 with MRI, that saw a significant number of long length of stay patients be supported in alternative care settings and reduced the average length of stay at MRI by 5 days.

2.3 As part of this work MLCO have agreed multipoint action plans with MRI, Wythenshawe, and RMCH. These have now been mobilised and are at various stages of delivery.

2.4 However, despite the additional capacity that has been mobilised to deliver the initial action plans that were developed in July, it has been identified that further work is now required and over a longer period of time. This includes working to establish an effective and sustainable seven-day Integrated Discharge Team that is able to respond to the pressures within the system and in particular, MRI. The establishment of this team is reliant on commissioner support and discussions remain ongoing in regards to how the resource requirement can be met.

3. Integrated neighbourhood working

3.1 As Board are aware the 12 neighbourhoods are the principal building blocks of MLCO and underpin our strategic planning. As part of this, and as part of the business planning process, we have developed 12 neighbourhood plans and have worked to establish a leadership quintet in each of the 12 comprising of an INT lead, Mental Health Lead, Lead Social Worker, Lead GP, and a Nursing Lead.

3.2 Critical to the effective functioning of the neighbourhood operating model is the recruitment to the INT lead posts. All 12 have now taken up post, and through the governance that has been established will now work with partners to deliver the neighborhood plans.

3.3 MLCO therefore have leadership teams in place across the city and the 12 neighbourhoods:

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

3.4 Work is now underway to develop an appropriate performance and impact framework to assess the efficacy of interventions at a neighbourhood level. This work is being supported by Manchester Health and Care Commissioning.

4. Phase II and business case development

4.1 As the Board will be aware Manchester Health and Care Commissioning are responsible for the commissioning of the health and care system in Manchester; this includes MLCO.

4.2 In the latter part of 2018 it was agreed by commissioners that the commissioning and procurement of MLCO would be achieved through the production of a comprehensive joint business case. This business case will be required to offer assurances in multiple areas, and will be assessed against the ability of MLCO to deliver the requirements placed upon it. The working intention is that this will be produced for October 2019.

4.3 The successful mobilisation of the services outlined within the business case will see MLCO grow significantly and as a result, through 2019/20, it will become responsible for the delivery of £287m of services. The second tranche of services that will transfer under MLCO management will include certain primary care contracts, continuing healthcare contracts, learning disabilities contracts, social care contracts, and a range of other smaller contracts.

4.4 It should be noted that not all of the contracts that transfer to MLCO will transfer to MFT, for example adult social care contracts will remain with Manchester City Council albeit managed by MLCO. It should be noted that for those services that transfer to MFT a process of due diligence is being undertaken to ascertain whether there is any historic or current risk in the contract and whether by shifting the contract this risk is managed, mitigated or increased. Work is also underway to identify the management resource that will transfer along with the contracts.

4.5 A key part of MLCO phase 2 is the work that is required to enable MLCO to become a 'commissioner' of services. As part of this work it has always been intended that a significant number of staff and functions transfer from MHCC to MLCO. As part of this over 60 staff have now been deployed to MLCO (effective 1st August 2019) to the delivery of a range of service improvement initiatives.

5. Trafford

5.1 As per previous updates to Board, MFT and MLCO continue to work with colleagues both in Trafford and at Pennine Care Foundation Trust to complete due diligence in respect of the proposed transfer of community health services.

5.2 As the Board are aware it has been agreed that MLCO will assume a leadership role in regards to community health services in Trafford. There are two services that transfer to MFT where leadership will be provided by RMCH - Child and Adolescent Mental Health Service, and Community Eating Disorder Services.

5.3 It has been agreed that Trafford Community Health Services will be governed through the existing arrangements that have been put in place to oversee and manage MLCO activity (with the exception of those services that will be delivered through RMCH).

5.4 Subject to agreement the transfer will take effect on 1st October 2019 and will see c700 staff TUPE to MFT from Pennine Care.

6. New Care Models and Evaluation

6.1 As Board are aware a key feature of the MLCO delivery model has been the mobilisation of new care models including High Impact Primary Care, and Manchester Community response.

6.2 As these models of care were primarily funded by investment from the GM Transformation Fund the efficacy of them is subject to ongoing evaluation. This evaluation includes three component parts: process evaluation; impact or outcomes evaluation; and economic evaluation.

6.3 Research and evaluation findings to date have identified a number of key themes.

6.4 There is emerging evidence of reduced demand in high cost services, however, increases in capacity in some services have caused pressures/capacity issues in others. For example, in the three evaluations to date:

- HIPC has shown, through a quantitative analysis of hospital activity, a statistically significant reduction in A&E attendances post service start.
- Reablement has shown that for the cohort of people who have had Reablement service during 2018/19 financial year and went on to have a home care package after leaving Reablement had, on average, 26% fewer homecare visits and 22% fewer homecare hours during the 6 months post reablement.
- ExtraCare has shown that neighbourhood apartments have likely necessitated up to 1,200 fewer days of residential / nursing care to the wider health and care system.

6.5 New care models have taken longer to implement than expected, largely due to recruitment of staff either due to organisational structures, or availability of suitably qualified staff compounded by new care models going out to recruit to roles seeking similar staff specialties, at similar levels of seniority, at similar times.

6.6 New Models of Care, so far, are mainly supporting those with the most complex needs (i.e. people with multiple Long Term Conditions) who are accessing multiple services generally at the point of crisis.

6.7 Work remains ongoing to mobilise new models of care across the city, including remodelling those where the evaluation or learned knowledge has identified that changes to the service delivery model is required (such as high impact primary care which has been remodelled into a Manchester Case Management Service).

7. Recommendations

7.1 The Board is asked to note the contents of this report.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Professor Cheryl Lenney, Group Chief Nurse
Paper prepared by:	Mrs Sarah Corcoran, Director of Clinical Governance
Date of paper:	August 2019
Subject:	**Regulatory Update**
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration of Risk against Key Priorities:	Patient safety and clinical quality
Recommendations:	The Quality and Safety Committee are asked to note the content of this report.
Contact:	Name: Sarah Corcoran, Director of Clinical Governance Tel: 0161 276 8764

1. Introduction

1.1. This paper sets out an exception report on the current position in respect of the NHS Regulatory Framework in respect of Manchester Foundation Trust.

2. Care Quality Commission

2.1. Following completion of the comprehensive inspection in 2018 the CQC is continuing with its programme of oversight of the Manchester University NHS FT. This oversight consists of:

- Comprehensive inspection action plan oversight
- Routine Engagement Meetings
- Unannounced inspection programme
- Regular enquiries in respect of outlier reports and notifications to the CQC

2.2. This section sets out progress against the plan and details engagement with the CQC.

<u>Comprehensive Action Plan Oversight</u>

2.3. All Hospitals / MCS / MLCO / Corporate Services report progress on the action plan and this is being presented at the monthly CQC Inspection Response Group (CIRG).

2.4. Progress reported at July 2019 includes:

- Progress on records management, including changes made to the delivery and management process
- Progress on the action plan for both MREH and UDHM presented at the June CIRG
- Completion of the pilot project on the WHO checklist in Surgery (MRI) with plans for roll out I the coming weeks

2.5. The next Performance Assurance Meeting, chaired by the Chief Nurse, is scheduled for 25th September 2019. This meeting will be an in-depth review with Hospital / MCS / MLCO and Corporate Teams on progress against the plan and assurance evidence on outcomes.

2.6. A report will be provided to the Quality and Safety Committee and any issues escalated if necessary.

2.7. The CQC Relationship Team will be in attendance at these meetings.

2.8. Key messages for circulation are:

- Hospitals/MCS and the MLCO must agree self-assessment processes
- Hospitals/MCS and the MLCO are asked to ensure assurance evidence is in place before signing off completed actions

3. Statement of Purpose Update

3.1. As part of the transfer of Trafford Community Care Services from Pennine Care to MFT the organisation is required to update the CQC statement of purpose document. There is no change to function or purpose but the new locations have been added.

3.2. The statement of purpose is included for approval at appendix 1.

4. Unannounced and Routine Inspection

4.1. The CQC have undertaken no 'unannounced' inspections or routine visits in the period.

4.2. 144 Wythenshawe Road Short Break Service - 13 -17 May 2019

144 Wythenshawe Road is a respite service providing short term accommodation for up to three people with a Learning Disability.

The report has been received and the final rating given was 'Requires Improvement'. The service was rated 'good' for caring and responsive but RI for safe, effective and well-led. The recommendations made relate to the environment, escalation processes and access to information technology. The commentary in respect of care was very positive with staff being commended for their approach.

The MLCO are working on an action plan in response and the CQC will be invited back once the work is completed.

This rating does not impact on the overall rating for the Trust or MLCO.

5. Human Fertilisation and Embryology Authority (HFEA)

5.1. The HFEA visited the Saint Mary's Hospital IVF service in March 2019 and have granted a 3 year license. They made a number of recommendations for improvements and a team from Saint Mary's Hospital and Corporate Services are overseeing the improvements required.

6. Human Tissue Authority (HTA)

6.1. The HTA visited the Stem Cell Laboratory on the Oxford Road Campus for a routine inspection of License number 22596. The final report was a positive one with only minor recommendations for improvement.

7. Action

7.1. The Board of Directors is asked to approved the Statement of Purpose as detailed in section 2.4

Statement of purpose

Health and Social Care Act 2008

Part 3

Location(s), and

- the people who use the service there
- their service type(s)
- their regulated activity(ies)

Fill in a separate part 3 for each location

As the part 3 document now totals some 130+ pages, for ease, only the updated section is produced here for approval, new locations in **bold**.

Description of the location (The premises and the area around them, access, adaptations, equipment, facilities, suitability for relevant special needs, staffing & qualifications etc)
A number of our community sites as per the list below do not meet the criteria for standalone registration with the CQC. These are community clinics which need to be registered under Trust Head quarters. • Burnage Health Centre • Northenden Health Centre • Higher Openshaw Primary care Centre • Vallance Health Centre • Chorlton Health Centre • Maddison Place • Stratus House • The Power House • Pendleton Gateway • Abbey Hey Clinic • Starlac Centre • Alexandra Park Health Centre • Charleston Road Health Centre • Cheetham Hill Primary Care Centre • Clayton Health Centre • The Longmire Centre • Gorton Health Centre • Levenshulme Health Centre • Platt Lane Surgery • Specialised Ability Centre • Newton House • Ashton Primary Care Centre • ***Woodsend Clinic*** • ***Timperley Health Centre*** • ***Partington Health Centre*** • ***Meadway Health Centre*** • ***Delamere Health Centre*** • ***Waterside House Clinic*** • ***Chapel Road Clinic*** • ***George H Carnall Leisure Centre*** • ***Limelight Community Health Centre***

CQC service user bands The people that will use this location ('The whole population' means everyone).					
Adults aged 18-65	☐	Adults aged 65+		☐	
Mental health	☐	Sensory impairment		☐	
Physical disability	☐	People detained under the Mental Health Act		☐	
Dementia	☐	People who misuse drugs or alcohol		☐	
People with an eating disorder	☐	Learning difficulties or autistic disorder		☐	
Children aged 0 – 3 years	☐	Children aged 4-12	☐ Children aged 13-18	☐	
The whole population	☒	Other (please specify below)		☐	

The CQC service type(s) provided at this location	
Rehabilitation services (RHS)	☒
Community healthcare service (CHC)	☒
Community-based services for people with a learning disability (LDC)	☒

Regulated activity(ies) carried on at this location		
Treatment of disease, disorder or injury	☒	
Registered Manager(s) for this regulated activity: No		
Surgical procedures	☒	
Registered Manager(s) for this regulated activity: No		
Diagnostic and screening procedures	☒	
Registered Manager(s) for this regulated activity: No		
Transport services, triage and medical advice provided remotely	☒	
Registered Manager(s) for this regulated activity: No		
Maternity and midwifery services	☒	
Registered Manager(s) for this regulated activity: No		
Family planning service	☒	
Registered Manager(s) for this regulated activity: No		

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Professor Cheryl Lenney, Group Chief Nurse
Paper prepared by:	Karen Meadowcroft, Corporate Director of Nursing Anne-Marie Varney, Assistant Chief Nurse (Workforce)
Date of paper:	August 2019
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 • Accept • Resolution • Approval • Scrutiny & Assurance ✓
Consideration of Risk against Key Priorities:	1. Patient Safety 2. Patient Experience 3. Productivity and Efficiency
Recommendations:	To note the work that is being undertaken to ensure the safe provision of a nursing and midwifery workforce
Contact:	Name: Anne-Marie Varney, Assistant Chief Nurse (Workforce) Tel: 0161 701 5071

1. Executive Summary

1.1 This paper provides the bi-annual comprehensive report to the Board of Directors on Nursing and Midwifery staffing. The report details the Trust position against the requirements of the National Quality Board (NQB) Safer Staffing Guidance for adult wards 2016[1], and the NHS Improvement (NHSI) Developing Workforce Safeguards Guidance, published in October 2018[2].

1.2 The Board of Directors received a paper in March 2019 outlining the trusts position against the NQB standards. This paper will provide analysis of the Trust workforce position at the end of **June 2019** and the actions being taken to mitigate and reduce the vacancy position, specifically within the staff nurse and midwifery band 5 and 6 workforce.

1.3 At the end of June 2019, there was a total of **820.3wte (11.6%)** qualified Nursing and Midwifery vacancies across the Group which is an increase in the overall Nursing and Midwifery vacancies of **79.6wte** since December 2018. The majority of vacancies are within the Staff Nurse (band 5) workforce. At the end of June 2019 there were **567.1wte (14.2%)** staff Nurse (band 5) vacancies across the Trust which is an increase of **12.6wte** nursing and midwifery band 5 vacancies since December 2018. The overall number of staff in post has increased by **42.1wte** therefore the half of the increase in vacancies is a result of an increase in establishment since April 2019.

1.4 Trust wide recruitment campaigns continue to attract a number of nurses and midwives, predominantly those who are newly qualified. There are currently **446** nurses and midwives with conditional job offers whose appointments are being processed through the Trust recruitment process. 70 of these candidates are due to commence in post over the next 2 months with **345** due to graduate later in the summer and commence in post in October 2019.

1.5 A total of **155** International nurses have commenced in post since January 2019 with a further **150** nurses expected to arrive before the end of March 2020. This demonstrates a significant increase on the number of IR nurses recruited in previous years.

1.6 Following the introduction of the Nursing Associates (NA) training programme in January 2017 the first cohort of NAs has now completed the programme with 68 registered with the NMC. Nationally, the first wave pilot sites have seen a total of 1000 NAs now registered with the NMC. Work has been undertaken within the hospitals to profile the introduction of the NA role within the skill mix in the clinical areas to ensure inclusion of the role is safe and appropriate.

1.7 The Trust has seen an improved workforce position during Q1 in comparison to Q1 in previous years however, it is acknowledged that this improvement has been predominantly achieved due to the increase in International nurses (150 additional nurses) joining the Trust over the last 12 months. Whilst this improved position supports the Hospitals/MCS to achieve their workforce plans there is a recognition that more work is required to maximise domestic recruitment and specifically nurse retention.

[1] NQB 2016, Supporting NHS Providers to deliver the right staff, with the right skills in the right place at the right time.
[2] NHSI 2018, Developing Workforce Safeguards: Supporting providers to deliver high quality care through safe and effective staffing. NHS Improvement, London

1.8 The Trust has seen an overall reduction of 0.5% in the registered nursing and midwifery sickness rate since December 2018 with the biggest improvement seen in MRI where the registered nurse sickness rate has reduced from 6.6%in December 2018 to 4.1% in June 2019.

1.9 The national workforce model suggests that there will continue to be a supply and demand problem with the greatest workforce challenge in nursing, with **41,000** nurse vacancies and approximately **3,500** midwives[3] and an increased reliance on bank and agency staff. The Trust has piloted the Nursing Associate role and is in the process of embedding the role within the workforce to support the nursing and midwifery workforce.

1.10 The Trust is committed to the delivery of safe staffing levels. A training programme to expand the use of the electronic Health Roster applications has been introduced to support daily staffing reviews and deployment. An annual programme to review inpatient ward nursing establishments has commenced for all inpatient wards across the Hospitals/MCS. Ward establishment reviews will be undertaken using an evidence based approach and applying the Safer Care Nursing Tool (SNCT) to ensure staffing levels meet the acuity and dependency of patients within each ward environment. This is considered key to the retention of nurses.

1.11 Whilst it is recognised that there are Nursing and Midwifery staffing challenges nationally it is widely accepted that retention of staff must be a key focus on future workforce planning. Workforce data identifies that over 700 Nurses and Midwives have left the organisation since June 2018 and further work is required to fully understand the various reasons for staff leaving.

1.12 The Trust has been invited to join the NHSI Nursing and Midwifery Retention programme which will be launched in September 2019. This will provide an opportunity for the Trust to access NHSI resources and sharing good practice to support the development of retention schemes and improvement plans.

1.13 The Trust retention programmes are intended to support a sustainable workforce retaining the expertise and experience of Nursing and Midwifery staff and reducing the numbers of leavers. It is expected that investment in these areas will reduce the reliance on the use of bank and agency staff and support financial sustainability. Across the Trust each Hospital/MCS has established a workforce plan together with a retention strategy. These plans will inform a Trust programme of work.

1.14 The end of year report (March 2020) will include the first reporting of Allied Health professionals staffing in line with NHSI requirements.

1.15 The Board of Directors is asked to receive this paper and note progress of the work undertaken to address the Nursing and Midwifery vacancy position across the Group.

[3] State of Maternity Services Report 2108- England

2. Introduction

2.1 The bi-annual, comprehensive report is provided to the Board of Directors on Nursing and Midwifery staffing. The report details the Trust position against the requirements of the National Quality Board (NQB) Safer Staffing Guidance for adult wards 2016[4], and the NHS Improvement (NHSI) Developing Workforce Safeguards Guidance, published in October 2018[5]. The Guidance recommends that the Board of Directors receive a bi annual report on staffing in order to comply with the CQC fundamental standards on staffing and compliance outlined in the well-led framework[6].

2.2 The paper will provide analysis of the Trust workforce position at the end of **June 2019** and the actions being taken to mitigate and reduce the vacancy position, specifically within the staff nurse and midwifery band 5 and 6 workforce.

2.3 A workforce review has been undertaken to present the information by Hospitals and Managed Clinical Services (MCS). The Hospital/MCS Directors of Nursing and the Director of Health Care Professionals (HCP) are required to present a quarterly Nursing/Midwifery workforce report to their Hospital/MCS Board. The June 2019 reports have been presented to the hospitals/MCS Boards and inform this report.

3 National Context and Guidance

3.1 Nationally NHS workforce supply remains high on the agenda; NHS Digital (2018) data has shown there were more than **144,000** vacant NHS posts. The greatest workforce challenge is in nursing, with **41,000** nurse vacancies which equates to one in 8 posts (NHS Improvement 2018) with approximately 80% of the vacant shifts currently filled by bank and agency staff. Within maternity services, the Royal College of Midwifery (RCM) report a shortage of approximately **3,500** midwives[7].

3.2 The NHS and the political landscape within the UK continues to go through an unprecedented period of change which may impact on the ability to recruit and retain nursing and midwifery staff in the future:-

- A 25% increase in nurses leaving the NHS from 2012 to 2018, equating to an additional 7,000 members of staff[8]
- A growing demand on the health service due to a growing and ageing population and specific pressures to increase staff in response to safe staffing guidance.
- Imbalance between supply and demand and increasing acuity and dependency of patients.
- Brexit continues to create uncertainty and therefore the impact on the supply and retention of European Union (EU) based nurses is not clear.

[4] NQB 2016, Supporting NHS Providers to deliver the right staff, with the right skills in the right place at the right time.
[5] NHSI 2018, Developing Workforce Safeguards: Supporting providers to deliver high quality care through safe and effective staffing. NHS Improvement, London
[6] https://www.cqc.org.uk/files/inspection-framework-nhs-trusts-foundation-trusts-trust-wide-well-led
[7] State of Maternity Services Report 2108- England
[8] Closing the gap: Key areas for action on the health and care workforce. The Health Foundation, 2019

- The Universities and Colleges Admissions Service (UCAS) reported that applications by students in England to nursing and midwifery courses at universities has fallen by 29% since 2017, the year in which the nursing and midwifery training bursary was removed[9]. UCAS have advised that circa 37,000 people have applied to study on nursing courses in 2019, which represents nationally an overall fall of 15,000 applications since the change in student funding. From a GM perspective the HEIs are on track to recruit in excess of a **25% increase** in the number of Nursing and Midwifery students commencing a programme of education in the academic year 2019/20, in comparison to programmes of education in 2016/17 which was prior to the removal of the bursary.

3.3 In October 2018, NHSI published The Developing Workforce Safeguard's Guidance[10] which provides a resource to support the Trusts compliance against the NQB's guidance on safe staffing and to comply with CQC standards. The Guidance describes 14 key recommendations to strengthen governance arrangements and improve workforce outcomes. The Chief Nurse has commissioned a review of the guidance and a gap analysis to determine the requirements to support the nursing and midwifery workforce. A work programme will be agreed to support achieving the recommendations, and outcomes will be monitored through NMAHP Professional Board and HR Scrutiny Committee.

3.4 In January 2019, NHS England published the NHS Long term Plan (LTP)11 setting out the priorities for healthcare over the next 10 years. The plan recognises the key role that staff will take in delivering improvements to services and the need to develop the workforce to support these ambitions. The Interim People Plan was published in June 2019 and commits to a workforce implementation plan to lay the foundations to achieve this ambition. The MFT Workforce and Education Strategy is under development and will address the recommendations from both reports and provide a vision to develop the Trust workforce over the next 10 years. Progress on this work will be reported to Workforce and Education Committee, HR Scrutiny Committee and Group Management Board.

3.5 NHSI have established a national Safe Staffing Fellow programme, directly supported by the Chief Nursing Officer for England. The programme commenced in April 2019 and the Assistant Chief Nurse for Workforce has been selected as a Fellow on the 12 month programme. The aim of this programme is to strengthen nursing and midwifery scrutiny and oversight of staffing both nationally and locally and the Fellows will support evidence based decision making on safe and effective staffing.

3.6 The Safer Care Nursing Tool (SNCT) is essentially the only evidence based tool currently used in the NHS to support nursing workforce establishment reviews and safe staffing decisions. The development of the tool and ongoing review has been managed through the Shelford Chief Nurses and in partnership with NHSI. The Safe Staffing Fellows programme will develop a national faculty of expertise and skill to support the future development and increase use of evidence based workforce tools. The Trust has applied for a second fellow to undertake the training.

[9] https://www.rcn.org.uk/news-and-events/press-releases/nursing-application-numbers-still-at-crisis-point-despite-small-increase

[10] NHSI 2018, Developing Workforce Safeguards: Supporting providers to deliver high quality care through safe and effective staffing. NHS Improvement, London

4. Greater Manchester Context

4.1 The GM collaborative is led by the MFT Chief Nurse on behalf of GM providers.

4.2 Greater Manchester (GM) Provider organisations and Higher Education Institutes (HEIs) continue to work in collaboration in order to increase the pre–registration education pipeline. Due to the success of the collaboration in GM between the Chief Nurses and HEIs there has been an overall **increase of 23%** in the number of Nursing & Midwifery students commencing a programme of education in the academic year 2018/19, in comparison to programmes of education in 2016/17 prior to the removal of the bursary. Across GM, HEIs are on track to recruit a 25% increase in the number of Nursing & Midwifery students commencing a programme of education in the academic year 2019/20 in comparison to HEE commissioned programmes of education in 2016/17. Training lead times however, results in these nurses not translating into an additional workforce supply until 2022/23.

4.3 In July 2019 the GM collaborative led by MFT successfully bid for additional placement infrastructure funding from NHSI; to grow pre-registration nursing clinical placement capacity for the 2019 intake, and support students in practice. Whilst the overall sum of money allocated to GM has yet to be confirmed, MFT will utilise the funding from NHSI to put in place infrastructure and processes to support learners in practice in order to reduce attrition as well as supporting the rapid expansion of clinical placements; with the aim of offering in excess of 95 additional nursing and midwifery placements for programmes of education from September 2019.

4.4 The four GM HEIs have undertaken a bespoke recruitment campaign to attract students to train in GM and have developed various materials to promote the campaign at various events including a Piccadilly Rail Station event – which was highlighted on BBC local News/Radio and posters which were featured on the ITV Coronation Street set in June 2019.

4.5 The GM HEIs in collaboration with their practice learning partners have developed alternative routes into nursing education including the Degree Nurse Apprenticeship, a 4 year integrated Nursing Masters programme and a shortened Masters programme. Following NMC approval these programmes of education will be in place from September 2019.

4.6 Following the success of the GM Nurse Recruitment campaign, 'Be a Greater Manchester Nurse'[12] phase 2 of the campaign will run from September 2019 utilising impact evaluation intelligence from phase 1 of the campaign. Following conclusion of phase 2 of the campaign, HEIs and GM provider organisations will measure the success of the campaign in terms of increased recruitment and retention rates.

4.7 Following the launch of the national campaign to encourage people to return to practice *'We are Returning Nurses',* a specifically targeted GM project for the recruitment of Return to Practice nurses has commenced to develop a GM wide Employer Led RTP model in association with MMU.

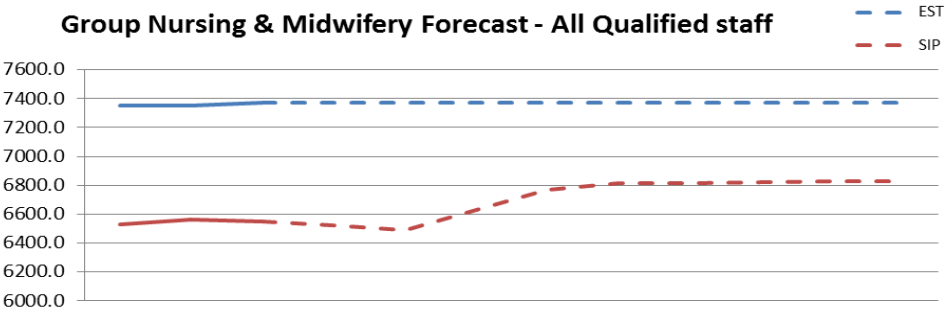
[12] https://www.greatermanchesternurses.co.uk

5 MFT Workforce Position

5.1 At the end of June 2019, there was a total of **820.3wte (11.6%)** qualified Nursing and Midwifery vacancies across the Group compared to **740.7wte (10.2%)** at the end of December 2018. Although this is an increase in the overall Nursing and Midwifery vacancies of **79.6wte** since December 2018, the number of staff in post has increased by **42.1wte** therefore the majority of the increase in vacancies is a result of an increase in establishment since April 2019.

5.2 **Graph 1** provides the overall Nursing and Midwifery vacancy trajectory until the end of Quarter 4 (2019/20). The Nursing and Midwifery vacancy position will be much improved from the previous year with an additional **302wte** nurses and midwives in post by March 2020 when it is predicted there will be **544.1wte (7.4%)** nursing and midwifery vacancies.

Graph 1



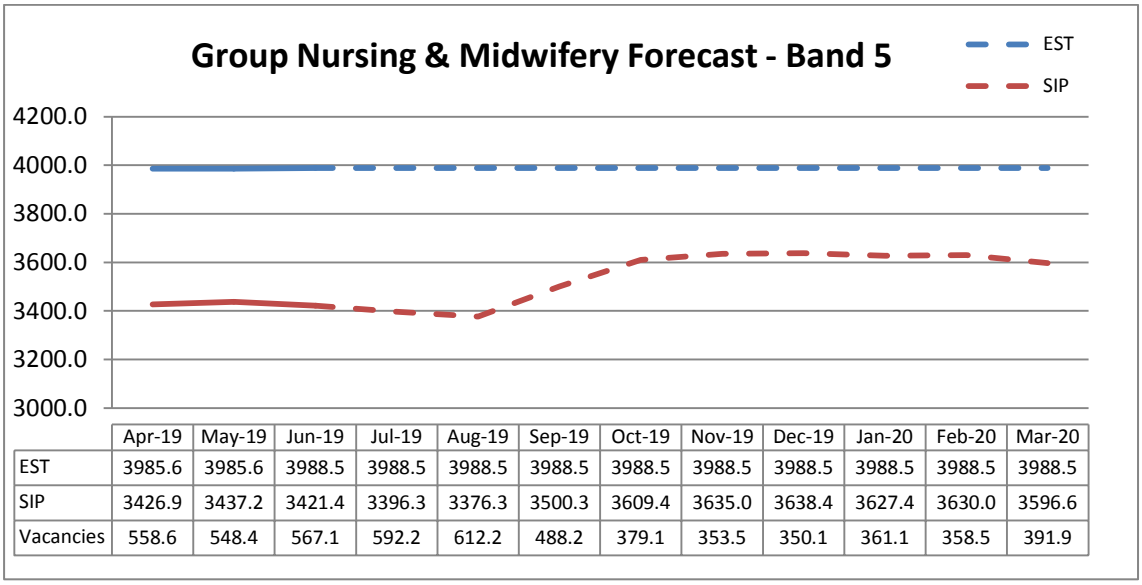
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
EST	7353.9	7353.9	7368.7	7368.7	7368.7	7368.7	7368.7	7368.7	7368.7	7368.7	7368.7	7368.7
SIP	6529.8	6559.9	6548.4	6523.3	6487.8	6631.3	6766.2	6813.3	6814.3	6823.1	6824.7	6824.6
Vacancies	824.1	794.0	820.3	845.4	880.9	737.4	602.5	555.4	554.4	545.6	544.0	544.1

5.3 The majority of vacancies are within the Staff Nurse (band 5) workforce. At the end of June 2019 there were **567.1wte (14.2%)** staff Nurse (band 5) vacancies across the Trust compared to **554.5wte (13.9%)** at the end of December 2018. This is an increase of **12.6wte** nursing and midwifery band 5 vacancies since December 2018.

5.4 **Graph 2** illustrates the Group-wide band 5 workforce position until March 2020. The number of band 5 nursing and midwifery vacancies is expected to increase in Q2 due to a reduction in the domestic recruitment pipeline which is known to occur at this time of year. This position will improve from September 2019 following the graduation and appointment of newly qualified Nurses and Midwives in Q3.

5.5 It is predicted that the number of band 5 vacancies at the end of March 2020 will be **391.9wte (9.83%).** This will be a reduction of **202.6wte** vacancies compared to the position in March 2019 when the vacancy factor was **594.5wte** (**14.9%).**

Graph 2



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
EST	3985.6	3985.6	3988.5	3988.5	3988.5	3988.5	3988.5	3988.5	3988.5	3988.5	3988.5	3988.5
SIP	3426.9	3437.2	3421.4	3396.3	3376.3	3500.3	3609.4	3635.0	3638.4	3627.4	3630.0	3596.6
Vacancies	558.6	548.4	567.1	592.2	612.2	488.2	379.1	353.5	350.1	361.1	358.5	391.9

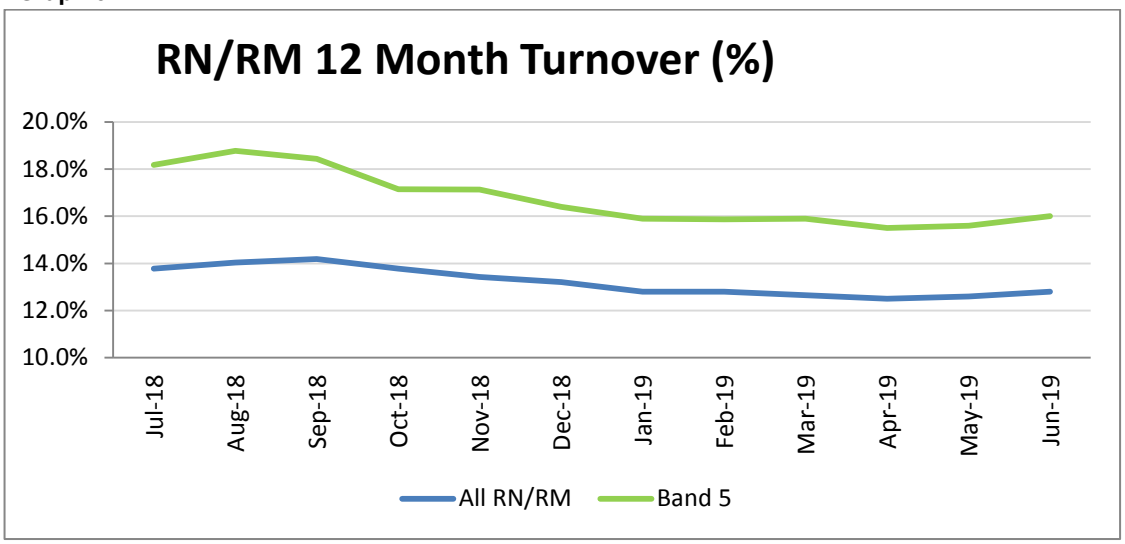
5.6 The continuing success of the trust international recruitment programme in 2018/19 when an additional 103 nurses (40 in previous years) has contributed to the improved workforce position in Q1 when the domestic recruitment pipeline is limited.

5.7 In February 2019, the first cohort of Nursing Associates (NAs) completed the two year training programme. MFT have 68 NAs registered with the NMC who are working across the hospitals and community settings. The hospitals are currently in the process of reviewing skill mix to support the introduction of NA's.

Nursing and Midwifery Turnover

5.8 At the end of June 2019, the 12 month rolling turnover rate for Nursing and Midwifery was **12.8%** and **16.0%** within the band 5 workforce (the national turnover rate for band 5 nursing and midwifery is 20.6%). **Graph 3,** illustrates an improving position over the last 12 months when RN annual turnover was 13.8% and band 5 turnover was 19.4%.

Graph 3



5.9 The top 2 highest known reasons for nurses and midwives leaving the Trust are recorded as work life balance and development opportunities, which account for over 50% of staff leaving. 43% of nurses and midwives leaving the Trust are within their first two years in post, with over half of these leaving within the first 12 months. Over 60% of leavers are recorded as going to another NHS Trust, with 15% leaving to go abroad and 12% taking retirement.

5.10 A retention workshop was held in January 2019 which was led jointly by the Chief Nurse and Director of Human Resources. The remit of the workshop was to generate ideas to improve retention and turnover within the Trust. A number of work streams were identified and work is progressing in areas such as an internal transfer guide with the aim of improving retention within the Nursing and Midwifery workforce.

Impact of Brexit

5.11 Brexit continues to create uncertainty for EU nurses and therefore the impact on the supply and retention of nurses recruited from Europe is not clear. The Trust currently employs **313wte** Registered Nurses and Midwives from the EU which equates to 5.0% of the Registered Nursing and Midwifery workforce. Over the past year, the Trust has reported a turnover rate of 25.7% (25% in 2017/18) within the EU national nursing and midwifery staff group against an average turnover of 12.7% for UK nationals.

5.12 Despite the UK's plans to exit the EU, an increase in turnover within the EU National Nursing and Midwifery staff group has not been noted over the last 12 months. The Trust will continue to monitor turnover within this staff group on a monthly basis as part of the Trust's Brexit planning. In addition, the Trust continues to promote the EU Settlement scheme to EU staff to enable them to live and work in the UK beyond 31st December 2020.

Sickness Absence

5.13 In June 2019, the sickness absence rate for the registered nursing and midwifery staff group was reported at 4.72%. Although this is above the Trust target of 3.6%, it is an improvement on the December 2018 position when the registered nursing and midwifery sickness absence was reported at 5.22%.

5.14 Managing sickness absence and ensuring robust processes are in place has been a priority for each of the hospitals/ MCS. The former UHSM utilised the electronic Absence Manager System which following implementation demonstrated a reduction in nursing and midwifery sickness rates. A programme to implement the system across all Hospitals/MCS sites have been launched with phase one now underway.

Recruitment

Domestic Recruitment

5.15 Trust wide recruitment campaigns continue to attract a number of nurses and midwives, predominantly those who are newly qualified. There are currently **446** nurses and midwives with conditional job offers whose appointments are being processed through the Trust recruitment process. 70 of these candidates are due to commence in post over the next 2 months with **345** due to graduate later in the summer and commence in post in October 2019.

International Recruitment

5.16 The international nurse recruitment programme was introduced in 2015 which has resulted in a total of **382** non EU nurses join the Trust. A total of **155** nurses have commenced in post since January 2019 with a further **150** nurses expected to arrive before the end of March 2020. This demonstrates a significant increase on the number of nurses recruited in previous years. The Trust will continue to work closely with our overseas recruitment partner to recruit international nurses through face to face and skype interviews in India and the UAE.

5.17 A programme to support UK recruitment of overseas nurses who are resident in the UK but not registered with the NMC has recently been introduced. The Trust have recently recruited and supported 9 nurses who previously trained overseas to gain NMC registration following the required training and assessment.

5.18 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 98%. MFT have recently been shortlisted for the Nursing Times 'Best International Recruitment Experience' with the awards ceremony due to take place in Sept 2019.

6. Nursing Associates

6.1 Following the introduction of the Nursing Associates (NA) training programme in January 2017 the first cohort of NAs has now completed the programme with 68 registered with the NMC. Nationally the first wave pilot sites have seen a total of 1000 NAs now registered with the NMC.

6.2 Work has been undertaken within the hospitals to profile the introduction of the NA role within the skill mix in the clinical areas to ensure inclusion of the role is safe and appropriate. A detailed Quality Impact Assessment (QIA) has been completed in order to mitigate any potential risks. The role has initially been introduced in general ward and community areas to ensure the role is successfully embedded in practice before expanding the role into more specialist areas. Work has now commenced to develop the NA role in adult and paediatric theatres.

6.3 Skill mix reviews are being undertaken by the Directors of Nursing for the Hospitals/MCS to profile the ward establishment and safe introduction of the Nursing Associate. This work will inform future recruitment and training plans to support the success and development of the role. The Trust is assessing the impact of the role by monitoring performance outcomes, including medication errors and patient harms which are also reported to NHSI on a monthly basis.

6.4 There are currently **170** Trainee Nursing Associates (TNAs) across the Trust of which **80** are due to qualify in April 2020. The Trust will continue to train through an apprenticeship model where affordable but has commissioned a number of self-funded trainees through both MMU and UoB.

6.5 Nationally there are approximately 7000 NAs undertaking a validated programme. Health Education England (HEE) have committed to recruit a further 7500 trainee nursing associates in 2019. This recruitment strategy will support the plan to grow the Nursing Associate workforce by 15,000 over the next 2 years.

7. Under-Graduate Pre-Registration Nursing and Midwifery Training

7.1 The Higher Education Institutions (HEIs) are currently recruiting to nursing and midwifery programmes of education in 2019/20 and are on track to recruit the additional Nursing and Midwifery students requested from the GM Directors of Nursing. Following the additional monies received by NHSI to support the rapid expansion of clinical placement capacity. Training lead times however, mean new investment in staff will not deliver additional supply in the workforce until at least 2022.

7.2 Board members will be aware that Saint Mary's reports a very favourable position against vacancies; however this remains an annual challenge and therefore confirms that retention is the biggest issue for this professional group.

8. Safe Staffing

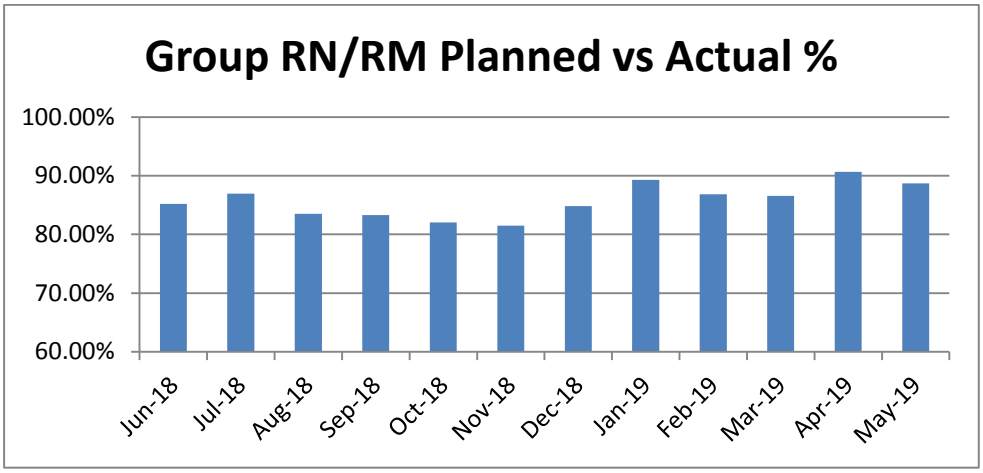
8.1 NICE first published guidelines on safe staffing in 2014, recommending a systematic approach to ensure that patients receive the required level of nursing care across adult in patient wards. The recommendations focus on accountability and monitoring of nursing establishments and responding to unplanned changes in daily staffing using a recognised and approved decision support toolkit. This includes the Safer Nursing Care Tool (SNCT) and Allocate Health Roster System to monitor planned and actual staffing levels. The guidance also advocates the use of professional judgement and monitoring of red flags to ensure the availability of nursing staff is appropriate to meet the needs of the patients on a daily basis.

8.2 In October 2018, NHSI released the Developing Workforce Safeguards Guidance[13] built upon the NQB Safe Staffing Guidance (2016) designed to help Trusts manage common workforce problems. The NQB guidance recommends trusts apply a triangulated approach to deciding safe staffing requirements combining, an evidence based tool such as the SNCT to measure patient acuity and dependency, professional judgement and patient quality outcomes and harm.

8.3 The Trust is required to submit the monthly Safe Staffing Report to NHSI detailing actual registered nurse and midwifery staffing levels as a percentage against those that were planned. **Graph 4** details the Trust registered nursing and midwifery fill rate which shows an average of 85.7**%** across the Trust over the last 12 months. The fill rate has improved since January 2019 with an average fill rate of 88.5**%** over the last 6 months.

[13] Developing Workforce Safeguards: Supporting providers to deliver high quality care through safe and effective staffing. NHS Improvement (2018)

Graph 4



8.4 A monthly report has been developed and shared with the Directors of Nursing to provide a comparison of Nursing and Midwifery workforce and safe staffing data against quality outcomes. On review of the planned staffing fill rate, there is no direct correlation found between wards with a lower fill rate and nurse sensitive indicators including patient falls, pressure ulcers and venous thrombo-embolism.

8.5 In 2017 the NQB published an improvement resource to achieve safe, sustainable and productive staffing of maternity services[14]. This resource is designed to be used by those working in clinical settings and leading maternity services. The Guidance endorses Birth-rate Plus (BR+) Midwifery Workforce Planning which is based upon the principle of providing one to one care during labour and delivery to all women with additional midwife hours for women in the higher clinical need categories. A BR+ study assesses the midwifery workforce on a service based upon the needs of women and records data for a minimum period of 3 months on intrapartum care, hospital and community activity and all other aspects of care provided by midwives from pregnancy through to postnatal care[15].

8.6 The Obstetric Strategy for Managing Capacity and Demand has used local intelligence using a methodology based on activity level (births), length of stay, bed usage and professional judgement and cross referenced the outputs with the Birth Rate Plus ratios to agree midwifery establishments.

8.7 The table below details the midwife to birth ratio for the SMH MCS. This complies with the national recommendation of 1:28. The ratio may increase in September 2019 whilst the service awaits the commencement in post of newly qualified midwives. These midwives were recruited in May 2019 and are expected to start in September and October 2019. The percentage of specialist midwives employed across the MCS accounts for 10% of the establishment and these are not included in the clinical numbers. They work closely with the multidisciplinary team to provide expert knowledge to the midwifery teams across the MCS.

[14] NQB 2018 Safe, sustainable and productive staffing: An improvement resource for maternity services
[15] NICE 2015, NICE guideline NG4: Safe midwifery staffing for maternity settings https://www.nice.org.uk/guidance/ng4

St Marys Managed Clinical Service	Midwife to Birth Ratio January 2019	Midwife to Birth Ratio May 2019	National Benchmark
Oxford Road Campus	1:29	1:28	1:28
Wythenshawe	1:26	1:26	1:28

8.8 Birth Rate Plus recommends 1:98 for community caseloads providing antenatal and postnatal care. The community midwifery caseloads on the Oxford Road Campus in January 2019 were 1:102 ratios with a midwifery staffing of 40.41wte. In May 2019 the caseload had increased to 1:112 with a midwifery establishment of 38.21wte. The reason for this increase is due to high maternity leave within the community core teams and registered midwifery vacancies in the in the hospital, restricting the opportunity to redeploy staff to the community. This situation will improve in Q3/4 following the graduation of student midwives who will commence in post from September 2019.

8.9 At Saint Mary's at Wythenshawe the community midwifery caseloads are unvalidated due to a data recording issue prior to the merger of the MCS. Initial analysis of service activity and workforce suggests the Birth-rate Plus caseloads ratios will be achieved by an increase to the community establishment 3wte.

8.10 As part of the community midwifery harmonisation project currently in progress, the total caseloads for each site are being reviewed across Saint Mary's Hospital MCS. The vision is working towards one community midwifery service across the City of Manchester delivering safe and effective care to all women and their families.

9. Care Hours Per Patient Day (CHPPD)

9.1 From April 2016, Care Hours Per Patient Day (CHPPD) has been the recommended nationally comparable metric to consistently monitor and report staff deployment. CHPPD is calculated by taking all the shift hours worked by registered nurses and nursing assistants over a 24 hour period and dividing this by the number of patients occupying a bed at midnight.

9.2 There is no national target for CHPPD, however NHSI publish the data on the NHSI Model Hospital portal in order for Trusts to benchmark the data against other organisations. **Table 1,** illustrates the monthly Trust CHPPD data against the median level across all NHS Trusts and those within the Shelford Group. The lack of national CHPPD targets limits the validity and use of this data to inform safer staffing decisions although it is recommended that benchmarking against other organisations is considered when undertaking a workforce review.

Table 1

Month	MFT average	National average	Shelford average
January 19	8.5	7.9	8.9
February 19	8.2	7.9	8.9
March 19	8.9	8.0	8.9
April 19	9.5	8.1	9.1
Average	**8.8**	**8.0**	**9.0**

10. Patient Acuity and Dependency

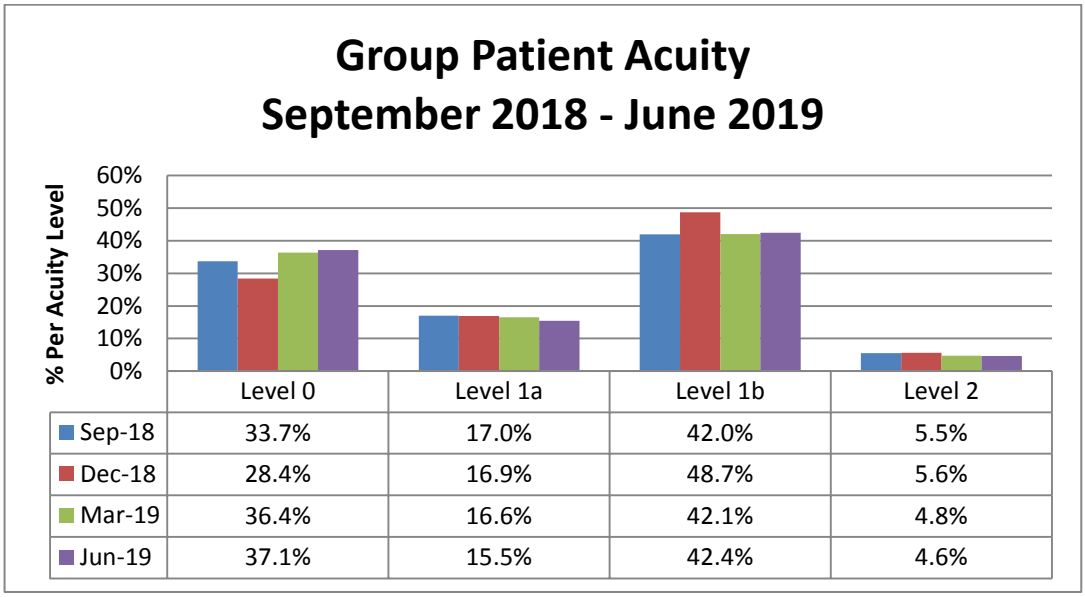
10.1 The acuity and dependency of ward patients is collected twice daily utilising the SNCT level descriptors shown in **Table 2** which determine the recommended number of staff required to care for the patient group in real time. This will guide the daily staffing requirements and supports managers to determine areas with greatest need and safe deployment of staff.

Table 2

Level	SNCT Level Descriptor
0	Normal patients who can be cared for on a general ward
1a	Acutely ill patients who can be cared for on a general ward
1b	Stable patients with an increased dependency on nurses
2	Patients in ward areas awaiting transfer to High Dependency care
3	Patients in ward areas awaiting transfer to Intensive

10.2 **Graph 5** demonstrates that with the exception of a slight increase in acuity over the winter months, patient acuity and dependency has remained relatively static over the last year amongst inpatient ward areas. The majority of patients are categorised as a level 1b, indicating that they have an increased dependency on nursing staff and in many instances these are patients requiring enhanced supervision. Although the descriptors do not specifically categorise enhanced supervision, daily safe staffing reviews indicate an increasing number of patients requiring enhanced supervision. The Shelford Chief Nurses have commissioned a review of the SNCT descriptors and tool to determine the care needs of patients requiring enhanced supervision to ensure this is accurately captured.

Graph 5



	Level 0	Level 1a	Level 1b	Level 2
Sep-18	33.7%	17.0%	42.0%	5.5%
Dec-18	28.4%	16.9%	48.7%	5.6%
Mar-19	36.4%	16.6%	42.1%	4.8%
Jun-19	37.1%	15.5%	42.4%	4.6%

10.3 The patient acuity and dependency reflects the national trends highlighting that the majority of patients are categorised as level 0 and level 1b. This would suggest that patients are less acutely unwell but are dependent on nursing care to meet most or all of their activities of daily living. This data enables senior nurses to make decisions relating to nurse establishment settings and appropriate skill mix reviews.

11. Daily Staffing Review

11.1 As recommended by NICE in 2014, daily staffing levels are assessed across each shift to ensure they are adequate to meet patients' nursing needs. Daily reviews of staffing requirements are undertaken by senior nursing and midwifery staff at the daily 'staffing huddles' within each hospital/MCS. During the staffing huddle, staffing levels are discussed and utilising professional judgement, resources are managed based upon patients' acuity and dependency, quality and safety indicators and issues that may affect patient safety and experiences. Escalation processes are in place to mitigate the impact of when planned staffing levels are not achieved to ensure the safe delivery of care.

12. Nursing Establishment Reviews

12.1 An annual programme to support nursing establishment reviews has been introduced for all inpatient wards across the Hospitals/MCS. The establishment reviews will be undertaken using the SNCT tool which was developed by Shelford Chief Nurses and is endorsed by NQB and NHSI. The SNCT is evidence based and calculates recommended staffing establishment levels following the analysis of patient acuity and dependency data collected over a 20 day census period.

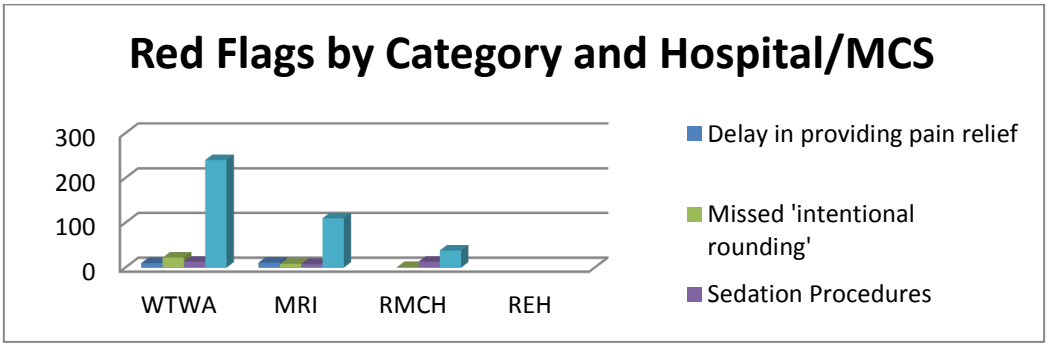
12.2 NHSI recommends that establishment setting should be completed annually with a bi-annual review. The Trust has introduced a schedule to collect data quarterly for the first year to establish a baseline, validate data and ensure compliance with the tool.

12.3 Two sets of data have now been collected in March and June 2019. Analysis of the June data is currently being undertaken and a full analysis will be provided to the Directors of Nursing once available to support future establishment reviews in conjunction with other workforce and patient outcome data. The SNCT data collection will be repeated in September 2019 and January 2020 to mitigate for seasonal variation. The requirement will be to undertake bi-annual data collections in January and June and report to the HR Scrutiny Committee.

13. Red Flags

13.1 Both NICE and NQB guidance recommends Trusts have a mechanism to capture 'red flag' events highlighting shortfalls in staffing and omissions in care. Poor compliance in submitting red flags has been reported previously. Following a programme of training the Trust has seen a substantial improvement to the number of red flags reported and how this is used in practice to support safe staffing decisions. **Graph 6** illustrates the number of red flags submitted since April 2019.

Graph 6



14. Hospitals and Managed Clinical Services Workforce

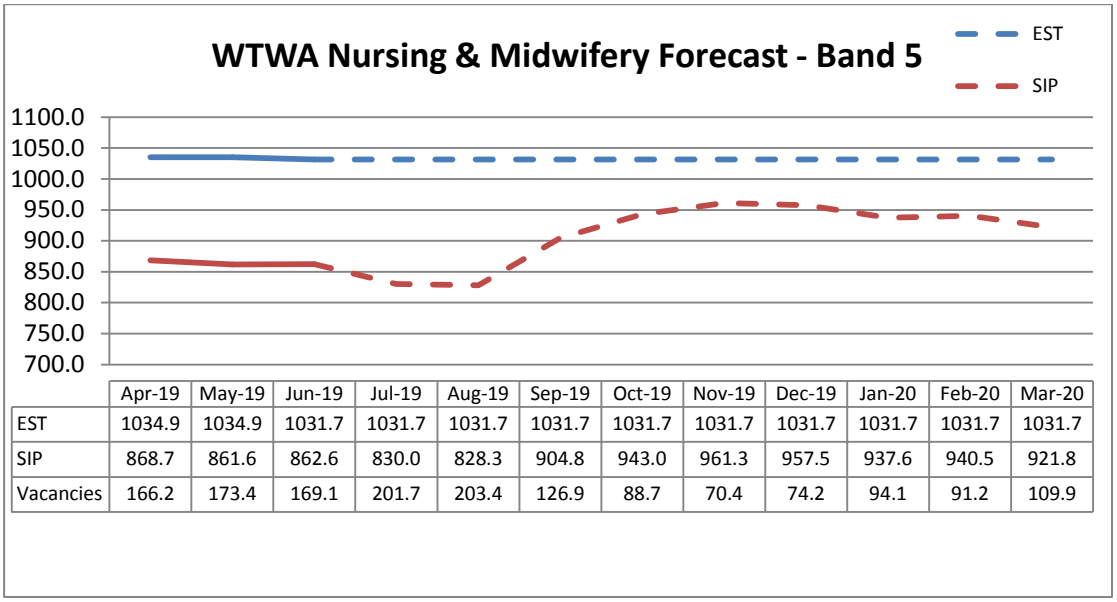
14.1 The Hospitals/MCS Directors of Nursing are required to present a quarterly nursing and midwifery workforce report to their hospital Boards. A summary from these reports follows, together with an updated workforce position compared to the same period in June 2018. The breakdown of workforce data by ward is provided in the detailed workforce report (see appendix 1).

15. Wythenshawe, Trafford, Withington and Altrincham Hospitals (WTWA) Workforce Position

15.1 At the end of June 2019, there was a total of **215.6wte (11.6%)** qualified nursing vacancies across WTWA. This is a reduction in overall nursing vacancies of **119.1wte** since June 2018. The Hospitals vacancy position is expected to improve by the end of Q4 when it is predicted there will be **130.5 wte (7.0%)** vacancies. This will be a reduction of **64.4 wte** vacancies when compared with the same period in the previous year.

15.2 The majority of the vacancies are within the Staff Nurse (band 5) workforce. **Graph 7** illustrates the WTWA band 5 workforce position until March 2020. At the end of June 2019 there was **169.1wte (16.4%)** band 5 vacancy which is a reduction of **73.9wte** vacancies since June 2018. The vacancy position is predicted to improve following the graduation and appointment of newly qualified Nurses, within **109.9wte (10.6%)** vacancies expected in March 2020. This will be an improvement on the same period in the previous year and a reduction of **107.6wte** vacancies.

Graph 7



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
EST	1034.9	1034.9	1031.7	1031.7	1031.7	1031.7	1031.7	1031.7	1031.7	1031.7	1031.7	1031.7
SIP	868.7	861.6	862.6	830.0	828.3	904.8	943.0	961.3	957.5	937.6	940.5	921.8
Vacancies	166.2	173.4	169.1	201.7	203.4	126.9	88.7	70.4	74.2	94.1	91.2	109.9

15.3 There are **96** Band 5 Staff Nurses currently in the domestic recruitment pipeline to start at WTWA, with over 95% of these due to commence employment before the end of October 2020. In addition, **20** internationally recruited nurses are anticipated to start in the hospital in September 2019 with similar sized cohorts expected to start at WTWA in November 2019 and March 2020.

15.4 Respiratory, elderly medicine, INRU, orthopaedics and theatres continue to be difficult to recruit to areas within the hospitals which is aligned to the national trends. The greatest challenge is within theatres and bespoke recruitment events have been held to target both newly qualified and experienced nurses and ODPs resulting in 22 candidates due to start in the next 3 months. Additional Skype interviews are being held on a monthly basis to specifically recruit international nurses with experience of working in theatres.

15.5 In January 2019, 24 Nursing Associates completed the TNA programme, with 22 of these now registered with the NMC and working across the medical and surgical wards at Wythenshawe and Trafford Hospitals. An operational group has been established to develop the NA role across Theatres, with a job description and competency framework currently being finalised.

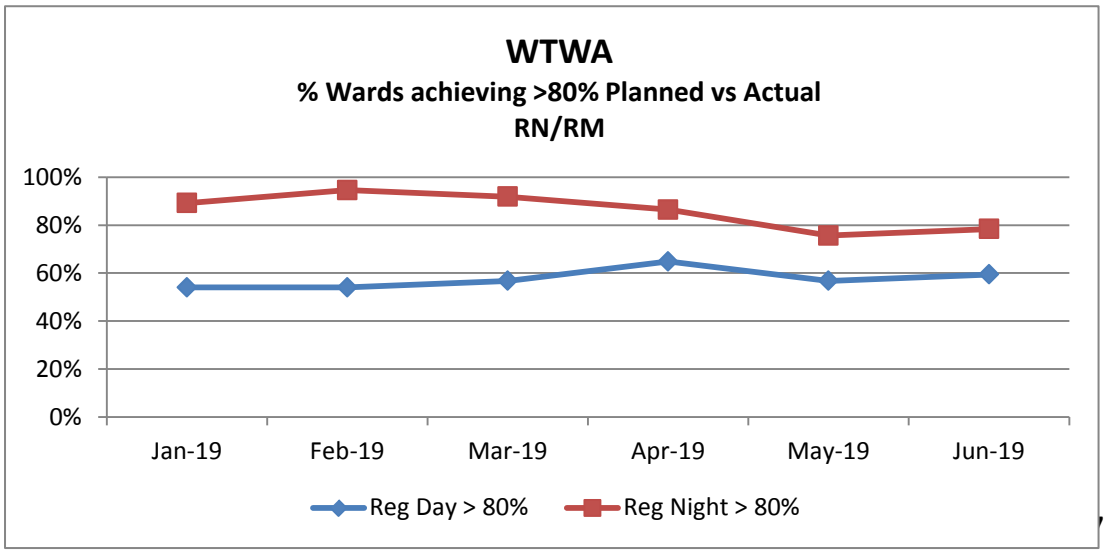
15.6 The rolling 12 month turnover for nursing is **13.1%** across WTWA with the highest turnover rate in the Division of Medicine (16.5%). The turnover for band 5 Staff Nurses is currently **17.2%.** An additional focus has been applied to retention across WTWA which has resulted in a reduction in turnover; in June 2018 nursing turnover was 15% and 18.3% across the band 5 workforce. The senior nursing team acknowledge that more work is required, particularly within the band 5 staff group and are reviewing areas with high numbers of leavers and the leaving reasons identified in order to influence focused pieces of work to improve retention.

15.7 Sickness absence within the nursing and midwifery staff group at WTWA continues to be above threshold at **5.8%** and has seen a worsening position since January 2019. Reducing sickness absence remains a key area of focus, particularly on the Trafford hospital site.

WTWA Safe Staffing

15.8 Across WTWA **87.9%** of planned Registered Nurse shifts were filled in May 2019. **Graph 8** shows that over the last 6 months, 31 of the 37 wards at WTWA are achieving more than 80% planned Registered Nurse staffing levels during the night. There are 21 of the 37 wards achieving 80% planned Registered Nurse staffing levels during the day shifts. 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. To ensure patient safety and support the Registered Nurse workforce areas with reduced RN fill rate have additional Nursing Assistants on duty with a 100% fill rate.

Graph 8



15.9 Over a 3 month period from April to July 2019, a total of **285** red flags were submitted across WTWA. As shown in table 3, the majority of those reported were a shortfall in registered nurse time, defined as a reduction of 25% registered nurse staffing against that planned.

Table 3

Hospital/MCS	Delay in providing pain relief	Missed 'intentional rounding'	Sedation Procedures	Shortfall in RN time	Total
WTWA	10	22	13	240	285

Key Actions

15.10 WTWA have identified specific areas of focus that align to the WTWA nursing workforce strategy that include the following:

- Each WTWA divisional Head of Nursing has developed a Divisional Delivery Workforce Plan that sets out the key areas of focus for improvement with agreed key performance indicators (KPIs). Progress and professional outcomes will be monitored through monthly divisional performance reviews and bi-annual confirm and challenge sessions.

- A specific focus on theatre staffing is ongoing; examining opportunities for alternative roles, strengthening the recruitment and retention of scrub nurses and developing the role of the NA within theatres.

- Skill mix reviews are to be undertaken to include additional Nursing Associates where the role has demonstrated a positive contribution to care delivery.

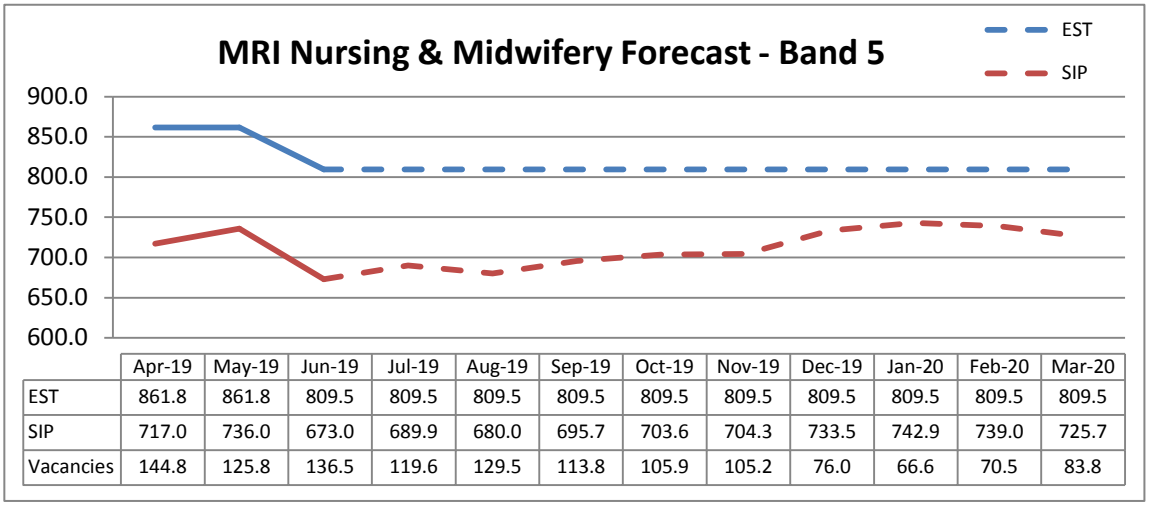
16. Manchester Royal Infirmary (MRI)

MRI Workforce Position

16.1 At the end of June 2019, there were a total of **212.7wte (14.3%)** registered nursing vacancies across MRI. This is an increase in overall nursing vacancies of **9.9wte** since June 2018. The hospital vacancy position is predicted to improve in Q4 when it is predicted there will be **166.5wte (11.2%)** vacancies by March 2020 which will be a reduction of **26.7wte** vacancies compared to the same period in the previous year.

16.2 The majority of the vacancies are within the staff nurse (band 5) workforce**. Graph 9** illustrates the MRI workforce position until March 2020. At the end of June 2019 there were **136.5wte (16.9%)** band 5 vacancies which is a reduction of **31.9wte** vacancies since June 2018. The vacancy position is predicted to improve further in Q4 to **83.8 (10.4%)** by March 2020. This will be an improvement on the same period in the previous year and a reduction of **55wte** vacancies.

Graph 9



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
EST	861.8	861.8	809.5	809.5	809.5	809.5	809.5	809.5	809.5	809.5	809.5	809.5
SIP	717.0	736.0	673.0	689.9	680.0	695.7	703.6	704.3	733.5	742.9	739.0	725.7
Vacancies	144.8	125.8	136.5	119.6	129.5	113.8	105.9	105.2	76.0	66.6	70.5	83.8

16.3 There are **84** Band 5 Staff Nurses currently in the pipeline to start at MRI, with the majority due to commence employment before the end of October 2019. In addition, **15** internationally recruited nurses are anticipated to start in the hospital in July with a further 20 in September 2020 and similar sized cohorts expected to start at MRI in December 2019 and January 2020. In January 2019, 22 Nursing Associates completed the Nursing Associate programme and are now registered with the NMC and working across the medical and surgical wards within MRI.

16.4 Within the MRI, vacancies are of particular concern in the following speciality areas: renal, hepatobiliary, orthopaedic and respiratory. There are a number of factors identified as impacting on the vacancy situation across these areas including the impact of introducing the of TReNDS renal dialysis service model which saw a freeze on registered nurse recruitment and high turnover of staff on the renal wards; and leadership challenges to caring for patients with a high level of dependency, confusion, and aggressive behaviour in the orthopaedic/surgical admissions area (ward 1&2) and respiratory medicine. There are recruitment improvement plans in place for each of these specialities which are monitored by the Director of Nursing and daily staffing review processes are in place to ensure nurse staffing resource is aligned to patient acuity and dependency. Work has been ongoing within respiratory and orthopaedic wards to support staff with the use of the zero tolerance policy against violence and aggression to improve the patient and staff environment.

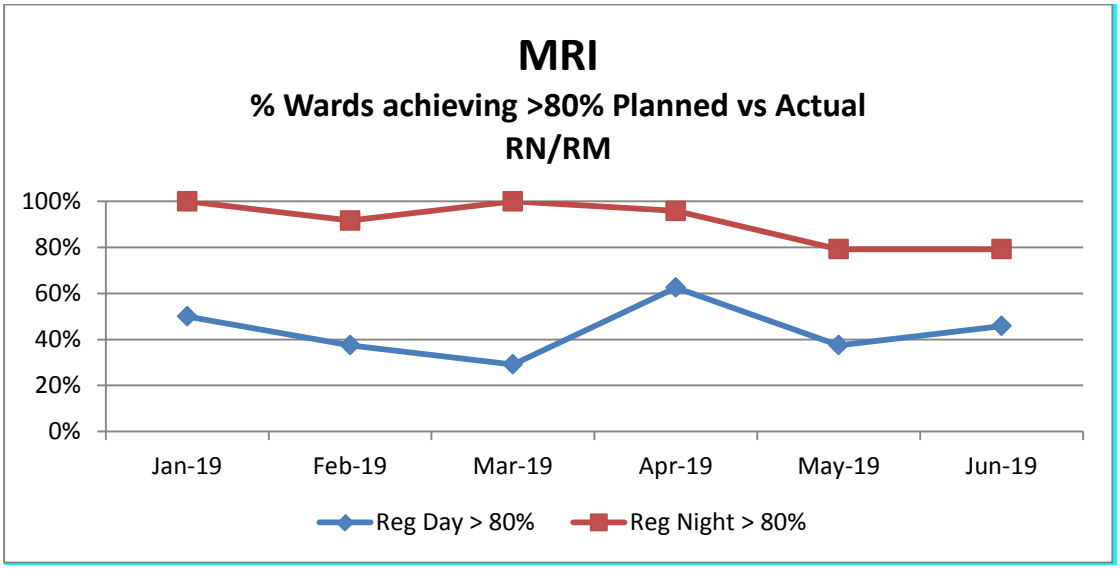
16.5 The 12 month turnover for nursing within MRI is **14.4%** with the highest turnover in the Division of Medicine (16.2%). The turnover within the Staff Nurse workforce is **18.1%** with the highest turnover in the Division of Surgery (**19.8%**). The 12 month rolling turnover rate has improved over the last 12 months when overall nursing turnover was 16.5% and band 5 turnover was 22% in August 2018.

16.6 Registered Nurse sickness absence levels have seen an overall improving trend. Registered nurse sickness absence has reduced from 6.6% in November 2018 (previously reported) to 4.1% in May 2019. Collaborative programmes of work led by the Heads of Nursing and HR Business Partners are in place to ensure there are robust processes for monitoring and managing absence which is further supported by programmes of well-being and self-care. Absence trends are being reviewed to identify where actions can be put in place to improve absence within the nursing staff group.

MRI Safe Staffing

16.7 Across MRI wards and departments, **85%** of planned Registered Nursing shifts were filled in May 2019. **Graph 10** shows that on average, 22 of the 24 wards at MRI hospital are achieving more than 80% planned Registered Nurse staffing levels 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 where there are 11 of the 24 wards achieving 80% planned Registered Nurse staffing levels.

Graph 10



16.8 Over a 3 month period from April to July 2019, a total of 137 red flags were submitted across MRI. As shown in table 4, the majority of those reported were a shortfall in Registered nurse time, defined as a reduction of 25% staffing against that planned.

Table 4

Hospital/MCS	Delay in providing pain relief	Missed 'intentional rounding'	Sedation Procedures	Shortfall in RN time	Total
MRI	11	8	8	110	137

Key Actions

16.9 Key work streams have been identified by the Director of Nursing and will be led by the Head of Nursing for Workforce and the Deputy Director of Nursing. Work will focus on exploration and delivery of the following:-

- The development of a MRI Nursing Recruitment and Retention Strategy
- Implementation of MRI Director of Nursing listening events with newly qualified nurses
- Undertake a series of focus workshops with nursing staff in their first 3 years of employment to gain a greater understanding of what influences staff to stay and work in MRI or consider leaving

- Develop an internal MRI transfer process and a 'career guardian' scheme to support new
- starters during their pre-employment phase and on starting in the Trust.
- Introduce the Ward Medication Administration Pharmacy Technician role into areas which require a greater level of technical application required for administering medication e.g chemotherapy.
- Review and redesign the nursing workforce following the appointment of future cohorts of Nursing Associates
- Explore the development of AHP posts in a blended skill mix/workforce
- Explore opportunities to support future theatre staffing
- Undertake a scoping exercise into aligning the band 3 dialysis assistant role with other band 3 roles across the Trust.

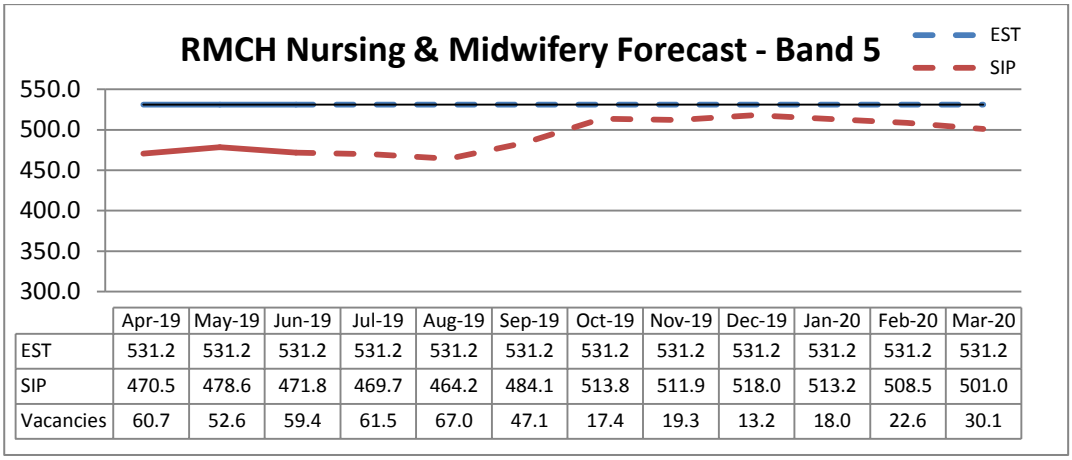
17. Royal Manchester Children's Hospital (RMCH)

RMCH Workforce Position

17.1 At the end of June 2019 RMCH had a total of **72.8wte (8.1%)** Registered Nurse vacancies. This is a reduction in overall nursing vacancies of **18.6wte** since June 2018. The hospital vacancy position is predicted to improve in Q4 when it is predicted there will be **30.8wte (3.4%)** vacancies by March 2020 which will be a reduction of **37wte** vacancies compared to the same period in the previous year.

17.2 The majority of the vacancies are within the Staff Nurse (band 5) workforce**. Graph 11** illustrates the workforce position in RMCH until March 2020. At the end of June 2019 there was **59.4wte (11.2%)** band 5 nursing vacancies which is a reduction of **19.5wte** vacancies since June 2018. The vacancy position is predicted to improve further in Q4 to **30.1wte (5.6%)** by March 2020. This will be an improvement on the same period in the previous year and a reduction of **25.9wte** vacancies.

Graph 11



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
EST	531.2	531.2	531.2	531.2	531.2	531.2	531.2	531.2	531.2	531.2	531.2	531.2
SIP	470.5	478.6	471.8	469.7	464.2	484.1	513.8	511.9	518.0	513.2	508.5	501.0
Vacancies	60.7	52.6	59.4	61.5	67.0	47.1	17.4	19.3	13.2	18.0	22.6	30.1

17.3 There are **68** Band 5 Staff Nurses currently in the pipeline to start at RMCH, with the majority due to commence employment before the end of October 2019. In addition,

4 internationally recruited nurses are anticipated to start in the hospital in July with a further 3 to 5 nurses expected to start at RMCH every 6 weeks for the remainder of the financial year.

17.4 Paediatric High Dependency Unit (PHDU) and ward 78 hold the highest registered nursing vacancy levels, with additional staffing pressures caused by a high number of staff on maternity leave in PICU. A number of international nurses have been appointed across RMCH over the past 12 months with a particular benefit noticed in PICU where the nurses are experienced in critical care nursing. In January 2019, 11 Nursing Associates completed the TNA programme, with all now registered with the NMC and working across the wards within RMCH. A further 35 Trainee Nursing Associates are undertaking their training within RMCH and introducing the NA role into specialist areas including PICU is currently being explored.

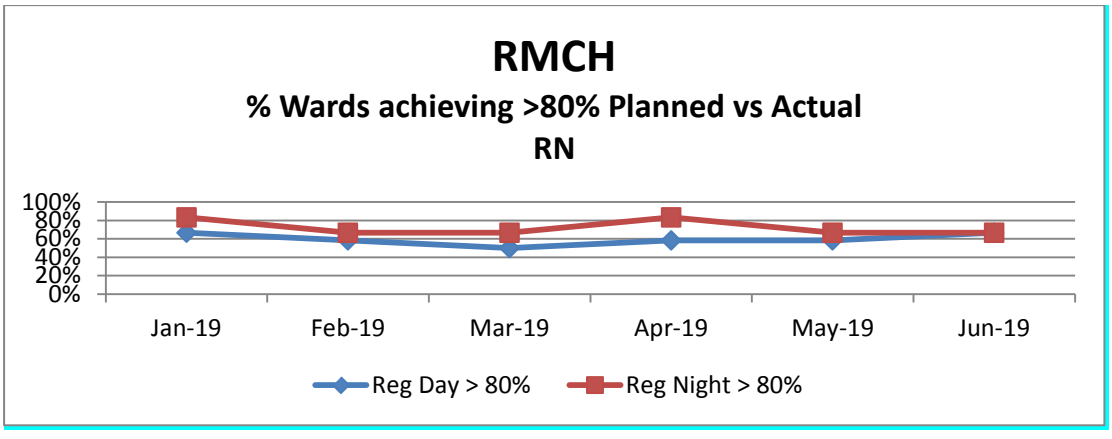
17.5 The 12 month turnover for nursing across RMCH is **11.4%** with an annual turnover of **14.3%** within the band 5 staff nurse workforce. There has been a focus within RMCH caring and valuing staff which was reflected in the positive feedback in the latest staff survey. RMCH have noticed a significant reduction in turnover of over the last 12 months when 13.4% was reported across the registered nursing and 18.3% within the band 5 staff nurse workforce in June 2018.

17.6 Registered Nurse sickness absence levels have seen a continuous improving trend since November 2018 with 3.6% sickness absence reported in May 2019 and therefore achieving the Trust target. Absence is monitored and managed at a local level and oversight provided at the weekly Director of Nursing and Director of Finance Bank and Agency Scrutiny Meeting. Programmes of work led by the Head of Nursing and supported by HR are in place to ensure that there are robust processes for monitoring and managing absence which is further supported by programmes of well-being and self-care both for physical and mental health.

RMCH Safe Staffing

17.7 Across RMCH wards and departments, **87.9%** of planned RN shifts were filled in May 2019. **Graph 12** shows that on average 9 of the 12 wards at RMCH are achieving more than 80% planned registered nurse staffing levels during the night and 7 of the 12 wards during the day. The submission of data is currently being scrutinised across all areas to address those areas achieving lower than 80% are producing accurate data.

Graph 12



17.8 Over a 3 month period from April to July 2019, a total of 52 red flags were submitted across RMCH. As shown in table 5, the majority of those reported were a shortfall in registered nurse time, defined as a reduction of 25% staffing against that planned.

Table 5

Hospital/MCS	Delay in providing pain relief	Missed 'intentional rounding'	Sedation Procedures	Shortfall in RN time	Total
RMCH		1	13	38	52

Key Actions

17.9 The Director of Nursing together with the Head of Nursing will oversee an deliver key actions to address a continued reduction in vacancies and turnover including:

- The development of a RMCH/ MCS Workforce Strategy
- Implementation of DoN/ HoN listening events with newly qualified nurses
- Ongoing work to support the NA role to be embedded
- A review of baseline budgeted establishments to include recent service developments
- Exploration of new roles within clinical areas to support the workforce

18. St Mary's Hospital MCS

SMH MCS Nursing and Midwifery Workforce Position

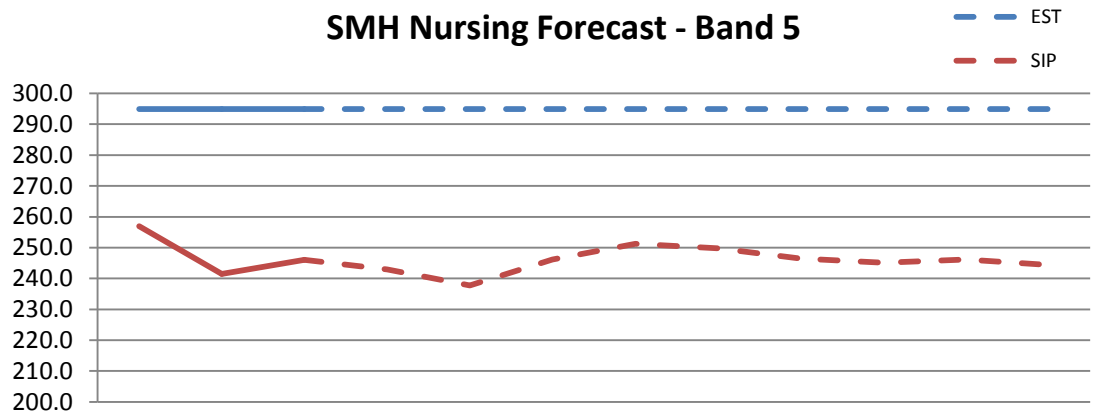
18.1 At the end of June 2019, there were a total of **122wte (11.1%)** qualified nursing and midwifery vacancies across SMH MCS. This is an increase of **14.2wte** overall nursing and midwifery vacancies since June 2018. The Hospital vacancy position will improve in Q2/3 following the graduation and appointment of newly qualified nurses and midwives.

SMH MCS Nursing Workforce Position

18.2 At the end of June 2019, there were a total of **91.6wte (16.2%)** qualified nursing vacancies across SMH MCS. The vacancy position will improve in Q3 following the graduation and appointment of newly qualified nurses, however it is anticipated that the number of vacancies will gradually increase over Q4 when it is predicted that there will be 97.8wte (17.3%) nursing vacancies.

18.3 The majority of the vacancies within SMH MCS are within the nursing (Staff Nurse Band 5) workforce. **Graph 13** illustrates the nursing workforce position in SMH until March 2020. At the end of June 2019 there were **48.8wte (16.5%)** Band 5 Staff Nurse vacancies which is a reduction of **9.6wte** since June 2018. The band 5 vacancy position is expected to remain relatively static over Q3/4 with **50.5wte** vacancies anticipated in March 2020 which is a reduction of **7.9wte** from March 2019.

Graph 13



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
EST	294.9	294.9	294.9	294.9	294.9	294.9	294.9	294.9	294.9	294.9	294.9	294.9
SIP	256.9	241.5	246.1	242.9	237.8	246.1	251.2	249.7	246.5	245.1	246.1	244.4
Vacancies	38.0	53.4	48.8	52.0	57.1	48.8	43.7	45.2	48.4	49.8	48.8	50.5

18.4 Across new born services there were **13.92 wte** vacancies at the end of June 2019 with the remaining vacancies (**34.8wte**) across the gynaecology specialities.

18.5 There are **41** Band 5 Staff Nurses currently in the pipeline appointed to work within neonatal services and gynaecology speciality before the end of October 2019. This follows a number of successful recruitment campaigns, including the annual SMH open day in May 2019. Over the last 12 months, 5 international nurses have been recruited to new born services and consideration is now being given to recruitment of international nurses within gynaecology services.

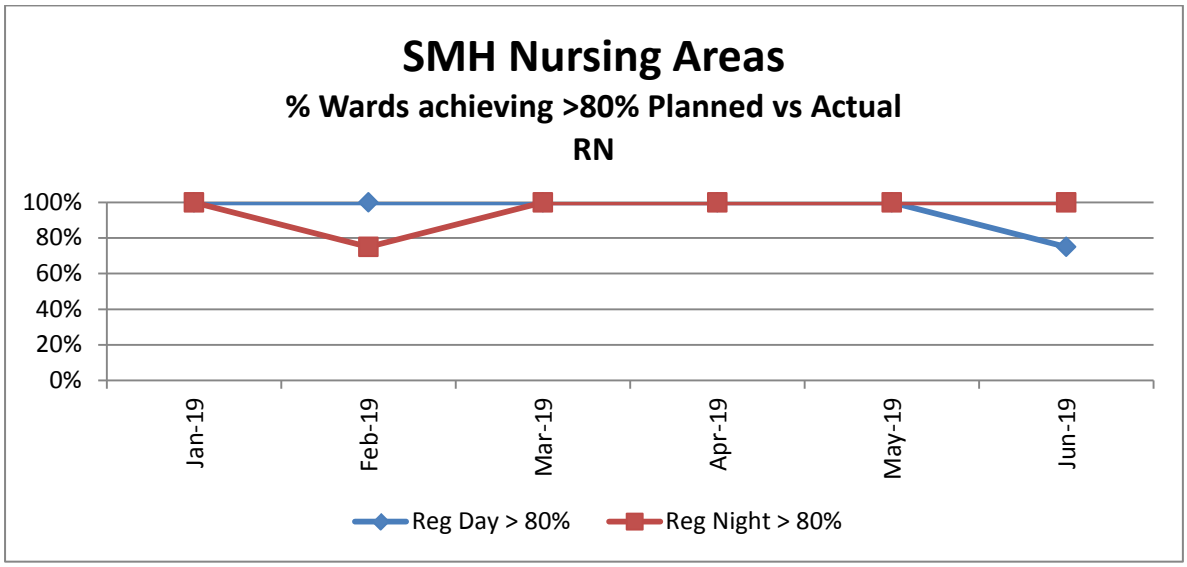
18.6 The Registered Nursing rolling 12 month turnover is **14.35%** within SMH and **19.66%** across the band 5 nursing workforce. Retention remains a key focus with retention plans being developed in conjunction with the hospital HR team to reduce the turnover of staff and the reliance on temporary staffing.

18.7 Although slight improvements were reported between February and April, Registered Nursing absence levels have seen a worsening position across SMH MCS, with **5.2%** absence reported in June 2019 when compared to 5.06% in January 2019.

SMH (Nursing) Safe Staffing

18.8 Across SMH MCS wards and departments, **98%** of planned Registered Nursing shifts were filled in May 2019. **Graph 14** shows that on average 3.8 of the 4 Nursing departments at SMH are achieving more than 80% planned Registered Nurse staffing levels during the day and night.

Graph 14



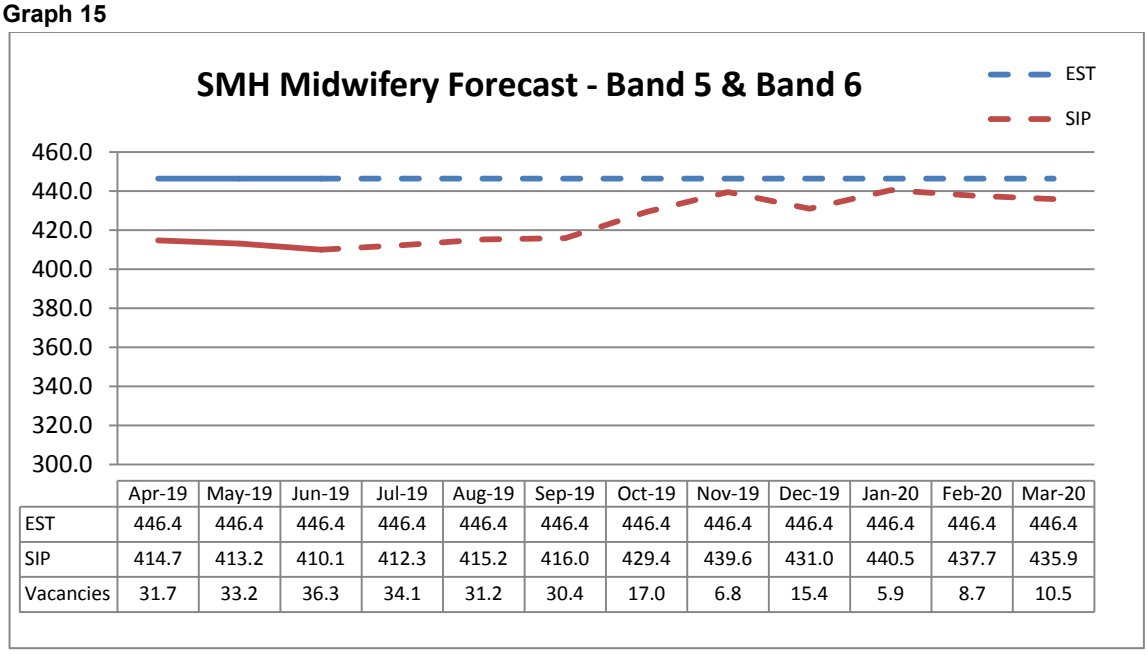
18.9 Over a 3 month period from April to July 2019, 0 red flags were submitted across SMH nursing areas.

SMH MCS (Midwifery) Workforce Position

18.10 At the end of June 2019, there was a total of **30.4wte** (**5.7%**) Registered Midwifery vacancies across SMH MCS. The MCS vacancy position is expected to improve by the end of March 2020 when it is predicted there will be **18.6wte (3.49%)** vacancies.

18.11 The majority of the vacancies are within the Band 5 and 6 midwifery workforce. At the end of June 2019 there were **36.3wte (8.1%)** band 5 & 6 midwifery vacancies. **Graph 15** illustrates the band 5 and 6 Midwifery workforce position in SMH MCS until March 2020 when it is predicted the vacancy position will be 10.5wte (2.35%).

Graph 15



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
EST	446.4	446.4	446.4	446.4	446.4	446.4	446.4	446.4	446.4	446.4	446.4	446.4
SIP	414.7	413.2	410.1	412.3	415.2	416.0	429.4	439.6	431.0	440.5	437.7	435.9
Vacancies	31.7	33.2	36.3	34.1	31.2	30.4	17.0	6.8	15.4	5.9	8.7	10.5

8.12 There are 93 Midwives in the pipeline to start at SMH and the vacancy situation is therefore expected to improve over Q3/4 following the graduation of student midwives who will take up posts within the MCS.

18.13 The overall midwifery rolling 12 month turnover is **10.44%** within SMH which is below the Trust average. The turnover rate for Band 5 and 6 midwives is **12.05%** which is also below the Trust average and Trust target of 12.6%. The midwifery team work in partnership with the Royal College of Midwives in their 'Caring for You Campaign'.

18.14 Whilst turnover is below the trust average this is high for the smaller numbers in this professional group and indicates that retention is a significant issue for Saint Mary's MCS.

18.15 Registered Midwifery absence levels have seen a slight improvement across SMH MCS, with **4.7%** absence reported in June 2019 compared to 5.16% in January 2019.

Key Actions

18.16 The senior nursing and midwifery team will work in partnership with other members of the hospital senior leadership team to embed nursing and midwifery workforce plans into the hospital vision to be recognised nationally as a centre of nursing and midwifery excellence. A number of actions have been set to address the workforce situation including:

- SMH are working to reduce vacancies and become an employer of choice focusing on opportunities for career development and maximising recruitment opportunities.

- SMH continue to work in partnership with the GM HEIs to explore innovative ways to attracts students to train in GM and have piloted the use of the Synergy model to support midwifery learners in practice

- Career opportunities have been provided through the role of the Nursing Associate and enhanced and advanced nursing practitioners to support retention.

- Future nursing and workforce strategies have been developed, introducing consultant posts in nursing and midwifery and a clinical research midwifery fellow.

- SMH have identified that retention must be a key focus and have established a workforce plan together with a retention strategy which will be monitored through the AOF and SMH Workforce Committee.

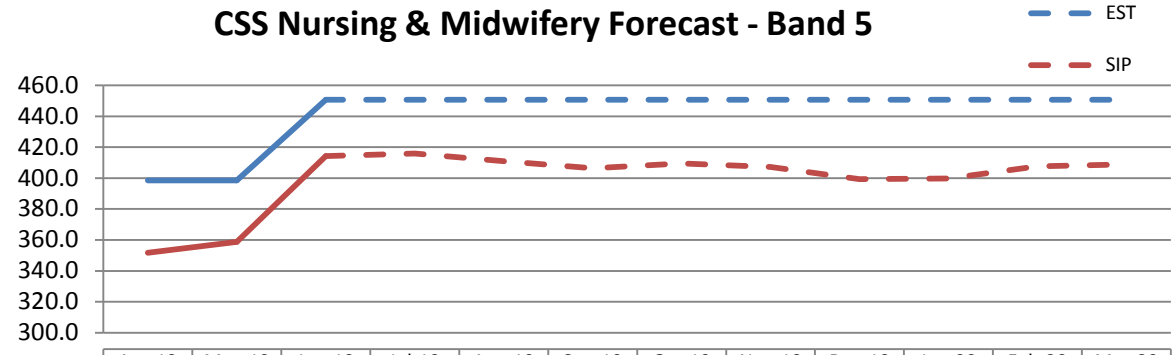
19.0 Clinical Support Services MCS (CSS)

CSS MCS Workforce Position

19.1 At the end of June 2019 there were a total of **59.7wte (8.4%)** qualified nursing vacancies across the CSS Managed Clinical Services. This is a decrease in overall nursing vacancies of **8.6wte** since June 2018. The hospital vacancy position is predicted to remain relatively static and it is predicted there will be **52.1wte (7.3%)** vacancies by March 2020 which will be a reduction of **17.2 wte** vacancies compared to the same period in the previous year.

19.2 The majority of the vacancies are within the Staff Nurse (band 5) workforce**. Graph 16** illustrates the CSS band 5 workforce position until March 2020. At the end of June 2019 there were **36.5 wte (8.1%)** band 5 nursing vacancies and as with the overall nursing vacancies, this is expected to remain relatively static with **42.0wte** vacancies projected for March 2020. This will be a slight improvement on the same period in the previous year and a reduction of **6.3wte** vacancies.

Graph 16



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
EST	398.5	398.5	450.8	450.8	450.8	450.8	450.8	450.8	450.8	450.8	450.8	450.8
SIP	351.7	358.7	414.3	415.9	411.0	406.4	409.4	407.2	399.4	399.7	407.7	408.8
Vacancies	46.8	39.8	36.5	34.9	39.8	44.4	41.4	43.6	51.4	51.1	43.1	42.0

19.3 There are **38wte** Band 5 Nurses currently going through the recruitment process, with the majority due to commence in post before the end of October 2019. In addition, **4** internationally recruited nurses are anticipated to start in CSS in July with similar sized cohorts expected to start every 6 weeks up to the end of March 2020.

19.4 Within CSS MCS the rolling 12 month turnover for nursing is **13.9%** and the band 5 rolling turnover is **17%**. Of the 60 nurses who left CSS between September 2018 and May 2019, 48% were reported as leaving to relocate, 17% for promotional opportunities and 13% for work life balance.

19.5 Registered Nurse sickness absence levels have seen an overall improving trend with registered nurse sickness absence reported below the trust target of 3.6% for the last 3 months. The senior nursing and HR teams have reviewed sickness absence for individual areas and agreed on a number of actions. These include alignment of reporting processes, agreement and training on absence management procedures, revision and development of HR processes.

Key Actions

19.6 The Deputy Director of Nursing, Head of Nursing and Lead Nurses will oversee and deliver key actions to continue to work towards a reduction in vacancies and turnover including:

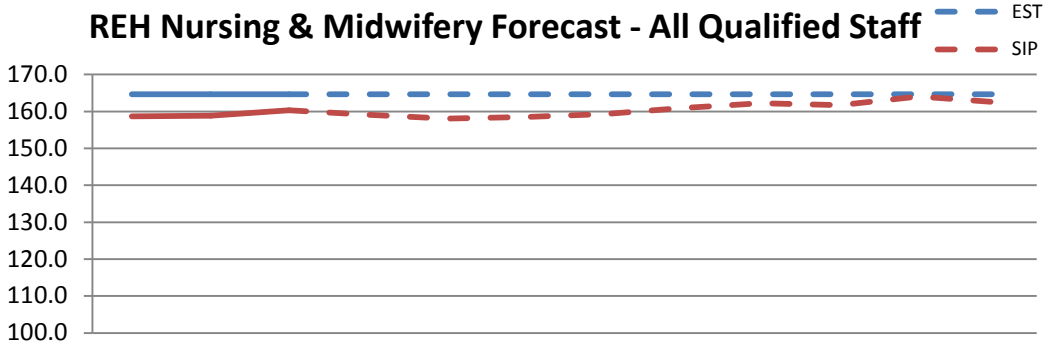
- Continue with monthly band 5 recruitment across all units
- Ensure attendance at Trust organised recruitment events in addition to holding critical care open days
- Align practice across the MCS to ensure that all matrons will meet with student nurses during their placements to discuss their career aspirations
- Education leads to keep in touch with newly appointed nurses during the recruitment process
- A focus on staff engagement with regards to particular interest in clinical practice, 'in house' leadership courses and support for link nurse group development.

20. Royal Eye Hospital (REH)

REH Workforce Position

20.1 At the end of June 2019, there were a total of **4.4 wte (2.6%)** qualified nursing vacancies across REH as illustrated on **Graph 17**. This is a reduction in the overall nursing vacancies of **11.1 wte** since June 2018. Vacancies remain low in REH and therefore the hospital will continue to recruit to turnover.

Graph 17



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
EST	164.6	164.6	164.6	164.6	164.6	164.6	164.6	164.6	164.6	164.6	164.6	164.6
SIP	158.7	158.9	160.3	159.1	158.1	158.5	159.3	160.9	162.3	161.7	164.1	162.5
Vacancies	5.9	5.8	4.4	5.6	6.6	6.2	5.4	3.7	2.4	3.0	0.6	2.1

20.2 Within REH the rolling 12 month turnover for Nursing is **7.3%.** The band 5 rolling turnover is **8.5%** which is below both the Trust average and the Trust target of 12.6%.

20.3 Registered Nursing absence levels have fluctuated each month within the REH, with the absence rate of **6.1%** in May 2019.

REH Safer Staffing

20.4 Within REH, **93.7%** of planned Registered Nurse shifts are filled. Planned and actual staffing data is submitted by ward 55 in REH. The ward consistently achieves more than 80% planned Registered Nurse staffing during both day and night.

20.5 Over a 3 month period from April to July 2019, 0 red flags were submitted across REH.

Key Actions

20.6 Whilst it is recognised that the turnover of staff and vacancies in REH remains low, workforce plans are focusing on the development and retention of staff which is key to supporting specialist services. Recruitment and retention plans are focused on offering opportunities for staff development into specialist nurse roles which provides an attractive offer when recruiting staff.

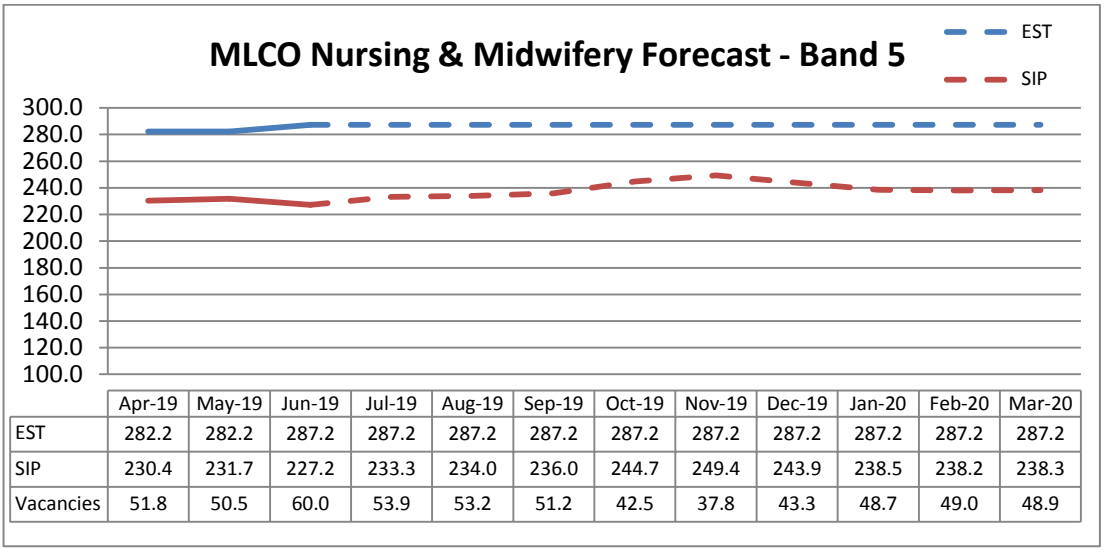
21. Manchester Local Care Organisation (MLCO)

MLCO Workforce Position

21.1 At the end of June 2019 there was a total of **116.1wte (13.7%)** Registered Nurse vacancies across the MLCO. This is an increase in overall nursing vacancies of **35.7wte** since June 2018. The vacancy position is predicted to improve in Q4 when it is predicted there will be **76.1 wte (9.0%)** vacancies by March 2020 which will be a reduction of **28.9 wte** vacancies compared to the same period in the previous year.

21.2 The majority of the vacancies are within the Staff Nurse (band 5) workforce**. Graph 18** illustrates the workforce position across the MLCO until March 2020. At the end of June 2019 there were **60.0wte (20.9%)** band 5 nursing vacancies which is an increase of **18.6wte** vacancies since June 2018. The vacancy position is predicted to improve in Q4 to **48.9wte (17%)** by March 2020. This will be an improvement on the same period in the previous year and a reduction of **6wte** vacancies.

Graph 18



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
EST	282.2	282.2	287.2	287.2	287.2	287.2	287.2	287.2	287.2	287.2	287.2	287.2
SIP	230.4	231.7	227.2	233.3	234.0	236.0	244.7	249.4	243.9	238.5	238.2	238.3
Vacancies	51.8	50.5	60.0	53.9	53.2	51.2	42.5	37.8	43.3	48.7	49.0	48.9

21.3 Recruiting staff to work within some services predominantly Health Visiting (HV), District Nursing and Intermediate Care Services (ITC), remains a challenge. The reasons are multifactorial and include increases to HV establishments, an increase in Intermediate Care beds and an increase in patient acuity and dependency as a result of more patients being cared for at home as an alternative to hospital.

21.4 There are **24** Band 5 Staff Nurses currently in the pipeline to start in the MLCO before the end of October 2019. In addition, **5** internationally recruited nurses are anticipated to commence in post in the MLCO in September with similar sized cohorts expected to start within the MLCO every 12 weeks. In January 2019, 8 Nursing Associates completed the TNA programme, with 7 of these now registered with the NMC and working across the community setting. To ensure the delivery of safe care, the HV service has recruited 5 additional nursery nurses to support the Health Visitor workforce.

21.5 Across the MLCO the rolling 12 month turnover for Nursing is **12.1%** with **13%** rolling turnover reported within the band 5 staff group.

21.6 Although Registered Nursing sickness absence remains above the hospital target, a continuing improvement has been noted with a 4.5% sickness absence reported in May 2019.

MLCO Safe Staffing

21.7 The MLCO has been working with community health partners to look at a methodology for measuring staffing levels and skill mix within community services with a proposal to pilot a clinical intelligent management system.

Key Actions

21.8 The MLCO has introduced a Workforce Committee chaired by the Director of Workforce who will explore the following:

- The development of a refreshed MLCO Nursing Recruitment and Retention Strategy
- Implementation of MLCO Chief Nurse and Professional Lead listening events with newly qualified nurses
- Review and redesign the nursing workforce following the appointment of future NAs, considering an expansion of the role within the Community.
- Explore the development of AHP posts to support safer staffing and a blended skill mix/workforce within ITC and Continuing Health Care Units.

22.0 Trust Workforce Summary

22.1 The workforce modelling untaken in this paper has been presented by hospitals and MCSs **table 6** provides a summary of the workforce position across the Trust which allows for assurance at hospital/MCS/MLCO level and ensures that variation is not disguised at trust reporting level.

Table 6

Hospital/ MCS	RN/RM vacancy wte	RN/RM vacancy %	RN/RM Turnover %	Band 5 vacancy wte	Band 5 vacancy %	Band 5 Turnover %	Fill rate %
Trust	**820.3**	**11.6**	**12.8**	**567.1**	**14.2**	**16.0**	**88.7**
WTWA	215.6	11.6	13.1	169.1	16.4	17.2	89.8
MRI	212.7	14.3	14.4	136.5	16.9	18.1	84.9
RMCH	72.8	8.1	11.4	59.4	11.2	14.3	87.9
SMH	122.0	11.1	12.3	85.1	11.5	14.9	83.5
CSS	59.7	8.4	13.9	36.5	8.1	17.0	99.8
REH	4.3	2.6	7.3	6.7	6.2	8.5	94.0
MLCO	116.1	13.7	12.1	66.0	20.9	13	n/a

23. Summary

23.1 This paper outlines the continuing challenges in relation to Nursing and Midwifery staffing. Since August 2018 the Trust has experienced an improving Nursing and Midwifery workforce position however, it is recognised that work is still required to reduce the number of nursing and midwifery vacancies.

23.2 The Trust has seen an improved workforce position during Q1 in comparison to Q1 in previous years however, it is acknowledged that this improvement has been predominantly achieved due to the increase in IR nurses (150 additional nurses) joining the Trust over the last 12 months. Whilst this improved position supports the Hospitals/MCS to achieve their workforce plans there is a recognition that more work is required to maximise domestic recruitment and ensure MFT is an employer of choice.

23.3 The Trust has seen an overall reduction of 0.5% in the registered nursing and midwifery sickness rate since December 2018 with the biggest improvement seen in MRI where the registered nurse sickness rate has reduced from 6.6%in December 2018 to 4.1% in June 2019. The reduction of sickness absence remains a key focus for Hospitals/MCS and MLCO supported by programmes of staff wellbeing. This is expected to improve following the introduction of the Absence Management System across the Trust.

23.4 Whilst it is recognised that there are Nursing and Midwifery staffing challenges nationally it is widely accepted that retention of staff must be a key focus on future workforce planning. Workforce data identifies that over 700 Nurses and Midwives have left the organisation since June 2018 and further work is required to fully understand the various reasons for staff leaving.

23.5 The Trust has been invited to join the NHSI Nursing and Midwifery Retention programme which will be launched in September 2019. This will provide an opportunity for the trust to access NHSI resources and sharing good practice to support the development of retention schemes and improvement plans.

23.6 The introduction of the Safer Nursing Care Tool to support establishment reviews and deployment of staff will support an evidence based approach to supporting safe staffing workforce decisions. This work will be underpinned with a quality assurance framework and policy to support nursing and midwifery managers in making safe workforce decisions. Progress on this work will be reported through NMAHP Professional Board.

23.7 Each Hospital/MCS has established a workforce plan alongside a retention strategy. These plans will inform a Trust programme of work and will support the following work streams:-

- Internal Transfer Process for band 5 staff Registered Nurses and Nursing Associates
- Develop an apprenticeship strategy to support nursing careers
- Develop a career framework and training strategy to support nursing assistants to navigate opportunities and widen access to nursing careers
- Develop the Nursing Associate role into speciality areas including theatres
- Develop a MFT guaranteed job offer on qualifying for student nurses training at the Trust
- Develop a framework to support career navigation for registered nurses and midwives

23.8 The Trust retention programmes are intended to support a sustainable workforce retaining the expertise and experience of Nursing and Midwifery staff and reducing the numbers of leavers. Investment in these areas will reduce the reliance on the use of bank and agency staff and support financial sustainability. Progress on these work streams will be reported to the Hospital/MCS Management Boards by the Directors of Nursing, Midwifery, Health Care Professions, and HR.

23.9 It is intended that the March 2020 end of year report will provide the first report on AHP staffing across the trust in line with NHSI requirements.

24. Conclusion

24.1 The Board of Directors is asked to receive this paper and note progress of the work undertaken to address the Nursing and Midwifery vacancy position across the Group.

Workforce and Quality Report - June 2019		Workforce Data - June 2019										Safer Staffing - June 2019						Friends & Family Test - June 2019		Nurse Sensitive Indicators - June 2019				
												Day		Night										
Hospital /MCS	Ward	Funded Establishment (WTE) Jun-19		Skill Mix % June 2019		Staff in post (WTE) from ESR - June 2019				Variance In Post (WTE) from ESR - June 2019		Average fill rate - RN/RM (%)	Average fill rate - care staff (%)	Average fill rate - RN/RM (%)	Average fill rate - care staff (%)	Total staffing fill rate (%) RN only	Overall Care Hours Per Patient Day (CHPPD)	% Recommended (Extremely Likely & Likely) %	Percentage Not Recommended (Unlikely & Extremely Unlikely) %	Hospital Acquired Pressure Ulcers (Cat 2-4)	Falls (All)	Falls with Harm	CAUTI	VTE
		Registered	Support Staff	% Registered	% Support Staff	Registered	Support Staff	Nursing Associate	Total SIP	Registered	Support Staff													
MRI	3	20.6	15.99	56%	44%	22.32	15.2	0	37.52	-1.72	0.79	88%	167%	91%	145%	89%	7.47	93%	0%	0	2	0	0	0
	4	32.5	18.79	63%	37%	22.52	17.67	1	41.19	9.98	1.12	69%	121%	82%	106%	75%	7.34	94%	3%	0	5	1	0	0
	8	22.1	17.74	56%	45%	9	17.59	2	28.59	13.1	0.15	61%	120%	60%	132%	61%	7.25	93%	4%	0	1	1	0	0
	30	11.8	20.48	37%	63%	10.72	15.03	0	25.75	1.08	5.45	91%	110%	99%	120%	94%	8.8	93%	7%	0	10	1	0	0
	31	20.28	19.48	51%	49%	16.23	24.24	0	40.47	4.05	-4.76	75%	96%	97%	107%	83%	6.31	91%	0%	0	9	0	1	0
	32	13	15.36	46%	54%	13.53	14.39	0	27.91	-0.53	0.97	77%	97%	99%	114%	85%	7.6	100%	0%	0	7	0	0	0
	36	15	15.95	49%	52%	14.56	10.8	0	25.36	0.44	5.15	63%	95%	96%	163%	74%	5.4	86%	14%	0	1	0	0	0
	37	17.72	15	54%	46%	8.53	13.45	2	23.99	9.19	1.55							78%	6%	1	2	0	0	0
	44	44.59	14.8	75%	25%	47.68	14.44	0	62.12	-3.09	0.36	89%	118%	90%	130%	89%	14.26	ZERO Response	ZERO Response	0	3	0	0	0
	45	20.28	25.09	45%	55%	15.53	28.07	0	43.6	4.75	-2.98	86%	90%	98%	99%	91%	6.59	64%	0%	0	10	2	0	0
	46	20.28	31.21	39%	61%	14.47	30.69	0	45.16	5.81	0.52	66%	102%	69%	105%	67%	7.17	100%	0%	0	5	0	1	0
	11&12	36.85	24.23	60%	40%	25.63	24.48	1	51.11	11.22	-0.25	62%	82%	82%	118%	70%	5.73	82%	0%	0	2	0	0	0
	9 & 10	39	28.19	58%	42%	26.4	26.37	1	53.77	12.6	1.82	66%	126%	95%	104%	76%	6.24	96%	0%	2	0	0	0	0
	Acute Cardiac Centre	27.99	9.7	74%	26%	28.84	7	1	36.84	-0.85	2.7	69%	295%	81%	-	74%	9.47	97%	0%	1	0	0	0	0
	AMU	62.43	36	63%	37%	53.48	30.42	3	86.9	8.95	5.58	85%	91%	76%	122%	81%	8.45	99%	0%	3	13	2	0	0

	AM1	21.96	17.24	56%	44%	16.92	12.33	0	29.25	5.04	4.91	104 %	127%	99%	106%	102 %	5.9	88%	9%	0	10	1	1	0
	AM2	21.96	16.56	57%	43%	19.53	11.8	0	31.33	2.43	4.76	100 %	132%	93%	157%	97%	6.26	88%	0%	0	6	1	0	1
	AM3	19.54	19	51%	49%	14.81	15.75	1	31.56	4.73	3.25	73%	124%	80%	107%	76%	5.66	74%	4%	0	6	2	1	0
	AM4	20	18	53%	47%	14.51	13.69	0	28.2	5.49	4.31	88%	121%	98%	105%	92%	5.66	93%	3%	1	7	1	0	0
	ETC	34.65	27.03	56%	44%	30.87	26.76	1	58.63	3.78	0.27	77%	72%	82%	58%	79%	5.9	92%	8%	2	3	1	0	1
	ESTU	35.66	33.47	52%	48%	24.53	25	2	51.53	11.13	8.47	71%	110%	70%	133%	70%	7.86	83%	17%	3	0	0	0	0
	HNSU	24.07	15.22	61%	39%	17.68	20.87	1	39.55	6.39	-5.65	90%	135%	93%	164%	91%	10.07	ZERO Response	ZERO Response	0	1	0	0	0
	Manchester Ward	14	21.16	40%	60%	9.95	21.89	0	31.84	4.05	-0.73	97%	91%	100 %	122%	98%	6.03	75%	8%	0	4	3	0	0
	MVC	19.39	15.59	55%	45%	19.41	14.36	1	34.77	-0.02	1.23	94%	84%	97%	130%	95%	7	95%	4%	4	2	1	0	4
REH	54 & 55	17.12	10.4	62%	38%	16.64	4	0	20.64	0.48	6.4	86%	115%	79%	100%	83%	11.05	98%	2%	0	1	0	0	0
RMCH	75	33.36	12.01	74%	27%	32.76	8.43	0	41.18	0.6	3.58	76%	130%	91%	113%	83%	6.52	85%	6%	0	0	0	0	0
	77	42.26	8.57	83%	17%	38.59	8.89	0	47.48	3.67	-0.32	62%	166%	70%	107%	65%	9.06	100%	0%	0	1	1	0	0
	78	45.93	8.39	85%	15%	40.95	13.99	0	54.93	4.98	-5.6	82%	101%	86%	90%	84%	7.74	90%	5%	1	1	1	1	0
	83	27.48	16.89	62%	38%	28.01	11.2	1	40.21	-0.53	5.69	100 %	111%	85%	125%	93%	14.53	82%	6%	0	0	0	0	0
	84	69.95	12.51	85%	15%	60.13	11.95	1	73.08	9.82	0.56	91%	104%	86%	90%	89%	8.13	67%	22%	0	0	0	0	0
	85	35.9	8.4	81%	19%	35.6	6.4	1	43	0.3	2	91%	106%	86%	90%	89%	6.22	94%	0%	0	0	0	0	0
	76 (ETC)	30.06	11.71	72%	28%	30.33	10.64	0	40.97	-0.27	1.07	81%	78%	81%	75%	81%	14.23	87%	8%	0	1	0	0	0
	81 (Burns Unit)	23.36	7.77	75%	25%	24.37	4.77	0	29.13	-1.01	3	63%	37%	66%	46%	64%	8.71	89%	0%	0	0	0	0	0
	84 (BMTU)	33.48	5.03	87%	13%	29.26	6.03	1	36.29	4.22	-1	92%	86%	88%	93%	90%	26.67	100%	0%	0	0	0	0	0
	Galaxy House	16.17	15.9	50%	50%	16.2	12.27	0	28.47	-0.03	3.63	76%	104%	100 %	103%	80%	10.2	ZERO Response	ZERO Response	0	0	0	0	0
	PICU	155.25	8.77	95%	5%	137.76	7.77	0	145.53	17.49	1	86%	88%	82%	95%	84%	15.99	88%	0%	1	0	0	0	0
	Starlight Unit	55.4	16.21	77%	23%	52.57	12.84	0	65.41	2.83	3.37	100 %	56%	97%	103%	99%	10.06	ZERO Response	ZERO Response	0	0	0	0	0

CSS	Acute ICU	78.67	7	92%	8%	93.63	4.99	0	98.61	-14.96	2.01	93%	-	97%	38%	95%	25.39	ZERO Response	ZERO Response	4	1	1	0	0
	CTCCU	177.07	17.08	91%	9%	152.14	11.88	0	164.02	24.93	5.2	100%	44%	95%	69%	98%	29.43	83%	0%	1	0	0	0	0
	CICU	75.97	10.28	88%	12%	71.82	11.53	0	83.35	4.15	-1.25	92%	99%	94%	105%	93%	29.17	ZERO Response	ZERO Response	1	1	0	0	0
	Urgent Care Centre	25.12	3.69	87%	13%	22.11	1.8	0	23.91	3.01	1.89	98%	90%	100%	100%	99%	36.8	ZERO Response	ZERO Response	0	0	0	0	0
	HDU & ITU	247.31	27.36	90%	10%	222.95	23.99	0	246.94	24.36	3.37	100%	15%	92%	23%	96%	24.16	100%	0%	6	1	0	0	0
SMH	47	31.72	14.2	69%	31%	27.06	8.07	0	35.13	4.66	6.13	76%	81%	68%	63%	72%	33.28	100%	0%	0	0	0	0	0
												88%	56%	100%	50%	92%	8.07	99%	1%	0	0	0	0	0
	62	35.51	16.6	68%	32%	32.67	10.92	0	43.59	2.84	5.68	100%	94%	95%	112%	98%	10.06	100%	0%	0	0	0	0	0
	65	13.35	7.6	64%	36%	13.8	0	0	13.8	-0.45	7.6	81%	69%	85%	77%	83%	5.96	89%	8%	0	0	0	0	0
	66	17.46	16.2	52%	48%	15.6	16.67	0	32.27	1.86	-0.47	88%	116%	95%	90%	90%	7.36	100%	0%	0	0	0	0	0
	64 -	56.01	13.6	81%	20%	53.67	12.67	0	66.33	2.34	0.93	70%	68%	72%	85%	71%	28.88	98%	0%	0	0	0	0	0
	Neonatal Unit	42.76	4.64	90%	10%	32.35	6.84	0	39.19	10.41	-2.2	74%	55%	81%	45%	77%	36.17	94%	0%	0	0	0	0	0
	NICU	267.55	29.7	90%	10%	227.62	15.86	3	246.48	39.93	13.84	78%	62%	82%	82%	80%	11.96	67%	0%	1	0	0	0	0
	Delivery Suite	60.38	17.22	78%	22%	81.98	17.59	0	99.57	-21.6	-0.37	98%	98%	100%	80%	99%	51.66	100%	0%	0	0	0	0	0
	Ward C2	9.41	23.65	29%	72%	8.98	17.45	0	26.43	0.43	6.2	100%	88%	95%	97%	98%	8.27	97%	2%	0	0	0	0	0
	Ward C3	6.88	3.08	69%	31%	6.88	1.28	0	8.16	0	1.8	100%	69%	100%	64%	100%	6.75	ZERO Response	ZERO Response	0	0	0	0	0
	Ward F16	29.72	13.04	70%	31%	23.92	12.4	0	36.32	5.8	0.64	98%	83%	100%	98%	98%	10.12	ZERO Response	ZERO Response	0	1	0	0	2
WTWA	2	20.26	16.57	55%	45%	14.25	16.11	0	30.36	6.01	0.46	64%	220%	98%	205%	75%	10.16	100%	0%	1	0	0	0	0
	4	32.5	18.79	63%	37%	22.52	17.67	1	41.19	9.98	1.12	74%	134%	98%	197%	82%	7.28	0%	0%	2	4	0	0	1
	6	21.34	16.68	56%	44%	15.13	12.03	0	27.17	6.21	4.65	71%	119%	99%	191%	81%	6.35	17%	4%	0	7	2	0	0

Acute CCU	26.19	4.89	84%	16%	24.87	4.79	0	29.65	1.32	0.1	85%	77%	98%	97%	90%	13.12	ZERO Response	ZERO Response	0	0	0	0	0
AMU (Wythenshawe)	54.79	45.68	55%	46%	44.79	30.73	1	76.52	10	14.95	85%	91%	76%	122%	81%	8.45	98%	1%	1	17	7	0	4
AMU (Trafford)	21.28	14	60%	40%	19.15	12.57	1	32.72	2.13	1.43	69%	76%	71%	117%	70%	8.55	98%	3%	1	3	1	0	9
Burns Unit	44.98	11	80%	20%	36.19	8.72	0	44.91	8.79	2.28	74%	94%	79%	102%	76%	17.86	100%	0%	0	2	0	0	0
Doyle Ward	19.17	13.56	59%	41%	16.13	13.88	0	30.01	3.04	-0.32	61%	125%	75%	151%	67%	7.14	100%	0%	0	1	0	1	0
Jim Quick Ward	18.17	6.28	74%	26%	17.28	4.33	0	21.61	0.89	1.95	95%	74%	6%	100%	62%	5.59	98%	2%	0	0	0	0	0
MOC Ward 12	32.53	20.85	61%	39%	27.07	19.89	1	47.97	5.46	0.96	71%	81%	65%	110%	69%	24.04	100%	0%	0	0	0	0	0
Pearce Ward	25.5	8.57	75%	25%	22.01	4.76	0	26.77	3.49	3.81	94%	62%	100%	87%	96%	5.88	100%	0%	0	0	0	0	0
POU	16.6	11.27	60%	40%	15.2	10.48	0	25.68	1.4	0.79	82%	119%	95%	102%	86%	6.51	100%	0%	2	7	0	0	1
Ward 1 Stroke Unit	16.1	12.12	57%	43%	15.49	10.4	1	26.89	0.61	1.72	82%	127%	100%	173%	89%	8.01	ZERO Response	ZERO Response	0	5	2	0	0
Ward 3 INRU	31.31	48.45	39%	61%	23.28	37.04	1	61.32	8.03	11.41	71%	110%	78%	123%	74%	10.12	25%	0%	1	7	0	0	0
Ward A1	18	14.8	55%	45%	12.73	17.25	1	30.99	5.27	-2.45	91%	86%	87%	157%	89%	7.04	ZERO Response	ZERO Response	2	9	2	0	3
Ward A2	9.78	6.45	60%	40%	9.19	5.28	0	14.47	0.59	1.17	79%	78%	100%	105%	81%	11.92	98%	0%	0	0	0	0	1
Ward A3	19.77	20.63	49%	51%	15.87	18.39	0	34.25	3.9	2.24	81%	66%	84%	109%	82%	5.62	91%	9%	2	3	1	1	0
Ward A4	21.4	12.22	64%	36%	15.12	9.16	0	24.28	6.28	3.06	72%	87%	96%	104%	81%	4.55	ZERO Response	ZERO Response	0	0	0	0	0
Ward A5	21.37	19.55	52%	48%	16.64	19.67	1	37.31	4.73	-0.12	80%	87%	96%	131%	86%	5.97	ZERO Response	ZERO Response	0	4	0	0	0
Ward A6	23.15	14.42	62%	38%	17.81	15.76	0.92	34.49	5.34	-1.34	90%	95%	93%	103%	91%	7.65	ZERO Response	ZERO Response	0	5	0	0	2
Ward A7	18.02	14.59	55%	45%	13.32	15.6	0	28.92	4.7	-1.01	68%	85%	100%	180%	81%	5.58	96%	0%	1	11	0	0	0

Ward A9	20	13.15	60%	40%	14.61	13.41	1	29.03	5.39	-0.26	85%	87%	80%	150%	83%	5.01	98%	2%	0	8	0	0	0
Ward F1	18.09	13.34	58%	42%	16.15	13.48	0	29.63	1.94	-0.14	76%	101%	93%	143%	83%	7.87	ZERO Response	ZERO Response	0	0	0	0	0
Ward F12	22.63	14.39	61%	39%	15.92	15.36	0	31.28	6.71	-0.97	96%	89%	99%	183%	97%	5.6	100%	0%	0	10	0	0	0
Ward F14	20.62	15.12	58%	42%	13.15	10.6	0	23.75	7.47	4.52	93%	81%	99%	125%	95%	5.69	100%	0%	0	3	0	3	0
Ward F15	23.72	17.29	58%	42%	18.96	13.67	0	32.63	4.76	3.62	89%	117%	72%	195%	82%	6.85	93%	0%	0	4	0	0	0
Ward F2 Lung	21.76	8.45	72%	28%	18.04	6.49	0	24.53	3.72	1.96	77%	48%	74%	100%	76%	6.76	100%	0%	0	2	1	0	0
Ward F2/F5	50.44	19.99	72%	28%	49.99	16.28	0	66.27	0.45	3.71	97%	81%	98%	106%	97%	6.97	100%	0%	0	6	0	0	0
Ward F3	19.77	15.39	56%	44%	15.64	13.44	1	30.08	4.13	1.95	80%	76%	86%	140%	83%	5.99	ZERO Response	ZERO Response	0	8	0	0	0
Ward F4	21.74	28.85	43%	57%	20.44	20.68	0.64	41.76	1.3	28.21	80%	96%	96%	102%	86%	6.3	90%	3%	4	9	0	1	0
Ward F6	31.71	15	68%	32%	31.14	12.2	0	43.34	0.57	2.8	100%	90%	100%	114%	100%	5.97	100%	0%	0	1	1	0	0
Ward F7	21.74	28.85	43%	57%	18.95	23.4	0	42.35	2.79	28.85	82%	106%	99%	131%	89%	6.9	100%	0%	0	11	0	2	0
Ward F9	17.51	7.13	71%	29%	16.73	4.84	1	22.57	0.78	2.29	84%	68%	89%	124%	86%	5.97	100%	0%	0	1	0	1	0
Wilson Ward	18	15.24	54%	46%	14.24	14.76	1	30	3.76	0.48	60%	152%	98%	153%	75%	6.8	100%	0%	4	3	0	0	0

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Professor Cheryl Lenney, Group Chief Nurse
Paper prepared by:	Karen Meadowcroft, Corporate Director of Nursing Debra Armstrong, Assistant Chief Nurse
Date of paper:	July 2019
Subject:	**Quarter 1 Complaints Report 2019/20**
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration of Risk against Key Priorities:	Patient & Staff Experience
Recommendations:	To note the content of the report and the progress of the Complaints Transformation Programme.
Contact:	Name: Debra Armstrong, Assistant Chief Nurse Tel: 0161 276 5061

Manchester University NHS Foundation Trust (MFT)

Complaints Report 1st April 2019 – 30th June 2019

1. Executive Summary

1.1. Members of the Group Board of Directors are asked to note the Quarter 1, 19/20 Complaints Report for Manchester University NHS Foundation Trust (MFT), covering the period 1st April 2019 – 30th June 2019 (Q1).

1.2 This report provides an overview of the Complaints and PALS performance for Q1. Due to new reporting capabilities to refresh and cleanse previous data, the data provided in this report for the periods prior to this quarter may differ slightly to the data presented in previous reports.

1.3 There was a total of 1,644 PALS concerns received. This compares to 1,748, a 5.9% decrease compared to the previous quarter.

1.4 There were a total of 361 new complaints received. This compares to 394 new complaints received in the previous quarter which is an 8.4% decrease.

1.5 Whilst the overall total number of complaints received has reduced when compared to the previous quarter there has been a small increase in the number of complaints received at Wythenshawe, Trafford, Withington and Altrincham (WTWA) by 11 (10%). The largest decrease in the number of complaints received was within Saint Mary's (SMH) Managed Clinical Services (MCS), with a reduction of 16 (31.4%) in Q1, compared to the number of complaints received in the previous quarter.

1.6 The total number of complaints closed in was 427, an increase of 76 cases compared to the previous quarter.

1.7 There was an increase in the number of complaints closed in 25 days, with 228 (53.4%) closed compared to 159 (45.3%) in the previous quarter. There was a decrease in the number of complaint responses, resolved over 41 days, compared to the previous quarter reflecting a reduction of 17 cases.

1.8 The NHS Complaint Regulations (2009) stipulate that complaints must be acknowledged in writing no later than 3 working days following receipt of the complaint. The Trust achieved 99.7% compliance with this Key Performance Indicator. The 1 acknowledgement breach was due to human error at the triage stage of the complaint process.

1.9 In accordance with the agreed schedule, the Complaints Scrutiny Group, which is chaired by a Non-Executive Director, met once during Q1. Management Teams from the Manchester Royal Infirmary (MRI) Divisions of Medicine and Surgery each presented a case at the June 2019 meeting. The learning identified from the cases presented is detailed in Section 5 of this report.

1.10 Improvements in the Complaint and PALS management processes are described in the report with future quality improvements identified in section 9.

1.11 The Board of Directors is asked to note the information within the report, which demonstrates the number of PALS Concerns and Complaints received have decreased and there has been an improvement in the timeliness of closing complaints, however there has been a slight increase in the time to close PALS Concerns during Q1.

2. Overview of Quarter 1, 2019/20 Performance: PALS

2.1 There was a decrease in the number of PALS concerns received with 1,644 PALS concerns being received, compared to 1,748 in the previous quarter. This is a 5.9% decrease in PALS concerns compared to the previous quarter and is numerically a decrease of 104 PALS concerns.

2.2 As appropriate and in agreement with the complainant, PALS concerns can be escalated to complaints or complaints de-escalated to PALS concerns. There were 11 PALS cases escalated for formal investigation during Q1, this is a decrease when compared to the 19 PALS cases escalated during the previous quarter. Cases are predominantly escalated due to the complexity of the concern received and following discussion and agreement with the complainant advising that formal investigation should be undertaken. Conversely, 1 complaint case was de-escalated during this quarter compared to 6 cases de-escalated during the previous quarter.

2.3 As in previous reports the Hospital/ MCS/ MLCO with the highest number of PALS concerns received was WTWA with 543 cases (32.0%), followed by MRI with 395 cases (24.0%) of the total number of PALS concerns received. Whilst the higher number of PALS concerns received by WTWA and MRI partially reflects the level of activity in these Hospitals, this is a decrease of 10.69% and 17.53% respectively compared to the number of PALS concerns received by WTWA and MRI previously in Q4. To support the Hospital/ MCS senior management teams to understand the PALS concerns the Corporate team continue to provide quarterly thematic PALS reports to WTWA and MRI. Analysis has identified 'Outpatient Appointment Delay / Cancellation' and 'Communication' as the most common themes from PALS concerns received at both WTWA and MRI. The information continues to provide the Hospital teams the detail to identify focussed areas for improvement.

2.4 The majority of PALS concerns related to Outpatient areas, which accounted for 1,281 (77.9%) of the 1,644 contacts received. This compares to 1,423 (81.4%) of concerns relating to Outpatient areas in the previous quarter.

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

Table 1: Closure of PALS concerns within timeframes.

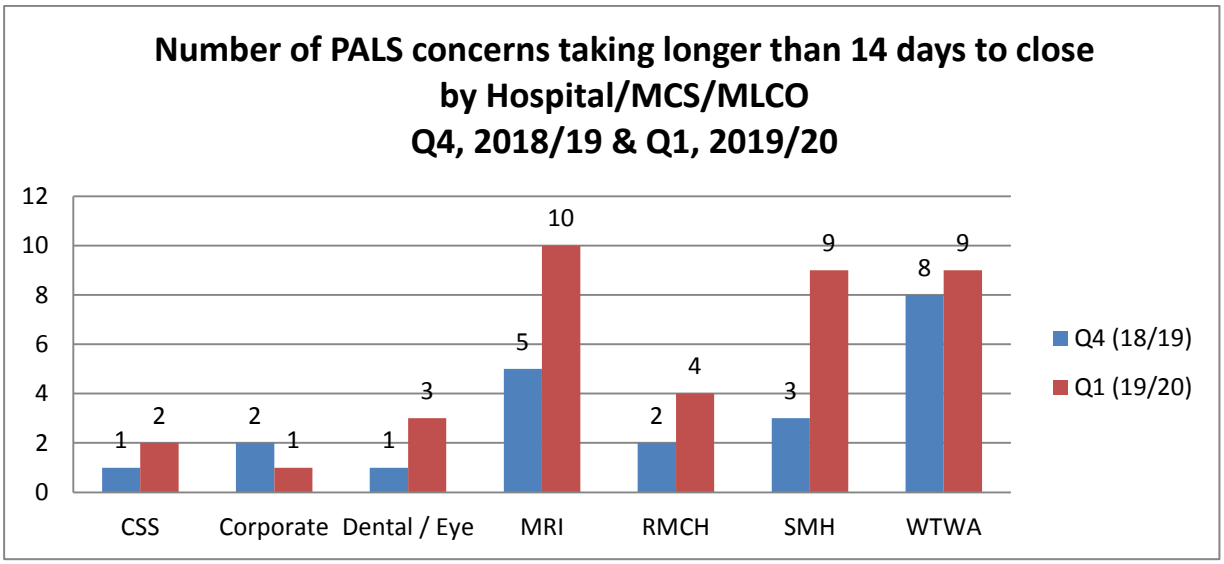
	Quarter 2, 2018/19		Quarter 3, 2018/19		Quarter 4, 2018/19		Quarter 1, 2019/20	
Days to Close	Number of Cases Resolved Within Timeframe	Percentage of Cases Closed Within Timeframe	Number of Cases Resolved Within Timeframe	Percentage of Cases Closed Within Timeframe	Number of Cases Resolved Within Timeframe	Percentage of Cases Closed Within Timeframe	Number of Cases Resolved Within Timeframe	Percentage of Cases Closed Within Timeframe
0-7	968	72.0%	1177	77.5%	1189	71.8%	1126	66.7%
8-14	313	23.0%	314	20.7%	444	26.8%	524	31.0%
15+	63	5.0%	28	1.8%	22	1.3%	38	2.3%

2.6 At the beginning of Q2, 2018/19 a new process was implemented for the escalation of all PALS cases over 12 days. All cases are now escalated to the PALS Manager on day 12 and this earlier escalation process has been successful in reducing the time to resolve PALS concerns. However, during this quarter there has been a slight increase from the previous quarter from 22 (1.3%) to 38 (2.3%) of cases that were resolved at 15+ days.

2.7 The delays in resolving PALS concerns have predominantly been due to difficulties the PALS Team have experienced in receiving responses from the Hospitals/ MCS's. This is despite the Hospital/ MCS Senior Leadership Teams receiving weekly reports detailing the unresolved PALS concerns. To enable their performance management processes a monthly 'days to close report' has been developed for each Hospital/ MCS and the Assistant Chief Nurse discusses all

PALS concern which are unresolved at 14+ days with the Hospital/ MCS Director/ Deputy/ Director of Nursing/ Midwifery requesting their support to expedite resolution. The Corporate team will continue to closely monitor the delays during the next quarter and escalate delays to the Hospital/ MCS Senior Management Teams.

Graph 1: Number of PALS concerns taking longer than 14 days to close by Hospital/ MCS Q4, 2018/19 and Q1, 2019/20.

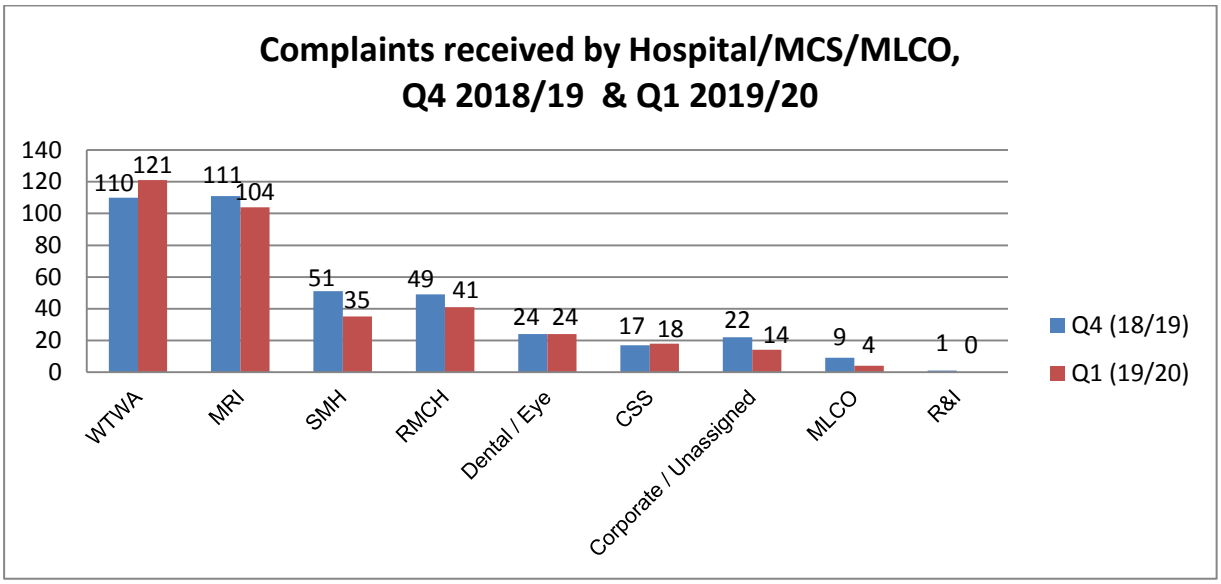


New Complaints

2.8 There were a total of 361 new formal complaints received. This compares to 394 in Q4, 2018/19, 332 received in Q3, 2018/19, 393 received in Q2, 2018/19 and 455 received in Q1, 2018/19. This represents an 8.4% decrease in formal complaints (decrease of 33 in number) when compared to the previous quarter. There continues to be a natural variation of complaints received on a monthly basis which has ranged from 120 (April 2019), 128 (May 2019) and to 113 (June 2019) complaints. The Assistant Chief Nurse continues to monitor the variation closely and work is ongoing to report this variation by Hospital/ MCS and MLCO to allow proactive management by the senior teams based on expected volumes of complaints, whilst improvement programmes continue to reduce the overall number of complaints.

2.9 **Graph 2** compares the total number of new complaints received by Hospital/MCS/MLCO in Q4, 2018/19 and Q1, 2019/20.

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



2.10 WTWA received the most complaints (121), which represents an increase of 11 (10.0%) of complaints received compared to the previous quarter. The largest decrease in the number of complaints received in this quarter compared to the previous quarter was at SMH MCS which had a reduction of 16 cases (31.4%).

2.11 There were 128 new complaints relating to inpatient services and 159 relating to outpatient services. For inpatient services, this represents an increase of 4 cases (3.2%) and for outpatient services, this represents a decrease of 22 cases (12.2%). The area with the highest number of outpatient complaints was WTWA with a total of 58 of the 159 complaints received (36.5%). Themes identified for inpatient services were treatment/procedure, communication and attitude of staff. Themes for outpatient services were treatment/procedure, communication and clinical assessment.

2.12 The national statutory requirement for the acknowledgement stage of formal complaints handling, according to the NHS Complaints Regulations (2009), is to acknowledge 100% of all complaints no later than 3 working days after the complaints are received. The Trust achieved 99.7% compliance with this key performance indicator (KPI) during this quarter compared to 99.8% in Q4, 2018/19, 99.5% in Q3, 2018/19, and 100% in Q2, 2018/19. The one acknowledgement breach in Q1, 2019/20 was due to human error at the triage stage of the complaint process. Work continues to strengthen the Trust's Complaint Triage process to ensure complaint correspondence is correctly triaged.

Current Complaints

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

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

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

2.15 The accountability for complaints management and monitoring has been fully devolved to the Hospital/ MCS and the MLCO Chief Executives since Q1, 2018/19 and performance is monitored at a Group level via the Accountability Oversight Framework (AOF).

2.16 Within Q1 there were 198 open complaints compared to 230 open complaints at the end of the previous quarter this is a 13.9% decrease equating to a numerical decrease of 32 complaints. The 198 ongoing complaints comprised 130 complaints which had been assigned a 25 working day timescale, 17 complaints which had been assigned a 40 working day timescale and 51 complaints which had been assigned a 60 working day timescale. At the end of this quarter 86.4% of ongoing cases were within the planned timescales, agreed with the complainant. **Table 2** shows a breakdown by the agreed working day timescales.

Table 2: Ongoing cases working day timescale (at 30/06/19)

	No of ongoing cases	In timescale	Number not responded to in assigned timescale
25 working day timescale	130	112 (86.2%)	18 (13.8%)
40 working day timescale	17	15 (88.2%)	2 (11.8%)
60 working day timescale	51	44 (86.3%)	7 (13.7%)
Total	198	171 (86.4%)	27 (13.6%)

2.17 There were 30 unresolved cases at 41 or more days compared to 37 complaints in the previous quarter which represents an 18.9% decrease in over 41 day cases.

2.18 MRI had the highest number of open cases in Q1 with 64 cases (47 of which were in the agreed timescale with the complainant). This compared to 65 open cases in Q4, 79 open cases in Q3, and 98 open cases in Q2, demonstrating a sustained improvement in the timely management of complaints. Of the open cases 42 were within 0-25 days, 11 were within 26-40 days (2 of which were in the agreed timescale with the complainant) and 11 were over 41 days, all of which were in the agreed timescale.

Resolved Complaints

2.19 The oldest complaint case closed during this quarter was registered within Corporate Services (Health Records) on 24th September 2018 and was 163 days old when closed on 17th May 2019. Delays in locating the patient's medical records, a Subject Access Request and requested time to review health records, which in turn raised further concerns requiring investigation, and the arrangement of a local resolution meeting unfortunately resulted in the exceptional delay with the Trust not being in a position to provide a timely response. The complainant was kept updated throughout the process.

2.20 **Table 3** provides a comparison of complaints resolved within each timeframe from Q2, 2018/19 to Q1, 2019/20.

Table 3: Comparison of complaints resolved by timeframe

	Quarter 2 2018/19	Quarter 3 2018/19	Quarter 4 2018/19	Quarter 1 2019/20
Formal complaints resolved	446	449	351	427
Resolved in 0-25 days	160 (35.9%)	161 (35.9%)	159 (45.3%)	228 (53.4%)
Resolved in 26-40 days	94 (21.1%)	132 (29.4%)	85 (24.2%)	109 (25.5%)
Resolved in 41+ days	192 (43.0%)	156 (34.7%)	107 (30.5%)	90 (21.1%)

2.21 There was an increase of 69 cases resolved within 0-25 working days, an increase of 24 cases resolved between 26-40 days and a decrease in the number of cases resolved at 41+ days by 17 cases in this quarter compared to the previous quarter.

Re-opened Complaints

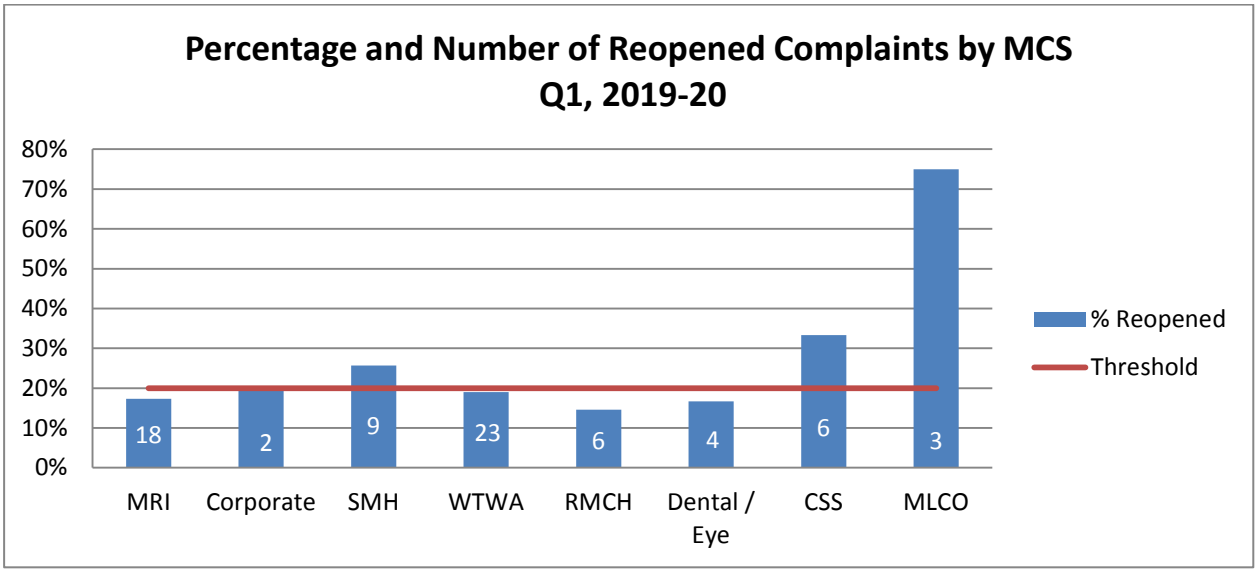
2.22 Re-opened complaints are used as a proxy indicator to measure the quality of the initial response. A tolerance threshold of 20% has been agreed by the Group Chief Nurse.

There were 71 re-opened complaints received in this quarter which is an identical figure to the previous quarter. Overall re-opened cases accounted for 19.7% of all complaints received in this quarter compared to 18.0% in the previous quarter.

2.23 The highest number of re-opened cases was received by WTWA (23 cases) compared to 18 cases in the previous quarter. Of the 23 re-opened cases received by WTWA the cases were predominantly re-opened due to unresolved issues or new concerns following the response.

2.24 **Graph 3** illustrates Hospital/ MCS/ MLCO performance against this threshold in Q1 with; SMH 25.7% (9 re-opened cases), CSS 33.3% (6 re-opened cases) and MLCO 75.0% (3 re-opened cases), exceeded the 20% threshold during Q1; with all the other Hospitals/ MCS's recording re-opened cases below the threshold. It should be noted, however, that small fluctuations in the total number of complaints received in a Hospital/MCS or the MLCO can result in large percentage changes for those areas with overall low number of complaints. Complaint management training continues to be offered to all Hospital/ MCSs and the MLCO teams focused on the quality of complaint responses as part of the educational sessions as detailed in Section 9.1.2 of this report.

Graph 3: Percentage of re-opened Complaints (Quarter 1, 2019/20).



3. Care Opinion and NHS Website feedback

3.1 The NHS Website and Care Opinion 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 NHS Website and Care Opinion comments by category; positive, negative and mixed, are detailed in **Table 4.**

3.3 More than half (56.5%) of the NHS Website and Care Opinion feedback comments received in this quarter were positive. This represents an increase of 7.5% compared to the previous quarter when the overall positive comments represented 49% of the total. Negative comments equated to 35.5% of the overall total received, which compared to 45.0% during the previous quarter which reflects a decrease of 9.5%.

3.4 There were a total or 35 positive comments received which is an increase of 11 since the previous quarter, when 24 were received. The increase in positive comments is largely attributed to WTWA who received a total of 20 positive comments in this quarter an increase of 9 compared to the 11 received in the previous quarter.

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

3.6 All responses to negative and mixed comments include a Ulysses reference number and offer the person posting the comment the opportunity to make contact with PALS should they require further support.

Table 4: Number of Care Opinion/ NHS website postings by Hospital/ MCS/ MLCO in Q1, 2019/20.

Number of Postings received by Hospital/ MCS/ Division Q1, 2019/20			
Hospital/ Managed Clinical Service (MCS)/ Division	**Positive**	**Negative**	**Mixed**
Manchester Royal Infirmary	**3**	**9**	**3**
Wythenshawe, Trafford, Withington and Altrincham	**20**	**6**	**1**
Clinical Scientific Services	**0**	**0**	**0**
Corporate Services (Estates and Facilities)	**0**	**0**	**1**
Manchester Royal Eye Hospital / University Dental Hospital of Manchester	**5**	**0**	**0**
Royal Manchester Children's Hospital	**2**	**1**	**0**
St Mary's Hospital	**5**	**6**	**0**
Overall MFT Total	**35 (56.5%)**	**22 (35.5%)**	**5 (8.0%)**

3.6 **Table 5** provides two examples of the feedback received and the subsequent responses posted on Care Opinion and NHS Website during this quarter.

Table 5: Example Care Opinion/ NHS Website Postings and Reponses Q1, 2019/20.

Quarter 1 , 2019/2020
Cardiothoracic Surgery - Wythenshawe Hospital
Anonymous gave Cardiothoracic surgery at Wythenshawe Hospital a rating of 5 stars Had lung surgery and can genuinely say that I have been overwhelmed by the level of care provided by the medical team on Ward F2. All the nursing staff were exceptional. All were absolute gems and were fully involved in my health care and I would like to thank them for their intervention and words of encouragement, because this contributed to my speedy recovery. Visited in April 2019. Posted in May 2019

Response
Thank you for your positive comments posted on the Care Opinion website regarding your care on ward F2 at Wythenshawe Hospital. It was very kind of you to take the time to write and compliment the staff as it is good to receive positive feedback which reflects their hard work and dedication. It was reassuring to read that you thought all the nursing staff were exceptional and that their involvement in your healthcare and words of encouragement aided your recovery. I can assure you that we have passed on your thoughts to the Head of Nursing who will share your kind feedback with all the staff involved.
Maternity Services, St Mary's Hospital
Anonymous gave Maternity services at St Mary's Hospital a rating of 4 stars I was admitted after developing high blood pressure, sadly I lost my baby in a life threatening condition I had developed. I was being monitored after losing the baby every hour for the first few days. I was updated daily on my medical condition to which I almost lost my life. The care I had whilst here was exceptional especially from a couple of staff members. There were times I was unable to do things for myself i.e. clean myself, change maternity pad as I was so weak. A few members of staff would also wipe around the table, sides and always ensured I was in a clean and tidy environment. It was the worst week of my life. I am now at home and miss the care I had, one particular nurse that stood out she had took the time to wipe me down and change my pads. Visited in May 2019. Posted on 12 May 2019
Response
Thank you for your positive comments posted on the NHS Choices website regarding your care on the Maternity Unit at Saint Mary's Hospital. It was very kind of you to take the time to write and compliment the staff as it is good to receive positive feedback which reflects the hard work and dedication of our staff. We do appreciate that this has been an extremely difficult and painful time for you and your family and to take the time to provide this feedback is very generous of you. The Trust has introduced a Behavioural framework within which all members of the midwifery and medical teams practice so it was reassuring to read that you found staff professional, attentive and supportive throughout your admission. I can assure you that we have passed on your thoughts to the Clinical Head of Division for Obstetrics and the Head of Midwifery and the staff involved. We would like to take this opportunity to wish you well for the future.

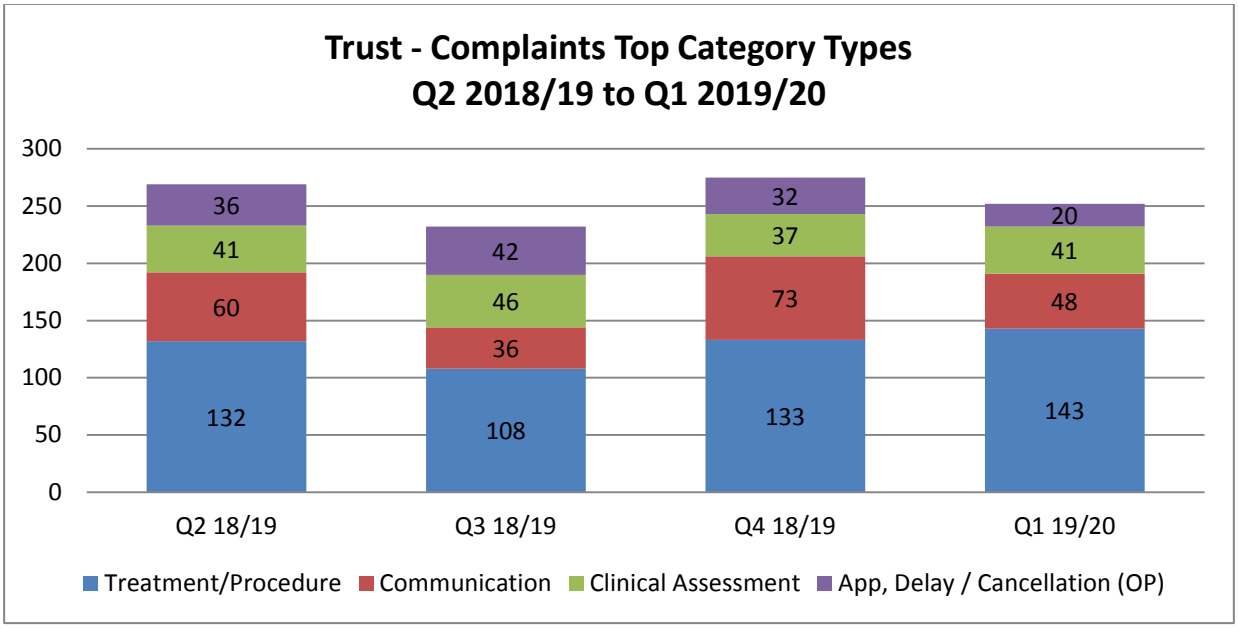
4. Themes from Complaints and PALS concerns

4.1 The medical staffing group were cited in 46.5% of all PALS concerns, compared to 47.5% in the previous quarter. Medical Staff were cited in 57.9% of complaints in this quarter compared to 49.5% in the previous quarter. Whilst recording limitations prevent further analysis of this data to determine whether these references relate to specific grades of medical staff it is recognised that medical staff, as the lead practitioner for episodes of care, it is not unusual for them to be cited by patients who wish to make a complaint. Actions in relation to this trend are undertaken on a case by case basis by the relevant Hospital/ MCS/ MLCO. In addition, the Head of Customer Services provides educational input with regard to customer service and complaints management on the New Appointed Consultants Programme (NACS).

4.2 The top category types for formal complaints from Q2, 2018/19 to Q1, 2019/20 are shown in **Graph 4.**

4.3 'Treatment/Procedure', 'Clinical Assessment' and 'Communication' remain in the top three categories in Q1, 2019/20.

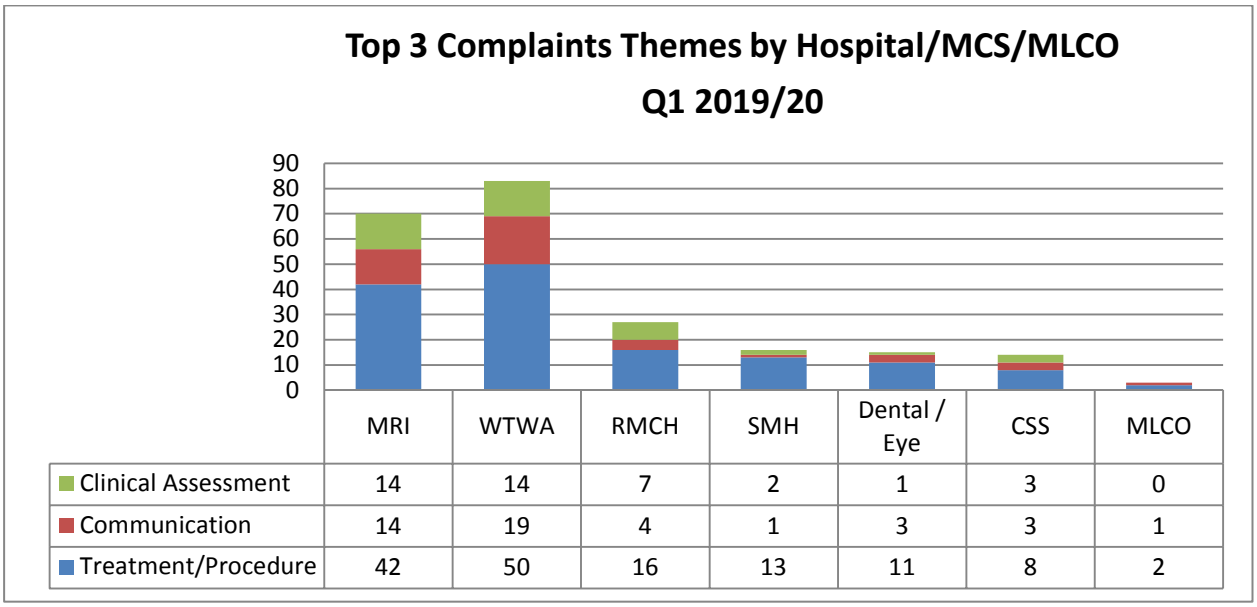
Graph 4: Formal Complaints – Top Categories Quarter 2, 2018/19 to Quarter 1, 2019/20



4.4 **Graph 5** illustrates the total number of top 3 categories by Hospital/MCS/MLCO in Q1 2019/20.

4.5 In this quarter the top category, 'Treatment/Procedure' (143) was cited in 41.3% of WTWA's complaints, 40.4% of MRI complaints, 39.0% of Royal Manchester Children's Hospital's (RMCH) complaints and 37.2% of SMH's complaints.

Graph 5: Total number of Top 3 Complaint Categories by Hospital/MCS/MLCO, Quarter 1, 2019/20



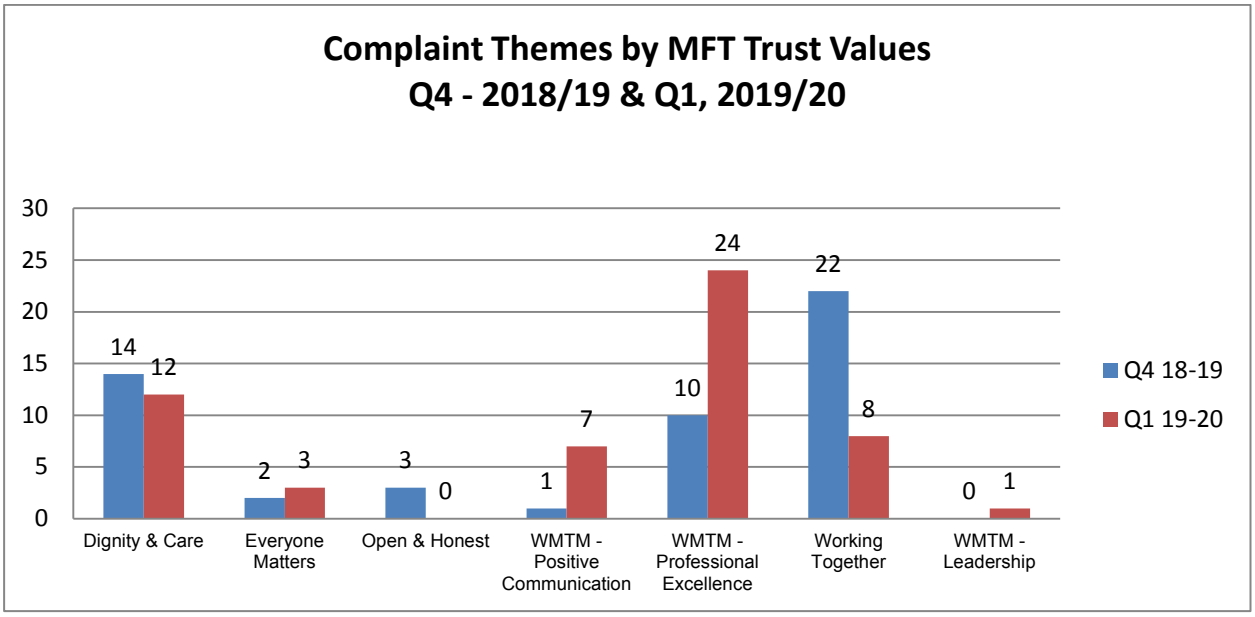
	MRI	WTWA	RMCH	SMH	Dental / Eye	CSS	MLCO
Clinical Assessment	14	14	7	2	1	3	0
Communication	14	19	4	1	3	3	1
Treatment/Procedure	42	50	16	13	11	8	2

4.6 **Theming Complaints**

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

The Trust-wide themes from the concerns identified in complaints compared to the MFT Trust Values from this quarter are shown in **Graph 6**. This is the third quarter this information has been reported. As more data becomes available it is anticipated that this information will provide an opportunity for the Group, Hospital/ MCS and MLCO teams to further understand where the adoption of the Trust Values is not embedded and will provide the Group, Hospital/ MCS and MLCO teams information to identify areas for focussed improvement.

Graph 6: Complaints – Theming of complaints to MFT Trust Values for Quarter 4, 2018/19 and Quarter 1, 2019/20



Due to the diversity of complaints received only 55 of the 361 new complaints received in this quarter, contained concerns which aligned with the MFT Trust Values. This compares to 52 out of 394 new complaints received in Q4, 2018/19 and 67 of the 332 new complaints received in Q3, 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 once during this quarter. MRI (Medicine) and MRI (Surgery) each presented a case at the June 2019 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 group.

Table 6: Actions identified at the Trust Complaints Scrutiny Group during Q1, 2019/20.

Division/ Hospital	Learning	Actions
MRI (DMACS)	No joint (Respiratory & Haematology) MDT clinic	Joint Respiratory & Haematology Multi-Disciplinary Team (MDT) clinic to be set up & all patients with Pulmonary Embolism to be invited to attend.

	The CT scans identified in this complaint were not reported adequately	Utilise complaint as a case study for teaching. Discuss case at the next Divisional Clinical Governance meeting.
	No formal recording of reason why radiology investigation was put on hold or not processed	Approach CSS to explore the possibility of this information being shared with a view to utilising this information for learning. Explore the possibility of an audit of radiology request forms.
MRI (Surgery)	Substandard quality of some of the theatre equipment	The equipment issues are being addressed at Group level and through the MRI Theatre Improvement Group.
	Lack of calming environment for patients in theatre	Patient's not to arrive in theatre before the environment is ready. The process of theatre set-up is to be reviewed to ensure the environment is prepared before the patient is brought in to the theatre anaesthetic room
	Lack of appropriate assistance and advice to some complex patients post-surgery	Transplant Co-ordinators are to provide teaching and training to all new nursing staff regarding pre and post-operative care of renal transplant patients and living donor. All nursing staff to be provide with training to assist and advise complex patients post-operatively.

6. Parliamentary and Health Service Ombudsman (PHSO)

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

6.2 The Trust had 15 cases under the review of the Parliamentary and Health Service Ombudsman at the end of this quarter compared to 13 under review at the end of the previous quarter. **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 June 2019

Hospital/MCS Division	Case/s	PHSO Investigation Progress
MRI (3)		
DMACS (1)	1	Awaiting draft report
Specialist Medical Services (SMS) (2)	2	Awaiting draft report
WTWA (7)		
Medicine (3)	2	Awaiting final report
	1	Propose to investigate
Surgery (2)	2	Awaiting draft report
Heart & Lung (2)	2	Awaiting draft report
CSS (1)	1	Awaiting draft report
RMCH (3)	2	Awaiting draft report
	1	Awaiting final report
SMH (1)	1	Awaiting draft report
Total	**15**	

6.3 The PHSO closed 3 cases in this quarter; of these cases 2 cases were partly upheld, and 1 case was upheld. The learning identified from the cases presented and the actions discussed and agreed at the meeting are outlined in **Table 8.**

6.4 The Trust was not asked to pay any financial redress in this quarter; however the recommendation of one case was exploration of financial remedy via NHS Resolution. This compares to £450 financial redress in Q4, 2018/19, £2,450 in Q3, 2018/19, no financial redress in Q2, 2018/19.

Table 8: PHSO closed cases in Quarter 1, 2019/20 presented by outcome.

Division/ Hospital	Outcome	Date original complaint received	PHSO Rationale/ Decision	Recommendations
MRI (SMS)	Partly upheld	28/08/18	Failings in incident reporting	Completion of incident report. Written formal apology and explanation of what actions have been taken to address the failings identified in the report
WTWA (Surgery)	Upheld	20/07/17	Failings in care, treatment and communication	Conduct a thorough investigation into the reasons why the serious failings identified in the report occurred. Explain what actions have been taken to address the failings identified in the report. Explore financial remedy via NHS Resolution. Provide evidence of the root cause analysis and action plan.
MRI (Surgery)	Partly upheld	20/12/18	Failings in discharge process	Develop an action plan outlining lessons learnt. Explain what actions have been taken to address the failings identified in the report.

7. Learning from Feedback

Implementing Learning to Improve Services

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

Table 9: Examples of the application of learning from complaints to improve services, Q1, 2019/20

Hospital/ MCS	Learning & Improvements
UDHM	**Patient Experience:** A patient attended the Emergency Dental Clinic (EDC) at the University Dental Hospital of Manchester (UDHM). Before attending, the patient had seen on the UDHM's website that patients are seen on a first come first seen basis, other than those presenting as a clinical priority. The patient identified themselves as a 'clinical priority'. On arrival the receptionist advised the patient that all of the EDC Appointments had been filled for that day but advised she would arrange for a Dental Nurse to see the patient. The patient was asked to take a seat and wait for the Dental Nurse; a considerable wait was experienced. When the patient was seen by a Dental Nurse, the Dental Nurse assessed the patient and told the patient that she needed to see a Dentist but unfortunately, there were no appointments available on the day and provided the patient with the following alternative options: the patient could return the following day or telephone an emergency dentist to be seen elsewhere. The patient asked to see a more senior member of staff and was then seen by the Senior Dental Nurse who provided the same advice. The patient was dissatisfied, she felt that there had been no privacy (all discussions took place in an open public place); no compassion or empathy for someone in pain and not one member of staff assessed the clinical need connected to the state of her teeth and gums. **Findings** ▪ It was acknowledged that the delay the patient experienced when she attended was unacceptable. ▪ The UDHM team had followed the protocol in place for the Emergency Dental Clinic and the patient was offered alternatives such as accessing emergency treatment elsewhere or returning the following day. ▪ It was established that the dental concern the patient presented with was not considered as a clinical priority at the time. **Actions** The Senior Nurse on the clinic is to ensure patients are attended to in a timely manner and if this is not possible, patients are kept informed as to how long the wait will be.
MREH	**Outpatient Appointment Waiting Time, cursory examination and staff attitude** A parent of a patient wrote to complaint about his attendance in clinic when he came to a hospital appointment to support his son who suffers from the eye condition Keratoconus. Specifically the parent complained about:

	1. They experienced a three hour wait in clinic 2. The patient was tested for a comparison eye test following his last appointment, and was back from the test within a few minutes. The patient's parent felt this was a cursory eye test at best. The patient was then tested for any degeneration against his previous visit, and then was seen by the Consultant. The patient was told there was no further degeneration, and asked the Consultant if there was anything that could be done to improve his vision. The consultant replied '*No, nothing really*'. The patient's father complained about the general apathy and lack of interest which he found disturbing. **Findings** ▪ The consultant had perceived to show a lack of interest in the patient's condition ▪ The patient had attended at 3:00pm for a 3:15pm outpatient appointment, and eventually left the hospital at 5:50pm. **Actions** ▪ An Outpatient Improvement Board has now been established to review existing processes and look at improvements that can be made to provide a more effective support to patients ▪ The doctor who saw the patient apologised that the patient perceived that he did not show an interest in his condition. ▪ Staff are to be reminded to offer pagers to patients to enable patients to leave the clinic for refreshments, if their appointments are delayed ▪ In response to the complaint response letter the patient's parent wrote to thank the Outpatients team l for all their efforts.
WTWA (Heart and Lung) Cardiac Surgery/ Transplant	**Poor nursing care in relation to pain management** A patient complained following admission for surgery. Although, the patient's surgery was performed successfully the patient raised concerns regarding the general nursing care he received. The patient explained that he had found a member of staff to be rude and unhelpful, alongside displaying a general lack of knowledge regarding various analgesics. Despite being given the standard analgesia of paracetamol and codeine his pain had not resolved. The patient was told that he could not be prescribed strong analgesia as this would prevent him from being discharged the following morning. However, on discharge he noted that he had been prescribed such analgesia as part of his take home medications. **Findings** ▪ Poor communication from nursing staff. ▪ Unprofessional and uncaring attitude of nursing staff ▪ Lack of knowledge of the Trust's Medication Policy **Actions** ▪ The anonymised complaint and the patient experience were shared with the member of staff the complaint related to for reflection. ▪ Education regarding pain assessment, reviewing patient responses to analgesia and the correct escalation process to be delivered to all nursing staff on the Ward.

	▪ Nursing staff to be familiar with the Trust's Medication Policy and ensure that all medication charts are reviewed for each patient during medication rounds.
WTWA (Division of Medicine) *Surgery and Medicine joint complaint*	**Effective Communication** A patient's next of kin raised formal concerns regarding her relative's unsatisfactory experience whilst in inpatient at Wythenshawe Hospital. The patient walked out of the Discharge Lounge unsupervised, whilst the nursing staff were busy with other patients, and suffered a fall. **Findings:** Complainant's relative walked out of the Discharge Lounge into the main hospital, without nursing staff noticing. He fell and was taken to the Emergency Department with a cut above his eye. The incident was reported on the Trust Incident Reporting System and was investigated. The investigation found that the referral form to the Discharge Lounge from the ward did include relevant information regarding the patient's past medical history. On arrival to the Discharge Lounge, the staff nurse on duty did not recognise that the patient required close supervision due to his past medical history and also his risk of falls. **Actions:** The investigation findings included several identified areas for improvement and an action plan was implemented with significant progress being made to date. The actions identified included: ▪ The need to update the Discharge Lounge's Referral Form to include any concerns regarding a patient's cognitive state with a prompt to complete a verbal handover for patient's identified as having additional needs. This has been completed and the new form is in use. ▪ An escalation process to be established for the Discharge Lounge, empowering the staff to seek support to enable them to provide for any additional needs their patients have, including close supervision. This has been completed as is now in use in the Discharge Lounge. ▪ A requirement to improve documentation for ongoing care providers when a patients' care needs change whilst in the Discharge Lounge. This has been implemented and an updated form is now in use. ▪ A consideration for the role of a volunteer in the Discharge Lounge. This action is currently ongoing, and a job description and risk assessment for the role has been completed. The Patient Flow Deputy Lead as met with the Volunteer Coordinator to discuss and agree the role. The role of the volunteer in the Discharge Lounge is expected to provide additional supervision in the area. ▪ The incident has been discussed with the Staff Nurse responsible. All members of the nursing team who work in the Discharge Lounge have been made aware of the incident, the lessons learnt as a result, and also the actions taken above to prevent a recurrence.
WTWA (Division of Surgery)	**Delayed Procedure** A complaint was received from a patient raising concerns about the delay in receiving the results of their CT scan, and monitoring of patient's conditions whilst waiting for procedures. The complainant queried why they were not told of the reason their procedure had been delayed and worried that the earlier CT scan would need to be repeated due to the delay.

	The Service Manager for Head and Neck Services apologised for the delay and the Waiting List team were able to find identify an appointment for the procedure, which they offered to the complainant, and the consultant advised that the complainant would not require a further CT scan prior to the procedure. **Actions:** As a direct result of the complaint the following actions have been identified: ▪ The Service Manager for Head and Neck Services is holding weekly meetings with the Waiting List (Booking and Scheduling Team) to review the waiting list for the service. This is to ensure all long waiting patients are monitored and prioritised as quickly as possible, to ensure that a date for their procedure is confirmed. ▪ The Head and Neck administration and clerical team are now fully staffed and all positions have been recruited to. All new staff members have commenced in post and have been given comprehensive training to effectively deliver their administration / customer service roles. ▪ The Service Manager for Head and Neck Services is holding regular monthly meetings with the administration and clerical teams to ensure that they are provided with any further support or relevant training. ▪ The Service Manager for Head and Neck Services has suggested to the Consultant Clinical Lead for the Ear, Nose and Throat service that this case is anonymously discussed at the next Ear, Nose and Throat divisional Clinical Effectiveness training day, so lessons learnt from the patient's experience can be discussed with the full clinical team.
MRI – Medicine	**Clinical Diagnosis** A complaint was received from a patient raising concerns about the failure to assess and diagnose a spinal fracture in MRI Emergency Department. The patient was discharged from the ED and after review of the CT scans the next day, had a confirmed fracture to the spine and was transferred to Salford Royal Hospital to the specialists in spinal fractures. **Findings:** There is a clear protocol in place for the assessment and imaging of potential spinal fractures and this was not followed. This is an unusual occurrence and the individuals concerned will be educated about their responsibilities to follow the protocol. **Actions:** Ongoing education of Emergency Department and Radiology staff related to the protocol for spinal imaging
MRI – SMS	**Communication and ReSPECT** A patient's daughter complained that a Do Not Attempt Resuscitation (DNAR) decision was made for her relative without her (the daughter) being informed. The patient lacked capacity. The ReSPECT form stated that the family had been present for the discussion and decision, but this was not the case. The patient was discharged with the ReSPECT form in place. Following the patient's discharged to a care home, the patient experienced a cardiac arrest, and the staff of the care home complied with the patient's

	DNAR status. However, the patient's daughter insisted the staff attempt CPR, which they did. The attempt at resuscitation was unsuccessful, but the patient's daughter was satisfied that all efforts were made to save the patient's life. The patient's daughter was distressed that, if she had not been present at the time of the cardiac arrest, no attempt at CPR would have been made. **Findings:** It was found that the consultant had been asked to complete the ReSPECT form by the ward staff and matron in order to facilitate the patient's discharge. Despite not having access to the MDT documentation to base their decision on, the consultant completed the form. Furthermore, the patient was not under the consultant's specialty and was an outlier on the ward. Although the patient's daughter had been present at a discharge planning meeting, the issue of resuscitation had not been discussed. **Actions:** The Consultant of the Week model will improve communication within the team, and the process of discharge planning is being reviewed on the relevant ward to ensure that the correct processes are followed. The Consultant involved has committed to ensuring that they have reviewed the necessary documentation in future prior to completing any future ReSPECT forms.
MRI Surgery	**Communication and Patient Experience.** A patient attended the Outpatient Department having left home at 11.00 hours in order to arrive well in time for a 13.45 hours appointment. Upon arrival, the patient was directed to Suite E and was told by the administrator working on the desk, that she had no idea if this particular clinic was being held within this area of the Department. The administrator made no attempt to find out any further information and the patient was told to sit and wait for the nursing staff to arrive. The nursing staff arrived and also did not know about the particular clinic and also did not attempt to seek any further information. After an hour wait, the patient asked for an update and was told by the administrative staff to ask the nurses. The patient approached a nurse who advised the patient they were next to be seen by the Doctor. After a further hour long wait, the patient re-checked what was happening and nobody was able to tell them anything. Eventually, after a wait of over two hours the patient was told that Consultant was not in attendance, nobody knew where the Consultant was and nobody was certain the Consultant had arrived for his clinic. The patient was upset that not one person in the Outpatient Department had made the effort to check earlier. The patient wanted to make a formal complaint regarding the member of administrative staff on the desk, who took no initiative, was dismissive and displayed a poor attitude. The patient felt that this person should not be at the forefront of any organisation when they display such inept behaviour in dealing with the public.

	Findings: The Outpatient Matron discussed with all the nursing team involved and discovered there had been miscommunication on the day of this clinic. It was identified that the nursing team believed the doctor was in attendance. However, this was not the case as the room intended for the patient's consultation was in use by a different speciality doctor. The afternoon clinic was to be covered by a Locum Consultant Doctor he went to Main Outpatients at the start of the clinic, but was unable to find out what Suite he would be based in and due to some confusion was informed he was not scheduled to undertake a clinic in Outpatient Department that afternoon. The Administration Manager received a call from Main Outpatients at 15:20 hours, informing her that the clinician had not turned up to this clinic which should have commenced at 13:30 hours. The Administration Manager called the Locum Consultant to find he had gone to Trafford Hospital to help out with a clinic there. The Administration Manager requested that the Locum Consultant come back to the MRI immediately as he had a full clinic and patients had been waiting a considerable amount of time. The Locum Consultant was very surprised to hear this as he had been informed he did not have a clinic that afternoon by the Outpatient Department staff. This created anxiety and dissatisfaction amongst the patients who were waiting in the clinic. **Actions:** The Outpatient Manager has confirmed that the outpatient team have been reminded to ensure every room is checked at the start of a clinic to make sure the correct clinician is using the consultation room they have been allocated. In addition, the theme of the staff training day on June 2019 was about patient experience and the team used the events from this complaint as a case study. The Outpatient Matron is undertaking regular spot checks and walk rounds to in outpatients to review staff adherence to the Values and Behaviours framework as part of the Outpatients Service Improvement Plan.
St Mary's Hospital	**Communication and Patient Experience.** The patient was admitted for planned procedure. The pre-operative appointment went as planned, however the patient was extremely unhappy with her care in the anaesthetic room where she reported that the insertion of an intravenous cannula was both painful and had to be re-inserted as it had been 'put in the wrong place'. Postoperatively, the patient was given an information leaflet for a procedure she had not undergone, which caused concern as she thought an additional procedure had been undertaken without her consent. She also experienced discomfort and was given no advice regarding wound care. She attended her local walk-in centre a week later as the sutures had not dissolved as she had been informed and these had to be removed. The patient also did not receive a follow up appointment as she had been advised to expect. **Findings:** ▪ The Anaesthetist acknowledged that the intravenous cannula had to be re-sited and apologised for the discomfort but could not recall why it had been 'incorrectly' sited.

	▪ The Consultant Gynaecologist reviewed the patient's medical records and confirmed that only the procedures consented to have been undertaken. ▪ The Ward Manager has discussed the patients experience with the Staff Nurse responsible for the patient's discharge and highlighted the importance of providing accurate patient information and ensuring the patient understands the information given and has an opportunity to discuss it prior to discharge. ▪ **Pain and Wound Management:** Pain management following a laparoscopy is detailed in the patient information leaflet provided as part of the preoperative care. The patient had not expressed any concerns during her postoperative period, but it was recognised that following discharge pain management and wound care arrangements had not been clarified with the patient. ▪ **Follow-up Appointment:** The Ward Manager has checked with the Ward Clerk whose role it is to communicate with the booking team. The Consultant undertaking the procedure had left post-operative instructions for a review appointment in 3 months with the Consultant Gynaecologist the patient had originally been referred to. However, the appointment was made for the operating Consultant's next outpatient clinic, an appointment the patient did attend. **Actions:** The Patient information leaflets provided in the Gynaecology Clinic will be amended to clearly inform patients that following discharge, ibuprofen and paracetamol are recommended for pain relief and as these are easily available, these are not routinely provided at discharge unless specifically requested.
RMCH	**Medication Error** A complaint was received from a patient's mother raising concerns that her son had been administered incorrect medication (eye drops) during his inpatient stay at RMCH. On investigating the matter it was discovered that the child had been given 'Gentamycin' eye drops (which contained hydrocortisone) in the Paediatric Emergency Department (PED). The eye drops had been incorrectly selected from the 'out of hours' stock cupboard in PED. The child was then admitted and transferred to Ward 75 where a further two doses were given before a Staff Nurse discussed the medication with the Ward Pharmacist. The Ward Pharmacist advised that the drops were incorrect as they contained hydrocortisone. The child's mother was immediately informed, the Trust Drug Errors Policy was followed and the nurses who had selected and administered the medication were temporarily suspended from further drug administration until a full investigation had been completed. No harm occurred to the patient as a result of this error. As a result of the complaint and to avoid a similar incidents happening in the future the following actions were agreed: ▪ Sister in PED and Ward 75 Manager will remind stiff to be more vigilant when checking medications. This action was completed immediately.

	▪ Medication Error Workshops to be developed to look at how errors occur and provide staff with prompts to reduce the risk of error. A number of workshops have been arranged during 2019.

8. Equality and Diversity Monitoring Information

8.1 **Table 10** provides Equality and Diversity information gathered from complainants for this quarter. As in Q4, 2018/19 it is evident that the collection of this information is not consistent. The Corporate PALS team will continue to explore opportunities to improve the quantity and subsequently quality of this data. One current line of enquiry is utilising the information from the patient's electronic records and the team are currently exploring this option.

Table 10: Quarter 1, 2019/20 Equality and Diversity Monitoring Information

Disability	**No.**
Yes	13
No	15
Not Disclosed	333
Total	**361**
Disability Type	
Learning Difficulty/Disability	0
Long-Standing Illness Or Health Condition	4
Mental Health Condition	3
No Disability	0
Other Disability	0
Physical Impairment	4
Sensory Impairment	1
Not Disclosed	349
Total	**361**
Gender	
Man (Inc. Trans Man)	174
Woman (Inc. Trans Woman)	184
Non Binary	0
Other Gender	0

Not Specified	3
Total	**361**
Sexual Orientation	
Heterosexual	27
Lesbian / Gay/Bi-sexual	2
Do not wish to answer	0
Other	0
Not disclosed	332
Total	**361**
Religion/Belief	
Buddhist	0
Christianity (All Denominations)	18
Do Not Wish To Answer	329
Muslim	3
No Religion	8
Other	2
Sikh	0
Jewish	0
Hindu	1
Not disclosed	0
Total	**361**
Ethnic Group	
Asian Or Asian British - Bangladeshi	1
Asian Or Asian British - Indian	3
Asian Or Asian British - Other Asian	4
Asian Or Asian British - Pakistani	5
Black or Black British - Black African	3
Black or Black British - Black Caribbean	3
Black or Black British - other Black	2
Chinese Or Other Ethnic Group - Chinese	1
Mixed - Other Mixed	0
Mixed - White & Asian	1
Mixed - White and Black African	1
Mixed - White and Black Caribbean	6
Other Ethnic Category - Other Ethnic	2
White - British	121
White - Irish	4
White - Other White	8
Not Stated	196
Total	**361**

8.2 In this quarter the number of complaints received from patients who report they have a learning difficulty/disability remained equal with Q3 and Q4, 2018/19, continuing to highlight that complainants that identify having a disability are low in number and not representative of the overall patient population.

8.3 Work continued in this quarter exploring the alternative methods of improving the capture of equality and diversity data from complainants and will continue during Q2, 2019/20.

9. Quality Improvements

9.1 Improvements Q1, 2019/20

9.1.1 Relocation of PALS office at Wythenshawe Hospital

During 2019, work started on the design phase to relocate the PALS office to a new, central, more visible location within Wythenshawe Hospital. Work commenced in March 2019 and hand over of the new facility took place at the end of June 2019.

The new PALS facility will enable members of the public to make enquiries and book appointments to see a PALS case worker.

Picture 1: Newly built PALS Reception and Office at Wythenshawe Hospital, Entrance 5, opened July 2019

9.1.2 Educational Sessions

During this quarter educational sessions were facilitated by The Parliamentary and Health Service Ombudsman (PHSO) for staff involved in responding to complaints.

Picture 1: (R to L)**:** Parliamentary and Health Service Ombudsman, Anna Neills, Sam Stone and Elliot Riley, pictured with Mrs Claire Horsefield, Head of Customer Services

The sessions focused on understanding the following:

- PHSO's role & their development work
- PHSO's casework process

- PHSO's decision making process
- Sharing of good practice & learning from PHSO casework

The sessions were very well received and further educational sessions, facilitated by the PHSO, are currently being arranged for Q3, 2019/20.

Following the previous successful educational sessions for staff involved in responding to complaints, the Corporate PALS team facilitated four further educational sessions at Wythenshawe Hospital and one further session at the MLCO in this quarter.

During this quarter the Helplines Partnership facilitated educational sessions to the PALS team. The training course focused on 'Understanding Vicarious Trauma (VT)' and provided the PALS staff with the knowledge and skills to:

- Identify the impact of VT
- Self-reflection in relation to practice
- Self-care techniques
- Understand what support is available

9.1.3 **'Tell us Today'**

During this quarter there continues to be no recorded activity on the Ulysses Customer Services Module. A total of only 3 calls were recorded on the system in 2018/19, compared to 5 in 2017/18. The Hospital/ MCS Senior Nursing Teams have explained that the low number of recorded calls is not reflective of the frequency which clinical staffs respond to concerns at departmental level.

In view of the low numbers an audit to evaluate the **'Tell us Today'** service was undertaken during this quarter.

The audit involved the Patient Experience staff visiting MRI, Wythenshawe and Trafford General Hospital (TGH) and seeking information about staff and service user knowledge of the **'Tell us Today'** Service. The results detailed below are a summary of 70 responses from a mixture of staff and service users:

Staff Results:

- 6 staff at TGH were aware of the **'Tell us Today'** Service and where aware what it is used for and where they could find information about service.
- 0 staff at MRI and Wythenshawe were aware of the **'Tell us Today'** Service.

Service User Results:

- 3 service users (patients', carers, relatives) at Wythenshawe were aware of and understood the function of the **'Tell us Today'** Service.
- 0 of the service users at MRI and TGH were aware of the **'Tell us Today'** Service, and did not understand the function of the **'Tell us Today'** service or where to find information about the service.
- None of the service users had used the **'Tell us Today'** service.

Next Steps:

- Promotional Campaign of the **'Tell us Today'** service will be developed and undertaken during the next 6 months, which will involve the corporate complaints team engaging with the senior nursing/ midwifery teams in each Hospital/ MCS to identify their local need to promote the service and increase awareness of the service.
- A further audit to be undertaken during Q3, 2019/20

9.1.4 Complainant's Satisfaction Survey

The Complaints Satisfaction Survey is based upon ***'My Expectations'***[1] paper and has been developed by the Picker Institute. It is sent to complainants covering all MFT Hospitals/ MCSs/ MLCO and during this quarter 55 responses to the survey were received compared to 18 responses in the previous quarter.

Survey results for Quarter 1, 2019/20 indicate:

- 82.4% of complainants felt they had a single point of contact at the Trust who they could approach if they had any questions.
- 77.4% of complainants felt that they received acknowledgement of their complaint within an acceptable timeframe.
- 61.5% of complainants felt they were informed of a timescale for the Trust to respond to their complaint.
- 60.4% of complainants received the outcome of their complaint within the given timescales.
- 58.8% of complainants found it completely easy to make their complaint, with a further 27.5% of complainants finding it easy, to some extent.
- 56.9% of complainants felt that they were definitely taken seriously when they first raised a complaint, with a further 21.57% of complainants feeling they were taken seriously to some extent.
- 47.1% of complainants felt definitely confident that future care would not be negatively affected by making a complaint.
- 24.3% of complainants sought an additional response for the points that were not addressed.

Comments received during Quarter 1, 2019/20 include the following:

- PALS is an exceptional service. They take your complaint very seriously and investigate and address all your concerns. They are professional at all times. I was truly grateful for all their help.
- Initial response deadlines were not met, although I did receive apologies regarding this. I have answered this form in terms of the formal complaint I raised. This was done due to a lack of response to concerns I raised whilst I was in hospital. Had these been addressed earlier, the timely and costly (for NHS) process of formal complaint would have been avoided.
- The summary of the concerns raised was very thorough and accurate. Updates were very clear. The final outcome responded very well to the concerns raised. I was concerned that issues raised by procedures affecting me would be addressed so that others would not be affected in the same way. Proposals were made to do this.
- The length of time waited for responses was a bit long and I could have done with a text or something to tell me they had received my letters.
- I genuinely felt that the matron of the ward was very concerned about our complaint and that she took it seriously and had given the complaint a lot of thought. She was not defensive and had thought about how improvements could be made to the acute ward.

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

- The beginning of the complaints process works extremely well, and PALS are extremely good at keeping the patient/ representative up to date. The actual dealing of the issues of the complaint then becomes a series of apologies and the word of the hospital staff are taken seriously. This action then makes them void.
- Did not receive a response within the timescale given.
- The outcome was very satisfactory.

9.1.5 Complaint Response Audit

Following the development, piloting and detailed analysis of the findings of the Complaint Quality Audit and Analysis Tool during Q3 and 4, 2018/19, during this quarter the audit tool was shared with all Hospitals/ MCSs and MLCO at the Quality and Patient Experience Forum. With the support of the corporate team the Hospitals/ MCS and MLCO have been encouraged to undertake the audit.

9.2 Future Planned Improvements 2019/20

9.2.1 PHSO Research

Frontline Complaint Handling – 'Complaints Standards Framework'

The PHSO are undertaking research to inform an insight publication on Frontline Complaint Handling in the NHS and Government Departments. This will directly support their work to develop a 'Complaints Standards Framework'. The aim of this Framework is to set out a unified vision of best practice in complaint handling for the NHS and social care. As part of the PHSO's insight publication, they are identifying common themes in complaint handling by the NHS and Government departments in their final investigation reports.

With this in mind the Trust has accepted the request to participate in the research and specifically participate in research interviews to explore some of these themes in more detail. The interviews have been arranged to take place during Q2, 2019/20.

The Early Dispute Resolution (EDR) pilot

The PHSO have developed an EDR pilot programme to test how they can use informal mediation to help complainants and organisations they complain about, achieve local resolution to the dispute without the need for a PHSO investigation; the pilot is planned for a 12 month period. The PHSO has asked the Shelford Group NHS Trusts to work with them as pilot sites. The Trust has agreed with the PHSO to be an identified pilot site for the programme and a meeting will be held to discuss this programme further with the PHSO during Q2, 2019/20.

9.2.2 Education and Training

As detailed above following the previous successful educational sessions facilitated by the Parliamentary and Health Service Ombudsman (PHSO) further sessions are being arranged to be held in Q3, 2019/20 at Wythenshawe Hospital.

The Educational Programme for staff who manage complaints will continue to be further developed during 2019/20. This will also include the roll out of the in-house ***Complaints letter writing training course***, which was piloted with the Estates and Facilities Team during Q4, 2018/19 to the MLCO in Q2, 2019/20.

9.2.5 **Standard Operation Procedures (SOPs)**

Following the commencement of the review of the Complaints and PALS SOPs in 2018/19 the remaining SOPs will be reviewed and updated during 2019/20.

10. Conclusion

The Group Board of Directors is asked to note the content of this Complaints Report and the on-going work of the corporate teams and the Hospital/ MCS and MLCO teams to ensure that the Trust is responsive to concerns raised and learns from patient feedback in order to continuously improve the patient's experience. In conclusion, we will:

- Continue to monitor complaint response timescales against expected response timescales.
- Offer Corporate Nursing Support to Hospitals/ MCSs/ MLCO where performance is deteriorating.
- Continue to review and embed recommendations within MFT's policies from National Guidance
- Continue to progress the improvements as outlined in this report.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Gill Heaton, Executive Freedom to Speak Up Champion
Paper prepared by:	David Cain, MFT's Freedom to Speak Up Guardian Mags Bradbury, Associate Director Wellbeing, Inclusion & Community
Date of paper:	July 2019
Subject:	**MFT's Freedom to Speak Up Annual Report (2018/19)**
Purpose of Report:	Indicate which by ✓ • Information to Note ✓ • Support ✓ • Accept • Resolution • Approval • Ratify
Consideration of Risk against Key Priorities:	This report on Freedom to Speak Up Is in support of the Trust's priorities for safe patient care, being the best place to work and are aligned with the Trust values: • Dignity and Care • Open and Honest
Recommendations:	Board of Directors is asked to note and support the Freedom to Speak Up Annual Report (2018/19).
Contact:	Name: David Cain, MFT's Freedom to Speak Up Guardian Tel: 0161 276 6262

MFT's Freedom to Speak Up Annual Report

1. Introduction

1.1. This report provides a review of the work undertaken from April 2018 to March 2019 on progressing the programme of Freedom to Speak Up at MFT. In August 2018 MFT's Board supported the proposal to create new roles and responsibilities in relation to this work.

These roles and responsibilities were in line with NHS Improvement guidance issued in May 2018. MFT's Board supported the creation of an Executive Champion, whose responsibility it is to provide the board with assurance on the effectiveness of the Trust's processes. The Board committed as part of its responsibility to receive and scrutinise the Freedom to Speak Up Reports.

2. Scope of the Report

2.1 The purpose of this report is to summarise activity undertaken in the year, provide the GMB with the annual number of concerns raised to the Freedom to Speak Up Guardian or Champions and outline the future high level plans to continue to build a robust programme where staff feel safe to speak up safely. It should be noted that this report is not the sum of MFT's work to ensure there is a culture of openness and honesty across MFT. A significant amount of work has been undertaken by the Trust to embed its Values & Behaviours. This report supports the delivery of the Trust value of openness and honesty.

3. Key Points

3.1 The report outlines that 84 people made contact with the Freedom to Speak Up Guardian or Trust wide Freedom to Speak Up Champions in the last twelve months. Nationally the Guardians Office continues to see a rise in number of cases. The Trust established a key performance indicator as a rise in number of cases to demonstrate the effectiveness of the programme reaching out to all staff across MFT. The Trust saw an increase on cases from the first quarter of the year where two cases were raised, to the final quarter where thirty eight cases were raised. 23.8% of cases raised included an element of patient safety, 46% of the cases raised included an element of bullying or harassment. Whilst the national data for the year 2018/19 is not yet available, in 2017/18 nationally 45% of the cases raised included an element of bullying or harassment and 32% included an element of patient safety. A review of MFT data against the 2018/19 data set will be completed once the national office have compiled and released the data.

3.2 The Trust undertook a major engagement programme in October 2018 to engage staff across the Trust. The results of this work can be seen in the number of Freedom to Speak Up Champions recruited and the increase in the number of cases raised.

3.3 This work is continuing and recruitment of a further 10 champions will commence in July and a major staff engagement programme will be delivered in October 2019.

4. Recommendations

4.1 The Board of Directors is asked to note and support the Freedom to Speak Up Annual Report.

NHS
Manchester University
NHS Foundation Trust

Freedom to Speak Up Annual Report

1st April 2018 to 31st March 2019

Foreword

As the Freedom to Speak Up Guardian Manchester University NHS Foundation Trust (MFT) I am proud to present our annual report on the progress we have been making in 2018 – 2019 to ensure that all our colleagues across MFT feel confident to speak up. Freedom to Speak Up (F2SU) is a national programme that supports staff, students, governors and patients raise concerns. Good speaking up arrangements help to protect patients and improve the working experience of NHS workers. I was appointed the Guardian in August 2018 and I would like to take this opportunity to thank Ivan Bennet, one of our Non-Executive Directors who had been the Trust's Guardian before me and who continues to be the non-executive lead for Freedom to Speak Up.

I am passionate about supporting colleagues, having had a career in the NHS for over 40 years I have seen the impact when colleagues feel they are unable to share their concerns, feel bullied or intimidated. I want everyone at MFT to know how to raise concerns and to feel safe when they do so. All my life I have supported someone close to me who has often not had a voice because of their disability, I want to empower everyone to have a voice and to be heard. In this role I have spoken to lots of people here at MFT, it has been a privilege to hear their stories and work with them to help the organisation build a culture of speaking up. A highlight of this year has been appointing our Trust's Freedom to Speak Up Champions. We went out to recruit across the Trust and were overwhelmed by the number of colleagues who came forward. Listening to why colleagues were motivated to come forward to apply for the role, their passion for helping staff and patients was inspirational. We are now very fortunate to have 20 Freedom to Speak Up Champions who are working across the Trust to help everyone speak up.

Whilst we have made progress in 2018/19 there is still much more to be done. We need to recruit another 10 Champions to make all staff have someone they feel they can talk to, we need to train more staff on what freedom to speak up means and to continue to learn from the cases raised.

David Cain
Freedom to Speak Up Guardian

1. Introduction

This report provides details of all the activity that took place in 2018/19 across the Trust to deliver MFT's commitment to Freedom to Speak Up. The report provides the details of the number of contacts within the Freedom to Speak Up Programme and the changes we have made throughout the year as part of our philosophy to continually improve.

2. Performance Data

2.1 Number of Cases raised with the Freedom to Speak up Guardian or Champions

In the last year 84 cases were raised with the Freedom to Speak up Guardian or Champions. The increased activity on quarters 3 and 4 reflect the significant engagement work undertaken in October 2018 and the recruitment of the Freedom to Speak Up Champions in August 2018.

	Total number of cases	Number of Cases Raised Anonymously	Cases included an element of Patient Safety	Cases included an element of bullying / harassment
April - June	2	1	1	1
July - September	5	5	3	2
October - December	39	38	9	19
January - March	38	26	7	15
Total	**84**	**70**	**20**	**37**

44% of the cases raised had an element of bullying and harassment. This compares to the national figure for 2017/18 of 45% of all cases featuring bullying and harassment. At the time of writing the report the national data for Freedom to Speak Up Cases has not yet been released so no national comparators can be made.

2.2 Key Performance Indicators

The Trust has set 2 key performance indicators for the Freedom to Speak Up Programme.

Performance Measures				
Indicator	**1st October 2017 to 1st October 2018**	**1st October 2018 to 31st March 2019**	**RAG**	**Comments**
Increase in number of people raising a concern through the F2SU programme	6	77		Future annual reports will use the 1st April to 31st March time scale. Bringing the reporting cycle into line with Trust wide reporting.
Staff reporting a positive result for the staff survey question – 18 b -I would feel secure raising concerns about unsafe clinical practice	CMFT 2017 – 69% UHSM 2017 – 67%	70.9%		Whilst this is not a perfect measurement as there are many factors that would influence how staff feel about raising unsafe clinical practice, the F2SU programme should support an improvement in this score

3. Roles & Responsibilities

3.1 Leadership Roles at MFT

In 2018 NHS Improvement issued a guidance document to all Trust's with key recommendations. MFT has used this guidance to review the roles and responsibilities for Freedom to Speak Up. Key roles were developed to ensure that Freedom to Speak Up is supported across the organisation.

 David Cain	Freedom to Speak Up Guardian	The Guardian's Role is to: ▪ Protect patient safety and the quality of care ▪ Improve the experience of workers ▪ Promote learning and improvement By ensuring that: ▪ Workers are supported in speaking up ▪ Barriers to speaking up are addressed
ADD PHOTO Ivan Bennet	Non-Executive Champion	The Non-Executive Champion's role is to: ▪ Hold the CEO, Executive FTSU lead and the board to account for implementing the speaking up strategy. ▪ Role-model high standards of conduct around FTSU ▪ Act as an alternative source of advice and support for the FTSU Guardian ▪ Oversee speaking up concerns regarding board members
Picture Gill Heaton	Executive Champion Deputy Chief Executive	The Executive Champion's role is to ▪ Ensure the FTSU Guardian role has been implemented ▪ Ensure that the FTSU Guardian has adequate resources ▪ Ensure that a sample of speaking up cases have been quality assured ▪ Conduct an annual review of the programme ▪ Provide the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process

3.2 Freedom to Speak Up Champions

To support the Freedom to Speak Up Guardian, Champions have been recruited from across MFT. A recruitment campaign was launched in August 2018, champions were interviewed and appointed in September, and in October 2018 to coincide with the national Speak Up Month the trust launched the champions.

18 champions were recruited and trained as part of this first wave of recruitment. In January 2019 a targeted recruitment in RMCH successfully recruited a further two champions to the team. The champions have been working across the Trust promoting the roles, talking to colleagues and supporting people to raise concerns.

4. Board, Governor & Staff Development

It is critical to the success of the Freedom to speak Up Programme that all staff feel confident in raising concerns. To ensure that all staff are aware of the Trust's work MFT has embedded Freedom to Speak Up into the staff induction as part of the section on 'Together Care Matters' which explains how the Trust lives its values. The new staff induction programme was launched in October 2018 as part of a major review of MFT's induction programme for all new starters joining the Trust.

Freedom to Speak Up training is also included as part of MFT's core patient safety training. The Trust's Risk Management Team offer a Duty of Candour/Being open training day, available to all staff, in the last year 53 staff undertook this training which includes Freedom to Speak Up as part of the core training. Freedom to Speak up is also embedded in the Trust's core Patient Safety Training. The Trust runs two sessions of this training per month with 170 staff this year completed this training.

During the Trust Board development seminar in December 2018, members discussed Freedom to Speak Up; reviewing their responsibilities, how the board gains assurance and the impact of MFT's current programme of work to deliver its commitments to Freedom to Speak Up. Feedback from this session was built into the improvement plan for Freedom to Speak Up. In November 2018 MFT's Governors also had a development session and an report on the new programme of activity.

5. Policy

In 2018 the Trust renewed its Raising Concerns Policy to align with the NHS best practise model. The policy was agreed in September 2018 and launched during MFT's Speak up Safely Month programme .

6. Key Actions for 2019-2020

Whilst there has been a considerable amount of work undertaken in 2018-2019 we believe there is more that needs to be done to embed the Freedom to Speak Up programme across the whole Trust. Our commitment is in the next 12 months to:

Actions	**When**
Continue to promote the role of the Freedom to Speak Up Guardian	Ongoing
Develop a strong presence on the new Trust Intranet	September 2019
Recruit an additional 10 Champions focusing on key areas where champions are under-represented	October 2019
Continue to support and develop the F2SU Champions	Ongoing
Continue to develop and embed training and awareness across the Trust	Ongoing
Celebrate Freedom to Speak Up Month	October 2019
Work with the National Guardians Office to ensure that MFT continually learns from national best practise	Ongoing
Undertake an annual review on impact of work and develop plans to address gaps	September 2019
Develop training to support staff understanding of the Raising Concerns Policy	December 2019

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Miss Toli Onon, Joint Group Medical Director
Paper prepared by:	Cameron Chandler, Professional Standards Manager
Date of paper:	September 2019
Subject:	**Annual Report to the Board of Directors: Management of Medical Appraisal and Revalidation**
Purpose of report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration of Risk against Key Priorities	The issues contained in this report have an impact on medical staff engagement, quality improvement and organisational reputation
Recommendations	The Board is asked to receive this update as part of the Annual Board Report on the implementation of Medical Revalidation, and, approve submission of an Annual Statement of Compliance to the Higher Level Responsible Officer, NHS England (North); signed on behalf of the designated body by the Group Chief Executive Officer.
Contact:	Name: Mrs Toli Onon, Joint Medical Director Tel: 0161 701 0205

1. Executive summary

This report describes the progress of the Trust towards the management of medical appraisal and revalidation since its implementation in March 2013.

Summary of key points:

- at the end of the last appraisal year (31 March 2019), MFT had 1,680 doctors with a prescribed connection
- 93.7% of connected doctors had an appraisal within the year
- the Quality Assurance of the process is subject to ongoing review and appraisers are being trained or refreshed to ensure they all meet the required standards
- successful introduction of a new single electronics system for medical appraisal and revalidation
- a single appraisal policy has been introduced and ratified to cover all sites

2. Purpose of the paper

The purpose of this report is to:

- summarise the Trust's performance in relation to medical appraisal and revalidation for the period April 2018 to March 2019
- provide assurance to the Board that the Trust is compliant as a designated body for medical revalidation, continues its pursuit of quality improvement, and that the Responsible Officer (RO) is discharging her statutory responsibilities
- seek the approval of the Trust Board to submit the Annual Statement of Compliance to NHS England on or before 27 September 2019

3. Background

Revalidation was formally launched in the UK in January 2013 and is the process by which all licensed doctors are required to demonstrate, on a regular basis, that they are up to date and fit to practise in their chosen field and able to provide a good level of care. Revalidation aims to give extra confidence to patients that their doctor is being regularly checked by both their employer and the General Medical Council (GMC). Licensed doctors have to revalidate usually every five years, part of which is the requirement to have an annual appraisal based on the GMC's Good Medical Practice framework[1]. The Trust's appraisal and revalidation process is managed operationally by the Responsible Officer; a role established in statutory legislation[2] and currently undertaken by Miss Onon. The RO's role is supported by Professor Daniel Keenan and Dr Emma Hurley, Group Associate Medical Directors for Appraisal and Revalidation, in addition to the Chief of Staff and the Professional Standards Manager.

The revalidation process is based on a recommendation from the RO to the GMC. In order to make this recommendation, the RO must be assured that:

- the doctor has a track record of engagement with annual appraisals consistent with the guidance on strengthened medical appraisal and has been appraised the full scope of their practice (including in the independent sector) at a single appraisal meeting
- any concerns about the doctor raised through the appraisal have been brought to the attention of the relevant medical line manager and successfully addressed
- the doctor has undertaken a multisource feedback evaluation of their work, including feedback from both colleagues and patients, and that this has been discussed with their appraiser (one formal multisource feedback per 5 year revalidation cycle)
- there are no outstanding concerns about the doctor's performance or professional conduct known to the Trust

[1] http://www.gmc-uk.org/static/documents/content/GMP_.pdf
[2] The Medical Profession (Responsible Officers) Regulations 2010, amended 2013

Options available to the RO are to recommend revalidation, defer the recommendation for a period of up to 12 months (either due to insufficient information for a positive recommendation or because the doctor is subject to an ongoing process), or to notify the GMC of the doctor's non-engagement with the process.

Appraisal and revalidation are covered by the Trust's Revalidation and Appraisal Policy for Medical and Dental Staff (November 2018), which has been developed and ratified since the merger to cover all sites.

4. Designated body

Manchester University NHS Foundation Trust is a designated body, as established in the Responsible Officer regulations; this also determines which doctors should be connected to the Trust for appraisal and revalidation. At 31 March 2019 (the end of the last appraisal year), 1,680 doctors were connected; 1,160 Consultants, 130 SAS grade doctors, 376 temporary and short-term contract holders (including clinical fellows), and 14 other doctors (such as clinical trial physicians). Doctors who work jointly within the Trust and the University of Manchester in an academic position are required to undergo a joint appraisal under the Follett Principles. These doctors connect to the Trust for revalidation. Additional doctors who work for the Trust, who are not connected for appraisal and revalidation, include GPs who connect to one of the NHS England sub-regional teams, and doctors who work at MFT but also with another NHS organisation, who is their main employer and designated body. Despite not connecting directly with these doctors, the Trust still has an obligation to monitor their fitness to practise and report any concerns to the doctor's RO. Doctors in a training grade are appraised and revalidated separately by Health Education England.

5. Revalidation

For the appraisal year 01 April 2018 – 31 March 2019, 379 doctors were due to be revalidated. 325 doctors were recommended for revalidation and a further 20 were deferred and subsequently revalidated; 34 doctors were deferred with a future revalidation date after 31 March. Of the 54 deferrals, 53 were due to insufficient information and 1 due to involvement in an ongoing process. No notifications of non-engagement were submitted to the GMC. All of the recommendations to revalidate have been approved by the GMC.

6. Appraisal

All doctors must ensure that they undergo appraisal within each financial year and are responsible for the continuous collection of their portfolio of evidence covering their full scope of practice. For medical staff who are registered with the GMC as well as the General Dental Council, continued engagement with appraisal is necessary over the course of the 5 year revalidation cycle.

At 31 March 2019, 1,680 connected doctors were due to have an appraisal within year (01 April – 31 March). The appraisal rate for the 2018-19 appraisal year is as follows (table 1):

Table 1. Number of medical appraisals at MFT during 2018-19

Group	Connected	(1) Completed appraisal	(1a) Completed appraisal	(2) approved incomplete or missed appraisal	(3) Unapproved incomplete or missed appraisal
Consultants	**1,160**	1,132	782	24	4
SAS	**130**	122	71	6	2
Temporary or short term contract holders	**376**	306	184	53	17
Other	**14**	14	9	0	0
Total	**1,680**	**1,574**	**1,046**	**83**	**23**

Category definitions (as established by NHS England)[3]

1: Appraisal held within year

1a: Appraisal held within 9-12 months of the previous, signed off within 28 days of the appraisal discussion, and held and signed off by 31 March 2019

2: Appraisal not held or completed within year with approval from the RO (e.g. maternity leave)

3: Appraisal not held or completed within year without approval from the RO

NHS England has produced a comparison of appraisal rates against other NHS Foundation Trusts and all designated bodies within England, demonstrating that MFT is comparable or ahead of other organisations for completion of medical appraisals (table 2).

Table 2. Appraisal rates at MFT compared to other English FTs & all designated bodies

Group	MFT	Other Foundation Trusts	All Designated Bodies
Consultants	97.6%	93.5%	93.7%
SAS	93.8%	88.8%	88.2%
Temporary or short term contract holders	81.4%	77.8%	81.8%
Other	100%	72.1%	87.9%
Total	**93.7%**	**89.3%**	**91.5%**

7. Revalidation management systems

Medical appraisals in our legacy Trusts were documented via two different electronic systems provided by external suppliers. The contracts for both of these systems were extended to March 2019 to allow for a gradual transition to one system. Due to the extensive and complicated nature of the medical workforce at MFT, it is essential that the selected Revalidation Management System incorporates the requisite functionality in order to provide the necessary support for appraisees and appraisers, and relevant managers and administrators. A comparison of both systems, in addition to two other major systems used by other NHS Trusts, was undertaken with a list of system requirements developed in order to assess the system's existing functionality in addition to future developments, costings and supplier support. SARD was identified as the preferred RMS software, providing an almost complete package for supporting appraisal and revalidation, and also provided a significant cost saving to the Trust.

[3] england.nhs.uk/revalidation/qa/

The acquisition of the new SARD appraisal software has enabled the Managed Clinical Services working across multiple sites to have all of their staff within one single system, and Hospitals and MCS are able to report directly from this. This has also removed the need to use two separate systems for multi-source feedback as this can also be done via the SARD system. Medical Directors and other clinical managerial staff are able to view and report on the staff within their hierarchy level and monitor appraisal progress directly. The system can be developed individually for each user organisation allowing MFT to tailor the system to specific requirements; this will provide a bespoke appraisal portfolio for each clinician according to their role and specialty, so that only the relevant information is requested to be submitted.

8. Appraisers

The Trust has a responsibility to support appraisers in the maintenance and development of their skills, to assure the quality of medical appraisals, and to ensure the appropriate resources are available to support this. Those who undertake medical appraisals for the Trust must be adequately trained in this role. Refresher training should be undertaken every 1-3 years and a number of refresher sessions for existing appraisers and training for new appraisers have been held across both sites. These have been facilitated to date by the Group AMDs.

9. Quality assurance

The need for a robust Quality Assurance (QA) process for appraisal as part of the Medical Revalidation process is self-evident, but also explicitly expected by both NHS England, as the Senior Responsible Owner of the revalidation process, and the GMC. A need to review both the appraisers and the appraisal outputs is necessary to ensure a consistent, effective and beneficial appraisal system, benefiting both the doctor's development and the Trust assurance processes.

Appraisers are responsible for ensuring the quality of the appraisal outputs for the appraisals they undertake. They must ensure that both the appraisal summary and the Personal Development Plan (PDP) adhere to the required standards. Feedback is requested from doctors following an appraisal; this information is collated and used to assist appraisers with their development and given an indication of how the process is progressing.

An appraisal quality tool ASPAT (Appraisal Summary and PDP Audit Tool) developed by NHS England is being incorporated within SARD so that a randomised sample of appraisals can be audited to ensure the quality of the appraisal process.

The Trust is required to provide information to NHS England under their Framework of Quality Assurance. This includes quarterly reports on appraisal rates, confirmation of a report on appraisal and revalidation going to the Trust Board, a Statement of Compliance signed by the Chief Executive and an end of year Annual Organisation Audit (AOA) which covers appraisals, monitoring performance and responding to concerns, and recruitment and engagement.

10. Summary and future challenges

The appraisal rate of doctors across the Trust has been improved since the merger, despite the challenges of harmonising two systems and processes, and the number of unapproved appraisals has also decreased; however, work is still required to ensure that this progress continues with the new appraisal system. Work is on-going to ensure clinical fellows and doctors transferring from abroad in particular, many of whom have fixed term contracts, are not overlooked and are fully supported and engaged with the appraisal process; the roll out of appraiser allocation by Hospital sites will help to further achieve this.

Another initiative at MFT has been the appointment of a Deputy Group Director of Postgraduate Medical Education to support non-Consultant, non-training grade doctors with their professional development, including all elements of their practice that are annually appraised. The timely strengthened medical appraisal of these doctors has been recognised as an issue nationally, and work is being carried out by NHS England to support designated bodies in increasing the appraisal rate of short term contract holders, sometimes described as “agile doctors”.

Further work is required to ensure that the processes for all doctors in the Trust are aligned and consistently applied. This will require support and action from all the Hospitals/MCS Medical Directors and Appraisal Leads, and will be assisted by the new Appraisal and Revalidation Group due to meet monthly from October 2019 with clinical and managerial representatives from each Hospital / MCS in addition to the Group revalidation team.

11. Recommendation

The Board is asked to receive this update as part of the Annual Board Report on the implementation of Medical Revalidation, and, approve submission of an Annual Statement of Compliance to the Higher Level Responsible Officer, NHS England (North); signed on behalf of the designated body by the Group Chief Executive Officer.

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance

NHS England and NHS Improvement

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance

Publishing approval number: **000515**

Version number: 3.0

First published: 4 April 2014

Updated: February 2019

Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Lynda Norton on England.revalidation-pmo@nhs.net

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes bellows:

- **Annual Organisational Audit (AOA):**

  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. These were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

  The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basis compliance but continued improvement over time. Completion of the template will therefore:

  a) help the designated body in its pursuit of quality improvement,

  b) provide the necessary assurance to the higher-level responsible officer, and

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/media/documents/governance-handbook-2018_pdf-76395284.pdf]

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

  The Statement of Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The Board of Manchester University NHS Foundation Trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission: 28/05/19 Action from last year: None Comments: Action for next year: Maintain compliance with submission of AOA

2. An appropriate trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: None Comments: Miss Toli Onon (3442971) Action for next year: None

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Action from last year: None Comments: Action for next year: None

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: None Comments: Action for next year: Maintain accurate record

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: None Comments: Policy last ratified November 2018; due for renewal by November 2021 Action for next year: None

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: None

Comments: No peer review has taken place since the merger and creation of MFT; CMFT previously had a Higher Level RO Quality Review visit in February 2017

Action for next year: Liaise with similarly-large, multi-site organisation to arrange peer reviews

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: None

Comments: Miss Rowena Umaar has been appointed to the role of Deputy Group Director of Postgraduate Medical Education to support continuing professional development of fixed term (including locum) doctors, and liaise with Group AMDs and appraisal leads

Action for next year: Monitor appraisal rates & revalidation recommendations of fixed term doctors

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: None

Comments: 93.7% of connected doctors had an appraisal within year, with unapproved missed appraisal rate of just 1.37%

Action for next year: Maintain appraisal performance whilst improving quality

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year:

Comments: Of the 6.3% of doctors that did not have an appraisal, 4.9% had an approved reason and 1.4% did not. Those who were unapproved were written to formally for an explanation as to why the appraisal was missed and an agreed action plan for completion put in place

Action for next year: Ensure appraisal deferment request forms are consistently completed and submitted for any missed appraisal to understand the reason for this and allow a Trust-wide audit of this to occur

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: None

Comments: Policy last ratified November 2018; due for renewal by November 2021

Action for next year: None

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:

Comments: Current ratio is approximately 1 appraiser for every 4 doctors

Action for next year: Refresh appraiser list to remove any appraisers not conducting a minimum of 4 appraisals per year. Provide further training sessions to maintain the number of trained appraisers

5. Medical appraisers participate in ongoing performance review and training/development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: None

Comments: Appraisers should receive refresher training every 1-3 years. Feedback is obtained electronically after each appraisal from the appraisee, and summarised for the appraiser

Action for next year: Ensure appraiser training is appropriately delegated to Hospitals/MCS appraisal leads and continued effectively, with support of Group AMDs

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: None

Comments: Appraisees must complete an appraiser feedback form after their appraisal. Appraisal outputs were audited using the ASPAT tool and this is being incorporated into the new appraisal software so that this can be done online. Appraiser refresher training is held at regular intervals to ensure the quality of the appraisal process. An annual report on medical appraisal and revalidation is sent to the Board of Directors including a section on quality assurance

Action for next year: Ensure ASPAT is incorporated into MFT's Revalidation Management System (SARD)

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: None

Comments: Of the 402 recommendations made last year, 399 were on time. Of the three late submissions, one was for a doctor who connected after their revalidation date. The other two were late by one day

Action for next year: Ensure all recommendations are made on time

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: None

Comments: Confirmation letters are sent to all doctors who have a positive revalidation recommendation submitted. Those whose recommendation is deferred are contacted prior to this, to check for any ~~of~~ the outstanding information (if applicable), and doctors are notified of the intention to defer. Those who might have a non-engagement recommendation submitted will have had multiple communications from a Group Associate Medical Director explaining the consequences of non-engagement and the actions they need to complete to avoid this (no "non-engagers" were identified in 2018/19)

Action for next year: None

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: None

Comments: MFT has good governance systems in place, confirmed by CQC full inspection report March 2019

Action for next year: None

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: None

Comments: There is a strong reporting culture with feedback to staff. Sharing of relevant information with doctors can be improved.

Action for next year: Liaise with IT system supplier for SARD to develop e-link to Ulysses (incident reporting system) to facilitate transfer of information for doctors' appraisals.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: None

Comments: Policy for managing concerns about doctors ratified December 2018

Action for next year: None

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].

Action from last year: None

Comments: The Trust has procured a case management system Empactis which will consistently record such information and provide analysis about protected characteristics (such data is currently processed manually). Information about doctors excluded is reported to the board, with designated board members monitoring any exclusion until lifted.
QA of consistency in case management is handled through quarterly Medical Professional Matters Oversight Group (MPMOG)

Action for next year: Embed Empactis case management system
Report on MPMOG activity to workforce committee

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].

Action from last year: None

Comments: Transfer of information process within NHS is managed by appraisal administrator & professional standards manager. Sharing of information with 2 main private providers in locality is managed by RO & Group AMDs for professional matters.

Action for next year: Describe standard operating procedure for transfer of information that covers all doctors in NHS/private sector/academia

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: None

[4] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.
[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Comments: All members of MPMOG have undergone Equality Diversity & Inclusion mandatory training.

Action for next year: Monitor & report on management of doctors of concern, including protected characteristics

Section 5 – Employment checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: None

Comments:

Action for next year: None

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- General review of last year's actions
- Actions still outstanding: None
- Current issues
- New actions:
  - Consider similar sized Trusts to undergo a peer review with
  - Ensure appraisal deferment request forms are consistently completed and submitted for any missed appraisal to understand the reason for this and allow a Trust-wide audit of this to occur
  - Refresh appraiser list to remove any appraisers not conducting appraisals. Provide further training sessions to maintain the number of trained appraisers
  - Ensure appraiser training is appropriately delegated to Hospitals/MCS and continued effectively
  - Ensure ASPAT is incorporated into MFT's Revalidation Management System (SARD)
  - Ensure all recommendations are made on time

Overall conclusion:

The appraisal rate of doctors across the Trust has been maintained since the merger, and the number of unapproved appraisals has also decreased; however, work is still required to ensure that this progress continues with the new appraisal system. Work is still required to ensure clinical fellows and doctors transferring from abroad are not overlooked and are fully engaged and supported with the appraisal process; the roll out of appraiser allocation by Hospital sites will help to further achieve this.

Further work is required to ensure that the processes for all doctors in the Trust are aligned and consistently applied. This will require support and action from all the Hospital/MCS Medical Directors and Appraisal Leads, and will be assisted by the new Appraisal and Revalidation group, due to meet monthly from October with clinical and managerial representatives from each Hospital/MCS in addition to the Group Revalidation team

Section 7 – Statement of Compliance:

The Board of Manchester University NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body
[Chief Executive or Chairman (or executive if no board exists)]

Official name of designated body: Manchester University NHS Foundation Trust

Name: Sir Mike Deegan Signed:

Role: Group Chief Executive

Date:

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Peter Blythin, Group Executive Director of Workforce and Corporate Business.
Paper prepared by:	Mags Bradbury, Associate Director Wellbeing, Inclusion and Communities. Jane Abdulla, Assistant Director Equality and Diversity.
Date of paper:	9th September 2019
Subject:	**MFT Equality, Diversity and Inclusion Strategy 2019-2023**
Purpose of Report:	Indicate which by ✓ • Information to Note • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration of Risk against Key Priorities:	The MFT Equality, Diversity and Inclusion Strategy 2019-2023 (the Strategy) will meet the Trust's legal obligations under the Equality Act 2010 Public Sector Equality Duty to prepare and publish four yearly equality objectives. The Strategy sets out the Trust's ambition to be the best place for patient quality and experience, and for our diverse population to work.
Recommendations:	The Board of Directors is invited to consider and approve the Strategy for publication.
Contact:	Name: Mags Bradbury, Associate Director Wellbeing, Inclusion and Communities Tel: 0161 225 1464

1. Introduction

1.1. MFT is committed to ensuring that inclusion is embedded into how it operates and behaves. Creating an inclusive environment delivers the Trust's ambition to be the best place for patient quality and experience, and for our diverse population to work. The Trust is required to prepare and publish four yearly equality objectives, under the Equality Act 2010 Public Sector Equality Duty, and this Strategy meets that duty.

1.2. The Strategy has the support and approval of the Group Equality, Diversity and Human Rights Committee, the Group Quality and Safety Committee, the Executive Directors Team and General Management Board.

1.3. This paper sets out:

- The Trust's equality, diversity and inclusion ambitions.
- How the aims and objectives have been developed.
- Plans for disseminating and implementing.

2. Purpose.

2.1. The Board of Directors is invited to consider and approve the Strategy for publication.

3. The Trust's Equality, Diversity and Inclusion Ambitions.

3.1. The Trust serves what is called a, 'super diverse' population.

- One in five of the population has a disability or long-term condition.
- There are over 190 languages spoken in Manchester.
- One in three of the population of Manchester and one in seven of the population of Trafford are from a black and minority ethnic background.
- Manchester has one of the largest lesbian, gay, bi-sexual and transgender communities in the country estimated at between 6% to 8% of the population.
- Christianity remains the largest religion though the proportion has fallen from 62.4% to 48.7% between 2001 and 2011 whilst the percentage of people with no religious affiliation increased from 16% to 25.4%, and the percentage of Muslims increased from 9.1% to 15.8%. Manchester also has the largest Jewish population in Britain outside of London.

3.2. However, sections of the population experience differences in health and work outcomes. This Strategy aims to not only support a healthier population by ensuring equality of access to healthcare treatment and quality, but to ensure that the Trust is promoting inclusivity and recognising the power of diversity.

3.3. The equality, diversity and inclusion ambitions set out in the Strategy align to the Trust's vision, "to improve the health and quality of life of our diverse population."

4. How the aims and objectives have been developed.

4.1. Five key principles have guided the development of the Strategy as follows:

- **Be patient centric** – designed around patients, their families, carers and service users and reducing unwarranted variation in care and experience.

- **Be an employer of choice** - that recruits and develops staff fairly, taking appropriate action whenever ever necessary so that talented people choose to join, remain and develop within the Trust.

- **Be evidence based** – use internal data and external population and benchmark data to decide priorities and in actions.

- **Be mainstreamed** – build the capacity and capability of the over 20,000 colleagues working at the Trust to deliver the Strategy and embed the strategic objectives into Trust culture so that it is self-perpetuating.

- **Be integrated** – that the Strategy be the Trust's response to its equality and diversity legal duties, national standards and contractual obligations. To that end the aims and objectives have been structured around the Equality Delivery System domains.

4.2. In line with the principles, a community workshop was held to consult on the Strategy. The workshop was attended by patients and organisations of, and for, the protected characteristics. The Trust's Youth Forum engaged well along with staff from the Hospitals and Managed Clinical Services. A separate consultation session was also held with the Trust's Disabled Patients' User Forum (DPUF). A summary of the priorities identified at the community workshop and by DPUF are as follows:

- Patient Communication needs
- Patient Information needs
- Processes
- Staff awareness
- Estates and facilities
- Generic communications

4.3. These priorities are principally to do with the Accessible Information Standard, wayfinding and staff learning and development, all of which are written into the aims and objectives of the Strategy.

4.4. A workshop was also held, attended by the Trust's Human Resources community, staff diversity networks and staff side, to consult on workforce priorities. The outcomes of the workshop were shared in MFT iNews and through the Trust's Equality and Diversity Coordinators, Human Resources community, staff diversity networks and staff side.

4.5. Hospitals / Manged Clinical Services, Corporate Services and Senior Leadership Teams have also been consulted on the Strategy as well as a range of cross Trust groups.

4.6. Data on population demographics, the Trust's performance on equality and diversity as well as benchmarks with other Trusts have been used to design the Strategy.

4.7. Essentially the Strategy is a framework for action developed through detailed engagement with a wide range of opinion formers. It contains detail about rationale, legislative context, population and health inequalities data. In this way staff can understand why there is a need for the Strategy and understand their respective roles in delivering it.

5. Equality Impact Assessment

5.1. An equality impact assessment (EQIA) on the Strategy has been completed. The EQIA number is 74/19. The EQIA records the consultation that has been carried out, the data that has been analysed and the legislative, statutory and contractual requirements.

6. Dissemination and Implementation

6.1. The Strategy will be produced in two formats: a full version as presented to the Board of Directors and a summary plan on a page. Subject to approval by the Board of Directors, the Strategy will be formally launched on 25th September 2019.

6.2. In anticipation of approval a communications plan has been developed and endorsed by the Group Equality, Diversity and Human Rights Committee. The Committee, chaired by the Group Chief Finance Officer, will progress and monitor delivery of the plan.

6.3. The intention is that Hospitals / Managed Clinical Services, Community and Corporate Services include objectives to deliver the Strategy within their annual business plans. A management tool is being developed to help with this and support will be provided by the Equality and Diversity Team and Equality and Diversity Co-ordinators.

6.4. Some of the actions in the Strategy are already in progress. For example, the work on the Accessible Information Standard has a Trust project plan along with individual Hospital/ Managed Clinical Service and Corporate Service action plans. Some actions in the Strategy, such as roll out of a full-service equality monitoring, will commence in 2020.

7. Next steps

7.1. Hospitals / Managed Clinical Services, Community and Corporate Services will build objectives into their business plans in the next round of business planning. The Strategy aims and objectives will also be embedded into Trust wide strategies and initiatives such as the,' All Here for You', attraction and recruitment campaign.

7.2. Communications on the Strategy will begin once the Strategy is approved.

7.3. An equality, diversity and inclusion learning and development needs assessment has been undertaken by over 1,200 staff across the Trust and a plan will be developed to build capability and capacity to deliver the Strategy. The needs assessment was developed with the help of the Alliance Business School, University of Manchester.

8. Recommendation

The Board of Directors is asked to;

(i) Note the inclusive work undertaken to develop the Strategy and the subsequent scrutiny applied by the groups cited in section 1.2.

(ii) Consider and approve the Strategy for publication.

NHS
Manchester University
NHS Foundation Trust

Diversity Matters

Manchester University NHS Foundation Trust's Equality, Diversity, Inclusion Strategy 2019-2023

Manchester University NHS Foundation Trust (MFT) would like to thank all patients, community partners and colleagues for their help in developing this Strategy. We received great feedback about what we were doing well, what we need to continue with or do more of and where we need to change or improve and how we might do that. Wherever possible we have built your views and ideas into the Strategy. We appreciate the time given and the contributions made.

Should you have an enquiry about the Strategy please contact **equality@mft.nhs.uk**

Contents


DRAFT

Section 1: About Manchester University NHS Foundation Trust

Manchester University NHS Foundation Trust (the Trust) was established on 1st October 2017 following the merger of Central Manchester University Hospitals NHS Foundation Trust (CMFT) and University Hospital of South Manchester NHS Foundation Trust (UHSM) to become one of the largest Foundation Trusts in England.

The Trust is responsible for running nine hospitals, across six separate sites. The Trust also hosts the Manchester Local Care Organisation (MLCO) that brings together NHS community health and mental health services, primary and social care services in the city. The Trust provides a wide range of services from comprehensive local general hospital care, through to highly specialised regional and national services and community services.

The Trust's hospitals incorporate the following:

Manchester Royal Infirmary

Saint Mary's Hospital

Royal Manchester Children's Hospital

Manchester Royal Eye Hospital

University Dental Hospital of Manchester

Wythenshawe Hospital

Trafford General Hospital

Withington Community Hosptial

Altrincham Hospital


DRAFT

Section 2: Foreword

We are delighted to introduce Manchester University NHS Foundation Trust's Equality, Diversity and Inclusion Strategy (2019-2023). The Strategy sets out our ambition to be the best place for patient quality and experience and the best place to work. It provides a framework for action focussing on three, interrelated aims which are:

- Improved patient access, safety and experience.
- A representative and supported workforce.
- Inclusive leadership.

We believe that the only way to consistently provide the highest possible level of care is through being truly inclusive, creating the right conditions for staff to flourish and for patients to receive the services that they need, in the way that they need them and in the right environment based on their individual needs.

We are proud of the progress made over the last four years, examples of which include:

- Provision of almost four and a half thousand in-person interpretations on average each year.
- All patient areas have undergone an access audit and access guides are available on the Trust's website.
- Onsite multi-faith centre and prayer room.
- Post-operative therapy services for gender reassignment patients.
- Working with carers as part of John's Campaign.
- Disability Confident Employer.
- The Trust won a partnership award with the Greater Manchester Caribbean and African Health Network.

The Trust recognises however that there is more that needs to be done. Whilst Board and senior manager leadership is key, it is leadership at all levels that will really achieve the aims. The Trust is therefore asking all staff to adopt and embrace the Strategy within their individual roles and workplace.

Achieving the aims and objectives set out in this Strategy will also require joint working with communities and partners. On this basis we look forward to continuing to build on the positive working relationships with our community and statutory sector partners.

Thank you to everyone who has helped to prepare this Strategy and set out our ambition to be a leader in equality, diversity and inclusion.

Signatories

Section 3: Executive Summary

Equality, diversity and inclusion are key to achieving the Trust's vision of, "excelling in quality, safety, patient experience, research, innovation and teaching; dedicated to improving health and well-being for our diverse population."

The Trust's ambition is to be regarded as the best place for patient safety, quality and experience and the best place to work.

The Trust is committed to the elimination of discrimination, to reducing health inequalities, promoting equality of opportunity and dignity and respect for all our patients, their families, carers and staff.

This Equality, Diversity and Inclusion Strategy 2019-2023 will focus on three aims:

- Improved patient access, safety and experience.
- A representative and supported workforce.
- Inclusive Leadership.

The following pages, outline the Trust's equality and diversity objectives to deliver our aims.

Patients

Aim: Improved patient access, safety and experience.

Objectives:

- Understand the potential impacts of the decisions we make on patients, their families, carers and service users, by protected characteristics, and identify mitigating steps to reduce or remove adverse impacts.
- Identify any unwarranted variations in access, safety and experience of the Trust's services and develop plans to address these.
- Meet the information and communication needs of patients, their families, carers and service users with a disability, impairment or sensory loss by completing the implementation of the Accessible Information Standard (AIS).
- Ensure that people with learning disabilities, autism or both receive treatment, care and support which is safe and personalised and have the same access to services.
- Be the first Trust in the country to deliver Pride in Practice accreditation in partnership with the LGBT Foundation to better meet the needs to LGBT patients, their families, carers and service users and set the standard for the NHS hospital sector.
- Work with patients, their families, carers and service users to shape wayfinding and signage to make it easier to find their way journeying to and from hospitals and between hospitals and community services.

Staff

Aim: A representative and supported workforce.

Objectives:

- Understand the potential impacts of the decisions we make on staff, by protected characteristics, and identify mitigating steps to reduce or remove adverse impacts.
- Identify unwarranted variations in representation and experience that need to be improved and that resulting actions are identified and achieved.
- Take a zero tolerance approach to bullying, abuse and harassment in order to ensure that all staff feel safe at work.
- Deliver Disability Confident employer, recruiting, retaining and developing disabled staff.
- Harness the talents of all communities to provide high quality patient care, increased patient satisfaction and better patient safety particularly the ethnic diversity at Board and senior management levels.

Leadership

Aim: Inclusive Leadership

Objectives:

- Board members and senior leaders champion equality and diversity and apply a consistently inclusive approach.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Section 4: The Development Process

The Strategy has been developed in consultation with patients and community organisations of and for the protected characteristics, staff, Boards and Committees.

The Strategy seeks to answer the following three questions:

1. Where are we now?
2. Where do we want to be?
3. How will we get there?

The Strategy focuses on the long term vision for equality, diversity and inclusion, while also highlighting our immediate short-term strategic priorities.

Design Process

Five key principles have guided the development of the Strategy as follows:

1. Be patient centric.
2. Be an employer of choice.
3. Be evidence based.
4. Be mainstreamed.
5. Be integrated, ambitious and realistic.

The Strategy has also been created to meet the Trust's legal requirements, NHS standards and contractual obligations on equality and diversity.

What Equality, Diversity and Inclusion mean to us

The Trust thought it was important to have a shared understanding of what equality, diversity and inclusion mean in order to develop this Strategy. This is what patients, community partners and staff said the terms mean to them. (see page opposite)

EQUALITY

Treating people according to their needs.

DIVERSITY

People's abilities, beliefs, cultures, experiences, lifestyles, ideas and views are respected and are allowed to be heard.

INCLUSION

Taking an approach where we consider people, their diversity, their experiences, their preferences and their abilities. It is about healthcare that understands and meets people's diverse needs and where staff can be themselves and feel that they can contribute their views, which are valued, and are able to perform to their full potential.


DRAFT

Section 5: Strategy Context

There are a number of legal requirements, national standards and contractual obligations that the Trust must meet to eliminate discrimination, and advance equality and cohesion. The table below summaries these requirements and what they mean for the Trust.

Annex 1 provides more detail about the requirements.

What does the strategic context mean for our equality, diversity and inclusion Strategy?

STRATEGIC CONTEXT	WHAT IT MEANS FOR OUR EQUALITY, DIVERSITY AND INCLUSION STRATEGY
Human Rights Act 1998	Protecting human rights in clinical and organisational practice by adherence to the underlying core values of fairness, respect, equality, dignity and autonomy (FREDA).
	Placing these core values at the heart of policy and planning.
	Empowering staff with knowledge and skills to achieve a human rights-based approach.
	Enabling meaningful involvement and participation of all key stakeholders.
	Non-discrimination and attention to vulnerable groups.

What does the strategic context mean for our equality, diversity and inclusion Strategy?

STRATEGIC CONTEXT	WHAT IT MEANS FOR OUR EQUALITY, DIVERSITY AND INCLUSION STRATEGY
Equality Act 2010	Create a culture based upon positive attitudes towards welcoming the diversity of patients, their families and carers and the staff and meeting diverse needs.
	Ensure the decisions the Trust makes have completed equality impact assessment.
	Ensure that all staff understand their roles and responsibilities under the Trust's service and employment equality policies.
	Develop and roll out a learning and development plan.
	Embedding into daily practice.

What does the strategic context mean for our equality, diversity and inclusion Strategy?

STRATEGIC CONTEXT	WHAT IT MEANS FOR OUR EQUALITY, DIVERSITY AND INCLUSION STRATEGY
Equality Act 2010	Agree the focus for patient access equality monitoring and complete the roll out of service equality monitoring of access, safety and experience.
	Create reports to monitor the application of the Trust's service and employment equality policies using service and staff equality monitoring data.
	Hospitals/Managed Clinical Services/Corporate Services and Manchester Local Care Organisation build objectives and actions into business plans as part of their annual planning cycle to meet the general and specific equality duties under the Act.
	Local, regional and national partnerships with communities and networks.

What does the strategic context mean for our equality, diversity and inclusion Strategy?

STRATEGIC CONTEXT	WHAT IT MEANS FOR OUR EQUALITY, DIVERSITY AND INCLUSION STRATEGY
Accessible Information Standard (AIS)	Ensure that all our staff understand their roles and responsibilities in delivering the AIS.
	Hospitals/Managed Clinical Services, Corporate Services and Manchester Local Care Organisation action plans including embedded the AIS into their relevant Standard Operating Procedures.
	Hospitals/Managed Clinical Services, Corporate Services and Manchester Local Care Organisation use a communication passport to support people with accessible communication and/or information needs.
	Patient Electronic Record (PAS) and Electronic Patient Record (EPR) systems to be compliant with the AIS and bespoke departmental systems have plans in place to be compliant with the AIS.
	PAS letters project to enable the production of patient letters in people's preferred accessible formats.
	Explore how to meet ad hoc British Sign Language interpretation needs.
	Create resources on the learning hub to support delivery.

What does the strategic context mean for our equality, diversity and inclusion Strategy?

STRATEGIC CONTEXT	WHAT IT MEANS FOR OUR EQUALITY, DIVERSITY AND INCLUSION STRATEGY
Gender Pay Gap	Monitor our gender pay gap annually, publish our gender pay gap report by 31 March each year, and take action to address inequalities.
Equality Delivery System (EDS)	Create a culture of continuous improvement on equality, diversity and inclusion.
	Develop an integrated approach to EDS to review and rate equality performance and to set priorities and plans for improvement.
	Build improvement actions into business plans as part of the annual planning cycle.
Sexual Orientation Monitoring Standard (SOM)	Strengthen and develop our relationship with our lesbian, gay, bisexual and trans (LGBT) patients, their families and carers and the understanding and confidence of all our staff to deliver inclusive services to LGBT patients.
	Pilot Pride in Practice for acute hospital and community services and, following review, secure funding to roll out.
	Roll out sexual orientation equality monitoring as part of the roll out of service equality monitoring.

What does the strategic context mean for our equality, diversity and inclusion Strategy?

STRATEGIC CONTEXT	WHAT IT MEANS FOR OUR EQUALITY, DIVERSITY AND INCLUSION STRATEGY
Workforce Race Equality Standard (WRES)	Ensure we are an employer of choice that recruits and develops staff fairly so that talented people choose to join, remain and develop with us.
	Finalise and roll out the Removing the Barriers Programme to create the culture and opportunities to work towards greater ethnic diversity at leadership levels.
	Revise and relaunch a Trust wide approach to reducing the incidents of poor behaviour on patients, their families, carers and the staff.
	Hospital/Managed Clinical Service, Corporate Services and Manchester Local Care Organisation level WRES reports as well as group level and objectives and plans within staff plans.
	Partner in Greater Manchester Workforce Race Equality Charter.

What does the strategic context mean for our equality, diversity and inclusion Strategy?

STRATEGIC CONTEXT	WHAT IT MEANS FOR OUR EQUALITY, DIVERSITY AND INCLUSION STRATEGY
Workforce Disability Equality Standard (WDES)	Ensure we are an employer of choice that recruits and develops staff fairly so that talented people choose to join, remain and develop with us.
	Aim to be a Disability Confident Scheme Leader employer and explore doing that as a system with our health and social care partners in Manchester.
	Hospital/Managed Clinical Service and Corporate Services level WDES reports as well as group level and objectives and plans within staff plans.
	Partner in Manchester Disability Action Plan.
Manchester Health Care Commissioning (MHCC)	In addition to evidencing compliance with the above legislation and standards, our contract with MHCC includes achieving Level 2 of Disability Confident with a supporting action plan to achieve Level 3, an inclusion page on our website, list of inclusion training and list of completed Equality Analysis.


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Section 6: Who We Serve

Within Greater Manchester, and between local authority areas in Greater Manchester there exists significant diversity. This section provides some 'headline' statistics drawn from the Office of National Statistics Census 2011. More detailed information about the population is provided in Annex 2.

The average age of people in Manchester is 33 and in Trafford 39.

1 in 5 of the population has a disability or long term condition.

Manchester has one of the top ten largest populations in the country identifying as lesbian, gay, bi-sexual and transgender; 6% to 8%.

190 languages spoken in Manchester.

83% of people living in Manchester speak English.

94% of people living in Trafford speak English.

The proportion of Christians in Manchester has fallen from 62.4% to 48.7%, while the percentage of people with no religious affiliation increased from 16% to 25.4%.

The percentage of Muslims has increased from 9.1% to 15.8%. Manchester has the largest Jewish population in Britain outside of London.

1 in 3 people are from a black and minority ethnic background in Manchester. 1 in 7 people are from a black and minority ethnic background in Trafford.

71.6% of people living in Manchester were born in England.

85.8% of people living in Trafford were born in England.

50% of people in Manchester are female and 50% are male.

49% of people in Trafford are female and 51% are male.

Health Inequalities

Our health is influenced by a wide range of factors, known as wider determinants of health. Where protected characteristic groups experience differences in these wider determinants of health this can lead to health inequalities. The Trust's response to the Equality Act aims to lead to a healthier population by ensuring that people feel they have equal access to and quality of healthcare treatment.

This section provides some of the 'headline' health inequalities drawn from the NHS Rightcare Equality and Health Inequalities packs for clinical commissioning groups. More detailed information about health inequalities is provided in Annex 3.

The under 75 mortality rate from Cardiovascular Disease (CVD) is almost five times higher in the most deprived compared to the least deprived areas.[1]

People with learning disabilities are 4 times as likely to die of preventable causes.[2]

Suicide is currently the biggest killer of men under 35 in the UK.[3]

South Asians are up to 6 times more likely to develop type 2 diabetes.[4]

African-Caribbean and Asian females over 65 have a higher risk of cervical cancer.[5]

Muslim people report worse health on average compared to other religious groups.[6]

Lesbian and bisexual women are twice as likely to have never had a cervical smear test, compared with women in general.[7]

It is becoming more common for children to develop type two diabetes.[8]

Older people report receiving poorer levels of care than younger people with the same conditions.[9]

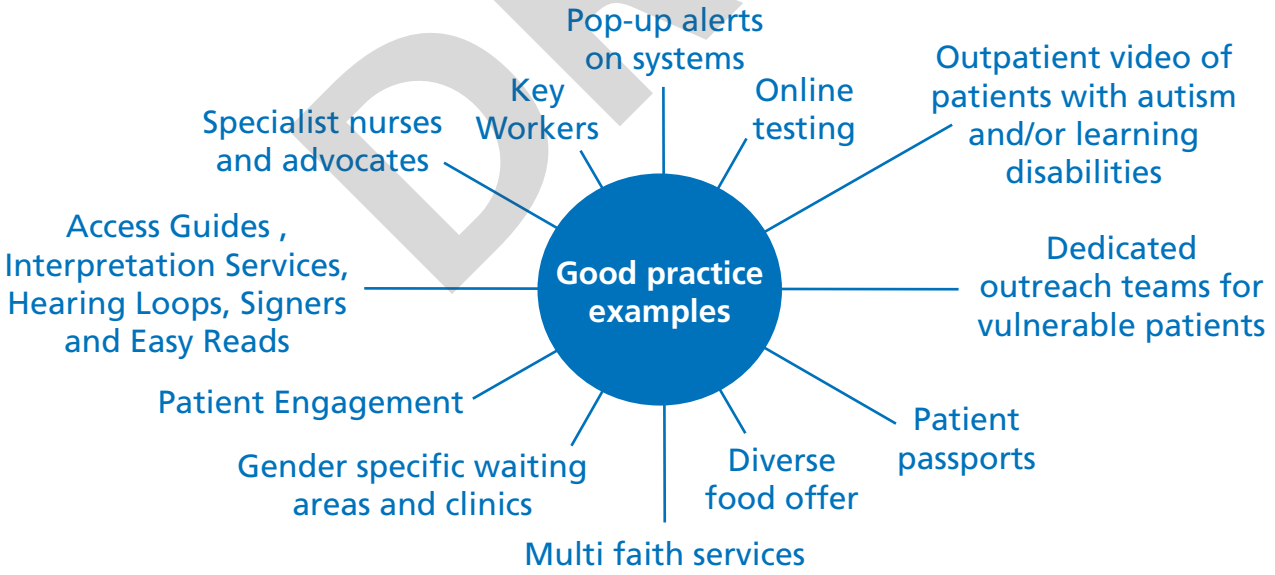
See page 66 for list of sources.

Section 7: Where We Are Now

Patients

The Trust has a long and strong history of providing personalised care that meets the individual needs of our diverse patients and service users. The Trust carries out an annual self-assessment that highlights good practice, some of which is illustrated in the diagram below.

These examples demonstrate that people's individual's health needs are being assessed and met in appropriate and effective ways.



Patients

However, there are gaps in the information the Trust collates about our patients by protected characteristic. The table below sets out a risk assessment of not having that information:

Risk Assessment

RISK	LIKLIHOOD	IMPACT	RISK RATE	MITIGATION
Gaps in the patient information by protected characteristics may result in unidentified differential outcomes for patients.	Moderate: Whilst the Trust endeavours to meet the individual needs of our diverse patients, national studies and patients of the Trust highlight differential outcomes for groups by protected characteristics.	The Trust's clinical safety data evidences that critical incidents are rare. However, the impact when a critical incident occurs can be severe.	9	The Trust will roll out service equality monitoring and reporting as a priority.

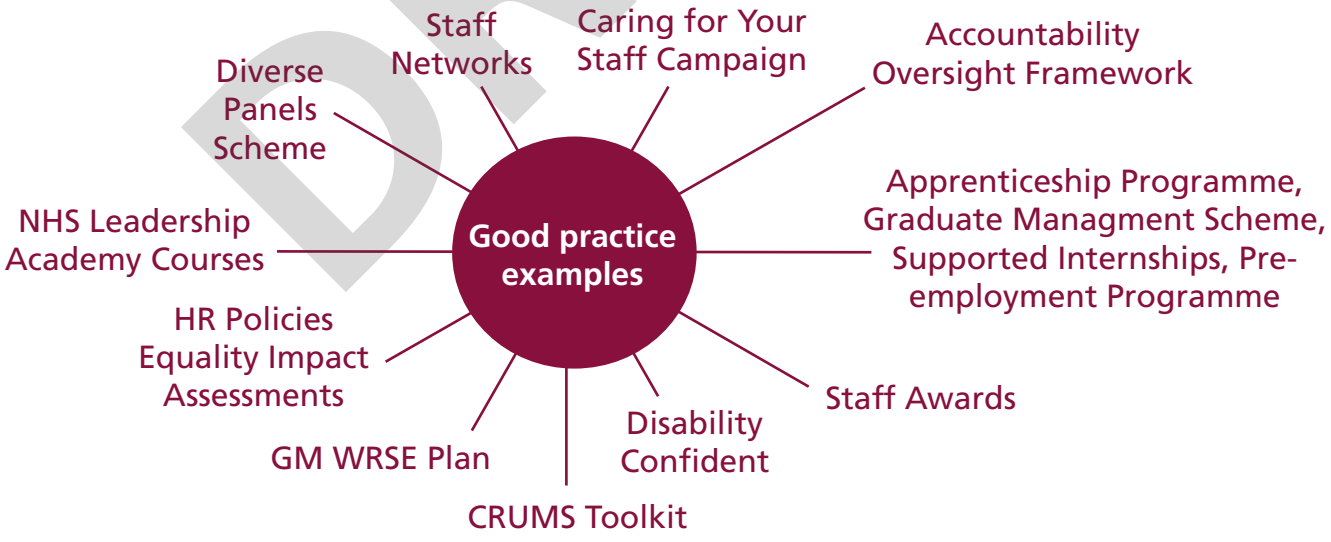
Feedback from Patients and Community Partners

The Trust held a workshop for our community partners of and for the protected characteristics and invited the Trust's Disabled Patients' User Forum and Youth Forum to say what mattered to them for the next four years equality, diversity and inclusion Strategy . The key priorities were as follows.

- Meeting patients' individual communication needs.
- Meeting patients' individual information needs.
- Flexibility of the Trust processes in order to meet patients' individual needs, for example, pre-visit appointments would make some patients feel less anxious.
- Raising staff awareness particularly around, though not restricted to, the social model of disability, religions and beliefs, trans issues and engagement with carers.
- Improving wayfinding and the built environment to make it easier to get around the Trust.
- Improving the Trust's website so that it is more accessible to all.

Staff

The Trust wants to become an employer of choice that recruits and develops staff fairly, taking appropriate positive action wherever necessary, so that talented people choose to join, remain and develop with the Trust. Patients are more likely to receive the services they need if staff are not only competent but drawn representatively from the population served. Our statistics are encouraging. For example, almost 20% of our staff are from black and minority ethnic (BME) backgrounds, in line with the working population of Greater Manchester, and there has been an increase in the percentage of BME staff in the top seven (AfC) pay bands over the last three years apart from Band 8a and Band 8d. Although the percentage of the male staff is disproportionately low, it is more reflective of the percentage of males within the NHS at 23%. The Trust has implemented a number of initiatives aimed at creating a more representative and safe workplace illustrated in the diagram below.

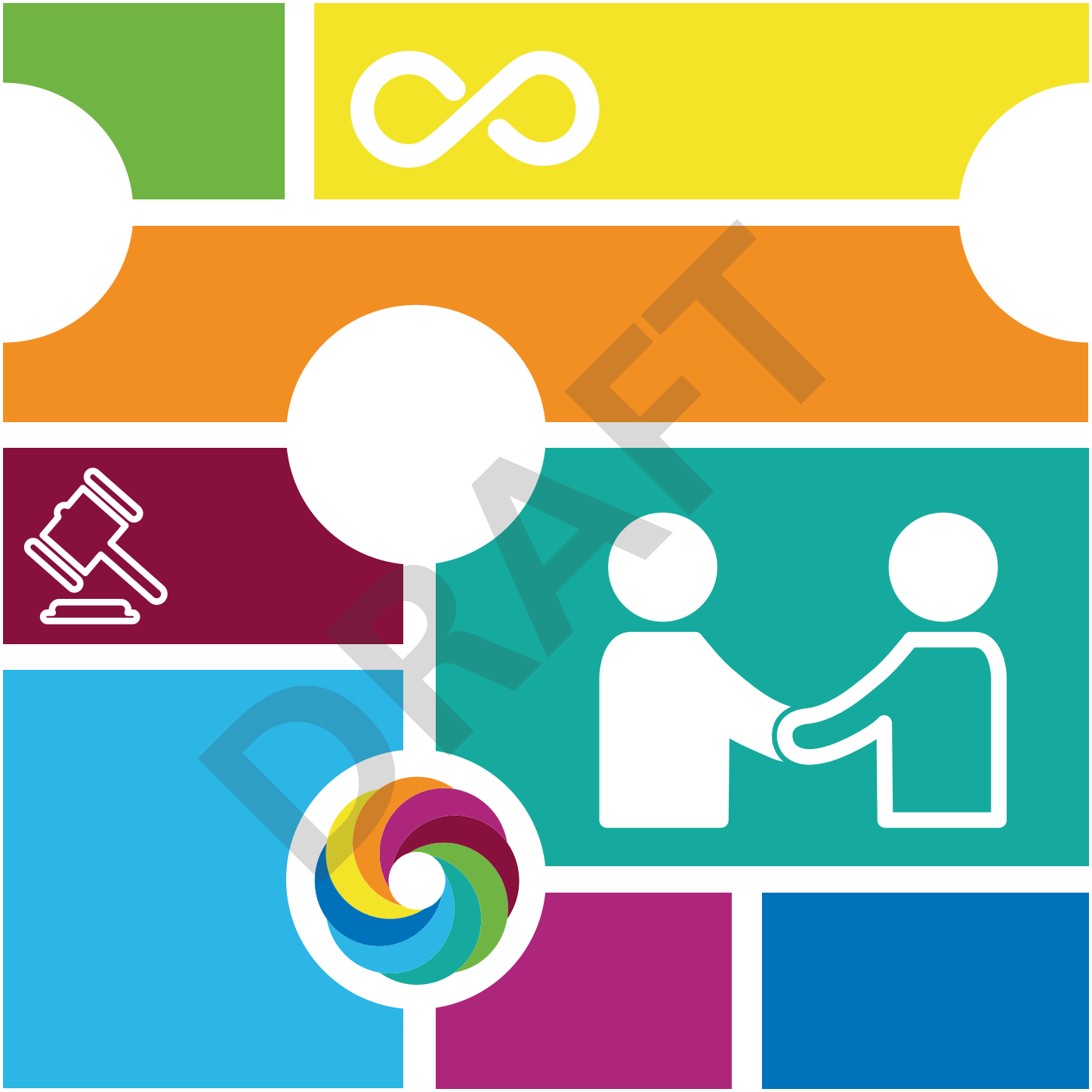


However, there is much to do.

- The Trust, like the rest of the NHS, has an ageing staff profile.
- There are not enough people from BME communities in senior management.
- There are not enough males in the workforce, the percentage of male applicants is low and there is disparity in the outcomes of recruitment by gender.
- Few staff identify as having a disability compared to the working population with a disability and few staff identify their sexual orientation.
- In the Staff Survey 2018, some groups of staff by protected characteristics reported experiencing higher levels of discrimination, harassment and bullying.

Staff, Staff Networks and Staff Side attended a workshop to discuss workforce equality, diversity and inclusion priorities. The outcomes of the workshop were shared for consultation throughout the Trust. The key priorities were as follows.

- Promote the benefits of a diverse staff.
- Attract more diverse applicants.
- Create opportunities for progression.
- Improve representation of diversity at senior levels.
- More support around reasonable adjustment.
- Expand work experience.
- Address poor behaviours.
- Further improve work-life balance and support to part-time staff, overseas staff and staff who are carers.
- Training on equality and diversity and supporting staff to understand the local multicultural context.
- A consistent approach across the Trust.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Section 8: Where We Want To Be

Our vision is, "to improve the health and quality of life of our diverse population."

Our equality, diversity and inclusion ambition is to be regarded as the best place for patient safety, quality and experience and the best place to work.

Equality, diversity and inclusion aims and objectives 2019-2023

PATIENTS

Aims	**Improved patient access, safety and experience.** The Trust will create a culture of care based on positive attitudes towards welcoming the diversity of patients, their families, carers and service users and meeting diverse needs. The Trust will be an organisation that continually improves by embedding inclusion principles and standards into every day practice and placing them at the heart of policy and planning.

Equality, diversity and inclusion aims and objectives 2019-2023

PATIENTS	
Objectives	We will: • Understand the potential impacts of the decisions we make on patients, their families, carers and service users, by protected characteristics, and identify mitigating steps to reduce or remove adverse impacts. • Identify any unwarranted variations in access, safety and experience of the Trust's services and develop plans to address these. • Meet the information and communication needs of patients, their families, carers and service users with a disability, impairment or sensory loss by completing the implementation of the Accessible Information Standard (AIS). • Ensure that people with learning disabilities, autism or both receive treatment, care and support which is safe and personalised and have the same access to services. • Be the first Trust in the country to deliver Pride in Practice accreditation in partnership with the LGBT Foundation to better meet the needs to LGBT patients, their families, carers and service users and set the standard for the NHS hospital sector. • Work with patients, their families, carers and service users to shape wayfinding and signage to make it easier to find their way journeying to and from hospitals and between hospitals and community services.

Equality, diversity and inclusion aims and objectives 2019-2023

PATIENTS

How we will achieve our objectives	• Patient policies, procedures, guidelines, business cases, clinical strategies, service reviews, tenders or other key decisions will be equality impact assessed. • Improve the quality of the protected characteristic data collected starting by establishing a baseline of service equality monitoring focusing on: - Did Not Attend and Cancellations. - Incidents. - Friends and family test, what matters to me local patient surveys and complaints. • Design the Accessible Information Standard (AIS) into all procedures and systems ensuring staff understand their roles and responsibilities in delivering the AIS. • Implement the Learning Disability Improvement Standards for NHS Trusts. • Pride in Practice pilots undertaken and evaluation completed by 2020 and plans are in place to roll out the programme across the Trust. • Have in place a Wayfinding Strategy shaped by engaging with the diverse patients, their families, carers and services users.
The results we are aiming for	• Everyone who needs to can readily access Trust services. • Individual people's health and care needs are met. • When people use Trust services, they are free from harm. • People report positive experiences of Trust services.

Equality, diversity and inclusion aims and objectives 2019-2023

STAFF

Aims	**A representative and supported workforce.** The Trust will be an employer of choice that recruits and develops staff fairly, taking appropriate action whenever necessary, so that talented people choose to join, remain and develop within the Trust. Strong equality, diversity and inclusion at all levels will underpin consistently good patient care across all services.
Objectives	We will: • Understand the potential impacts of the decisions we make on staff, by protected characteristics, and identify mitigating steps to reduce or remove adverse impacts. • Identify unwarranted variations in representation and experience that need to be improved and that resulting actions are identified and achieved. • Take a zero tolerance approach to bullying, abuse and harassment in order to ensure that all staff feel safe at work. • Deliver Disability Confident employer, recruiting, retaining and developing disabled staff. • Harness the talents of all communities to provide high quality patient care, increased patient satisfaction and better patient safety particularly the ethnic diversity at Board and senior management levels.

Equality, diversity and inclusion aims and objectives 2019-2023

STAFF	
How we will achieve our objectives	• Staff policies, procedures, guidelines, reorganisations or other key decisions will be equality impact assessed. • Improve the quality of the staff protected characteristic data collected starting by encouraging staff to update their records. • Revise and Relaunch Trust wide approach to reducing the incident and impact of poor behaviour on patients, their families and carers and staff. • Work towards becoming a Disability Confident Leader and work with health and social care partners to improve the outcomes for people across Greater Manchester. • Implement a Removing the Barriers programme to work towards increasing the representation of black and minority ethnic (BME) staff in (Agenda for Change) 8a-d and 9, VSM and the Board.
The results we are aiming for	• When at work, staff are free from abuse, harassment, bullying and physical violence from any source. • Staff believe the Trust provides equal opportunities for career progression and promotion. • Staff recommend the Trust as a place to work and receive treatment. • Greater diversity in our senior management and leadership structures.

Equality, diversity and inclusion aims and objectives 2019-2023

LEADERSHIP	
Aims	**Inclusive Leadership.** The Trust will be recognised as a vanguard for equality, diversity and inclusion creating organisational and system wide changes to improve equality outcomes for patients their families and carers, service users and staff.
Objectives	• Board members and senior leaders champion equality and diversity and apply a consistently inclusive approach.
How we will achieve our objectives	• Board members and senior leaders routinely talk about and engage their staff on issues of equality, diversity and inclusion and communicate the benefits. • Board members and senior leaders will understand the equality impacts of their decisions and that decisions will advance equality and cohesion rather than adversely affect sections of the population by protected characteristics. • Board members and senior leaders act as champions and change agents for equality, diversity and inclusion positioning the objectives at the heart of their local delivery plans. • Board members and senior leaders are mentors as part of positive action programmes.

Equality, diversity and inclusion aims and objectives 2019-2023

LEADERSHIP

How we will achieve our objectives	• Governance for equality, diversity and inclusion in place for Hospitals/ Managed Clinical Services, Corporate Services and Manchester Local Care Organisation. • Equality, diversity and inclusion objectives will be integrated into business plans. • Inclusive leadership competencies are integrated into the Trust's Leadership Competency Framework and used in recruitment and appraisal. • 'Inclusive Leadership' training is rolled out at Board level. • Unconscious bias recruitment training is rolled out.
The results we are aiming for	• Board members and senior leaders routinely demonstrate their commitment to equality, diversity and inclusion. • Board and Committee papers will identify equality-related impacts and how they are mitigated or managed.


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Section 9: How We Will Get There

Delivery – Four Year Roadmap

In order to deliver the Trust's equality, diversity and inclusion ambition, aims and objectives, a high level road map has been developed for the next four years. The road map is intended to identify the implications of the Strategy for the Trust's hospital and managed clinical services.

Roadmap

PATIENTS		
2019-2021	**2021-2022**	**2022-2023**
Put in place infrastructure for service equality monitoring and roll out monitoring in Outpatients.	Roll out service equality monitoring in Elective.	Roll out service equality monitoring in Elective and Emergency.
Accessible Information Standard codes into PAS system. Procure supplier of Accessible Information. Pilot Communications Passport. Staff training and implementation of action plans.	Audit the implementation of the Accessible Implement Standard and improvement plans.	Integrate into the HIVE and standardise provision continues across all services.
Trust wide plans against the NHS Learning Disability Improvement Standards.	Group wide and individual plans in place based on self-assessment.	Improvement action progressed and evaluated.
Implement new accessible spine and updated maps at Oxford Road Campus.	Align patient communication with new accessible spine.	Review feedback from accessible spine and identify opportunities to roll-out to other sites.
Pride in Practice pilots completed and evaluated, and model accredited.	Pride in Pride roll out in Outpatients.	Pride in Practice roll out in Elective and Emergency.

Roadmap

WORKFORCE

2019-2021	2021-2022	2022-2023
ESR campaign to increase self-reporting of protected characteristics.	Evaluate impact of the campaign whether further action needed.	Evaluate impact of the campaign whether further action needed.
Revise and Relaunch a Trust wide approach to reducing the incident and impact of poor behaviour on patients and staff.	Design and pilot culture audit to understand how culture and values impact workplace behaviours.	Roll out cultural audits to facilitate cultural change.
Put in place infrastructure for Removing the Barriers programme and pilot.	Roll out of Removing the barriers programme.	Evaluate the Removing the Barriers programme.
Hospitals, managed clinical services, corporate and community services Workforce Race Equality Standard action plans.	Evaluation of impact of actions and learning used to spread good practice.	Link across locally, regionally and nationally to learn from and adopt good practice and work collaboratively.
	Disability Scheme Level 3 audit and improvement plans.	Disability Scheme Level 3 audit and improvement plan.
Staff networks integrated across sites for single hospital service BME and LGBT networks and establish disability network.	Staff networks integrated across sites for single hospital service BME and LGBT networks and establish disability network.	Evaluate impact of networks and review current models in light of evaluation and learning from outside the Trust.

Roadmap

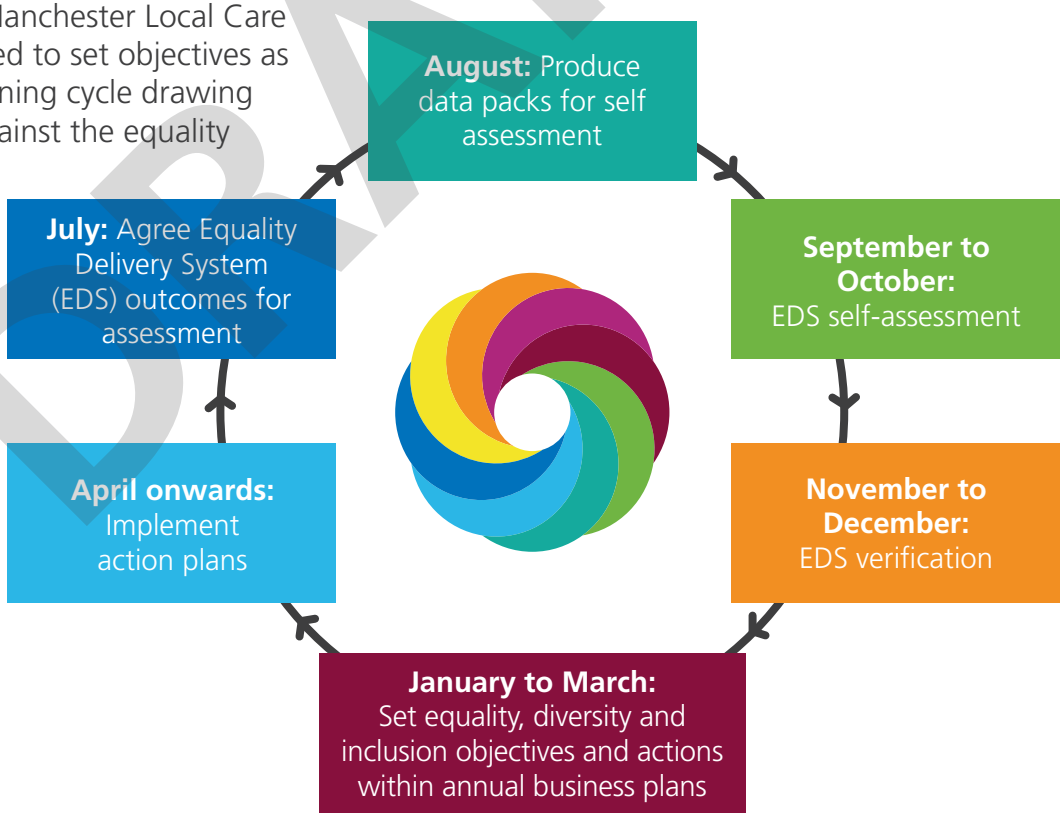
LEADERSHIP

2019-2021	2021-2022	2022-2023
Pilot Inclusive Leadership training and roll out to Boards and Very Senior Managers.	Inclusive Leadership training rolled out to bands 8 to 9.	Inclusive Leadership training rolled out to ands 5, 6 and 7.
Include an inclusion standard within our performance and capability frameworks.	Integrate inclusion standard career pathways, selection and performance management.	Integrate inclusion standard career pathways, selection and performance management.
Embed single hospital service approach to equality impact assessment across the Trust.	Embed equality impact assessment into hospital, managed clinical service, community and corporate services governance. ion standard career pathways, selection and performance management.	Build equality impact assessment into performance report.
Embed equality and diversity objectives into all business plans.	Embed equality and diversity objectives into all business plans.	Embed equality and diversity objectives into all business plans.

Planning and Reviewing

The Strategy provides a leadership framework for describing our ambitions and priorities. It is important that patients, the public, staff and volunteers feel a sense of reality and connection with what the Trust is striving to achieve.

Each Hospital/Managed Clinical Service, Corporate Service and Manchester Local Care Organisation will be asked to set objectives as part of their annual planning cycle drawing on their performance against the equality delivery system. It is suggested that objectives are agreed and monitored by their Equality, Diversity and Human Rights Groups. Patient access and experience and staff data will be available annually to inform the planning process as set out below.



Roles and Responsibilities

Boards and Senior Leadership Teams will:

- Ensure that equality, diversity and inclusion are at the heart of the organisation and everything it does.
- Ensure that everyone in their hospital/ managed clinical service and corporate services understands what the Strategy means for them and communicate the of benefits of equality, diversity and inclusion.
- Act as agents for change by positioning equality, diversity and inclusion at the heart of their local delivery plans.
- Ensure assessment of the impact of policies and practices upon those with protected characteristics, and act accordingly upon the results.

Managers will:

- Communicate the benefits of equality, diversity and inclusion and ensure that all staff for which they are responsible are made aware of their responsibilities under, and have access to Trust equality policies.
- Ensure that they lead by example, demonstrating behaviours conducive to a culture which promotes equality, diversity and inclusion.
- Ensure the application of agreed Trust initiatives
- Ensure that they are fully aware of and comply with their responsibilities under the Equality Act 2010, national standards and Trust equality policies and procedure.
- Ensure the application of reasonable adjustments for applicants, staff, patients and service users.
- Ensure that they participate in training provided on equality, diversity and inclusion including inclusive leadership and that they ensure that all staff for whom they are responsible similarly participates in training.

Roles and Responsibilities

Staff will:

All staff have a responsibility within the Strategy for ensuring we achieve our aims and objectives of making the Trust the best place for patient safety, quality and experience and the best place to work.
To do this staff will:

- Ensure that they are aware of their responsibilities under the Trust's equality policies, and that they seek further guidance if unclear.
- Comply with such responsibilities, including demonstrating behaviours conducive to a culture which promotes equality, diversity and inclusion.
- Raise concerns with the appropriate manager, where they perceive others not to be demonstrating such behaviours or otherwise not complying with their responsibilities under the local policy.
- Take responsibility for ensuring that they participate in training provided.

The Group Equality and Diversity Team will:

- Build the capacity and capability of the Trust to deliver its strategic equality, diversity and inclusion objectives.
- Provide managers with advice and support on implementation of the Strategy.
- Provide information, metrics, tools and resources to enable our managers and leaders (within clinical service units and groups function) to feel informed and skilled in supporting and promoting equality, diversity and inclusion.
- Develop training on the Strategy.
- Identify, share and celebrate good practice.
- Provide assurance to the Trust on progress against its strategic equality, diversity and inclusion objectives.

How We Will Measure and Oversee Progress

The Strategy will be underpinned by a reporting framework. The delivery of the Strategy will be overseen by the Group Equality, Diversity and Human Rights Committee. The Committee is responsible for recommending the strategic direction to the MFT Group Board and for championing and monitoring its delivery. This Committee has a membership of hospitals', managed clinical services' and corporate services' leads, staff network representatives and staff side representatives. The Group will review progress against the strategic equality, diversity and inclusion objectives. We will also report on progress as part of the Trust's Annual Report.

Each hospital, managed clinical services and corporate services has an equality, diversity and human rights group, which meets quarterly. They will ensure that equality objectives are set and monitored and will report to their Senior Leadership Teams and to the Group Equality, Diversity and Human Rights Committee on progress.

Our Staff Diversity Networks and Patient Fora are important to ensuring we hear directly from patients and staff about how we are doing and will continue to be an integral part of our Strategy.

Learning and Development

To support the successful implementation of this Strategy, we will add to the above activity by undertaking needs assessment against the competencies needed to implement the Strategy and use the results of the needs assessment to embed learning into mainstream training courses and team meeting events.

This section describes the following:

1. **Legal requirements**
2. **National Standards**
3. **Contractual obligations**

Legal Requirements

Human Rights Act 1998

The Human Rights Act aims to give further effect in UK law to the rights contained in the European Convention of Human Rights. In particular, public authorities have a duty under the Act not to act incompatibly with rights under the European Convention of Human Rights (ECHR).

Equality Act 2010

The Equality Act 2010 outlaws discrimination based on access to goods and services as well as employment, on the basis of the protected characteristics.

In addition, the Public Sector Equality Duty (PSED) requires public bodies to have due regard to the need to:

- Eliminate discrimination, harassment, and victimisation.
- Advance equality of opportunity.
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Specific duties require us to:

- Publish information to demonstrate compliance with the PSED annually.
- Prepare and publish equality objectives at least every four years.

Annex 1: Strategic Context

NHS Accessible Information Standard

The NHS Accessible Information Standard (AIS) was introduced in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand and that their communication needs are met. It is now the law for the NHS and adult social care services to comply with AIS.

Gender Pay Gap

The Gender Pay Gap regulations were introduced in 2018. All employers with 250 or more employees are required to comply with reporting and action planning each year on seven metrics. This covers: mean gender pay gap; median gender pay gap; mean bonus gender pay gap; median bonus gender pay gap; the proportion of men in the organisation receiving a bonus payment; the proportion of women the organisation receiving a bonus payment; the proportion of men and women in each quartile pay band.

National Standards

Equality Delivery System

The NHS Equality Delivery System (EDS) is a set of outcomes grouped under goals to help NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS. Trusts are required to carry out annual assessment of their performance against some or all of the outcomes and report the results. The EDS is currently being reviewed and EDS3 will be published in 2019.

NHS Workforce Race Equality Standard

The NHS Workforce Race Equality Standard (WRES) was introduced in 2014/2015 and included in the NHS Standard Contract for NHS Providers in 2015/2016. It comprises of nine metrics covering staff diversity, black and minority ethnic (BME) recruitment relative likelihoods, career development, disciplinary, responses to the national staff survey on equal opportunities, in career development, experiences of harassment, bullying and diversity.

Sexual Orientation Monitoring Standard

The NHS Sexual Orientation Monitoring Standard (SOM) was introduced in 2017. The SOM provides a consistent mechanism for recording the sexual orientation of all patients/service users aged 16 years and above to better identify health risks and will help support targeted preventative and early intervention work to address the health inequalities for people who are Lesbian, Gay or Bisexual.

The NHS Workforce Disability Equality Standard

NHS England is introducing the Staff Disability Equality Standard (WDES) in 2019. It will comprise a set of metrics that will enable us to compare the experiences of our disabled and non-disabled staff, to develop an action plan, and to demonstrate that all NHS Trusts will be required to comply with reporting and action planning each year.

Annex 1: Strategic Context

Contractual Obligations

Manchester Health Care Commissioning

Manchester Health Care Commissioning (MHCC) is the single commissioning body responsible for all health and care commissioning in Manchester. MFT hold a contract with MHCC to provide acute health services that includes the following specific equality metrics.

This annex outlines the distribution for populations within Manchester and Trafford for several of the established protected characteristics and compares these populations to Greater Manchester, North West and England and Wales averages including:

- **Sexual Orientation**
- **Age**
- **Disability**
- **Gender**
- **Ethnicity**
- **Religion**

Data is presented for both Manchester and Trafford based on the political boundaries of each Authority. The data provides the latest information across populations.

Sexual Orientation

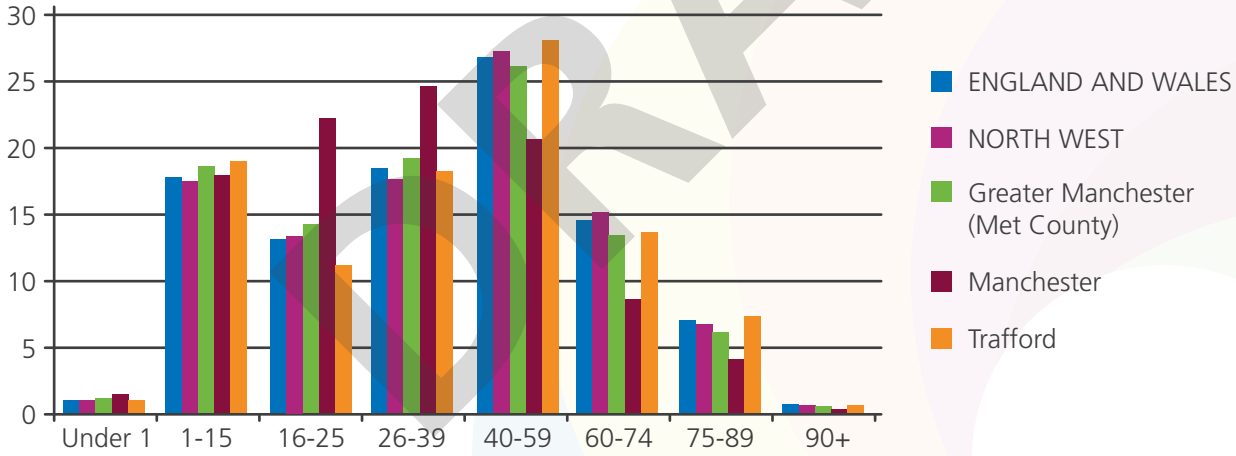
The estimated lesbian, gay, bi-sexual and transgender population across greater Manchester is between 6% and 8%. Manchester has a thriving lesbian, gay, bi-sexual and transgender community and feature in the top 10 local authorities with the largest populations who identify as gay or lesbian.

Annex 2: Who We Serve

Age

The age range across the Trust's sites varies with a younger more mobile population in Manchester (City) and high levels of deprivation affecting older people, and an older age profile in Altrincham, Trafford and Wythenshawe.

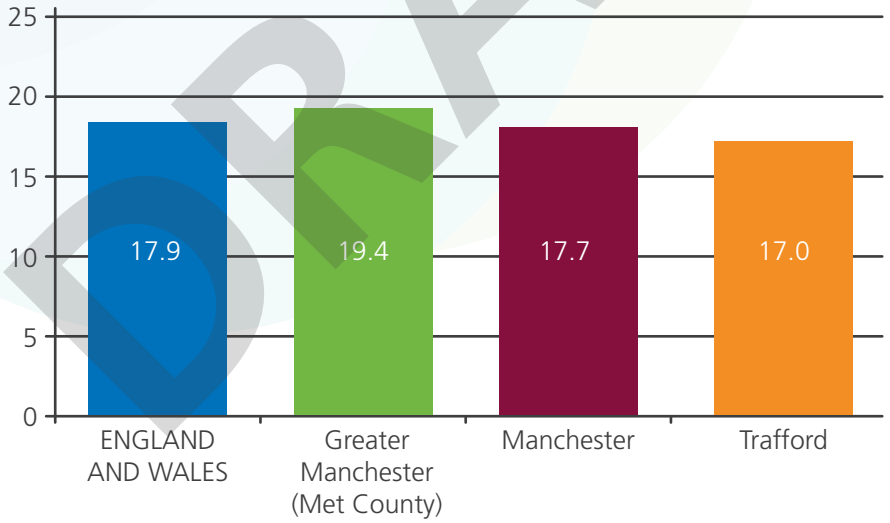
Comparison of age distribution across England and Wales, Greater Manchester (Met County), Manchester (City) and Trafford (MBC) (Census 2011)



Disability

There is little significant difference between Manchester, Trafford and regional and national patterns, all of which approximate to previously quoted averages of 20% of the population.

% of residents with a disability or long term health condition which limits day-to-day activities (Census 2011)

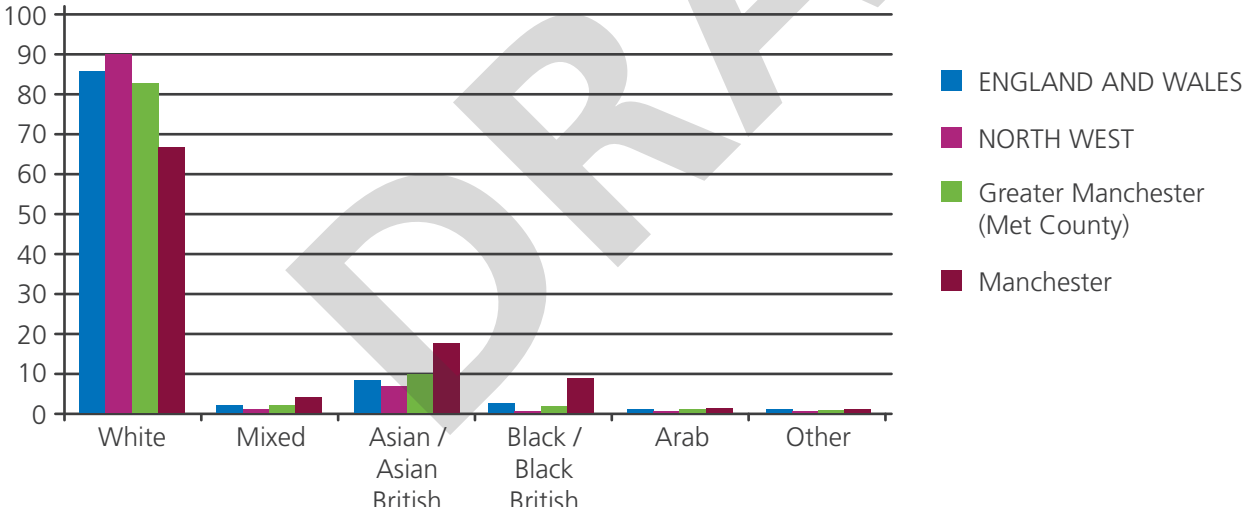


Annex 2: Who We Serve

Ethnicity

The White population of Manchester (City) is significantly lower than County, region or Country wide averages. There are larger population numbers of each of the minority ethnic populations in Manchester than regional or national figures. Conversely, the Black and minority ethnic populations form a larger section of the population in Manchester. The ethnicity figures for Trafford show that Trafford has a lower level of ethnic diversity, much closer to the North West average.

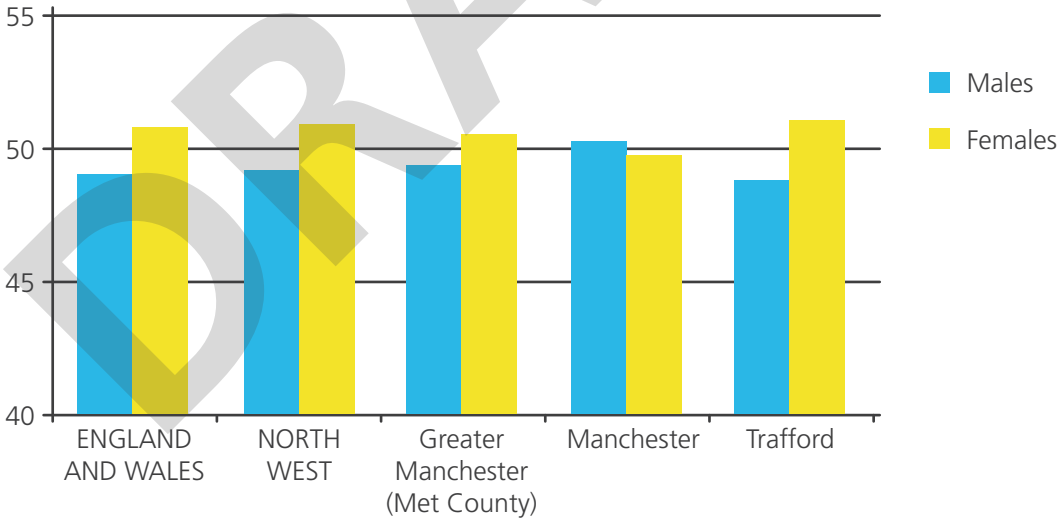
Comparison of ethnicity demographics across the region compared to Manchester (City Council) (Census 2011)



Sex

Trafford has a higher female population in line with national and regional profiles. However Manchester (City) figures show a slightly higher male population in contrast to these trends.

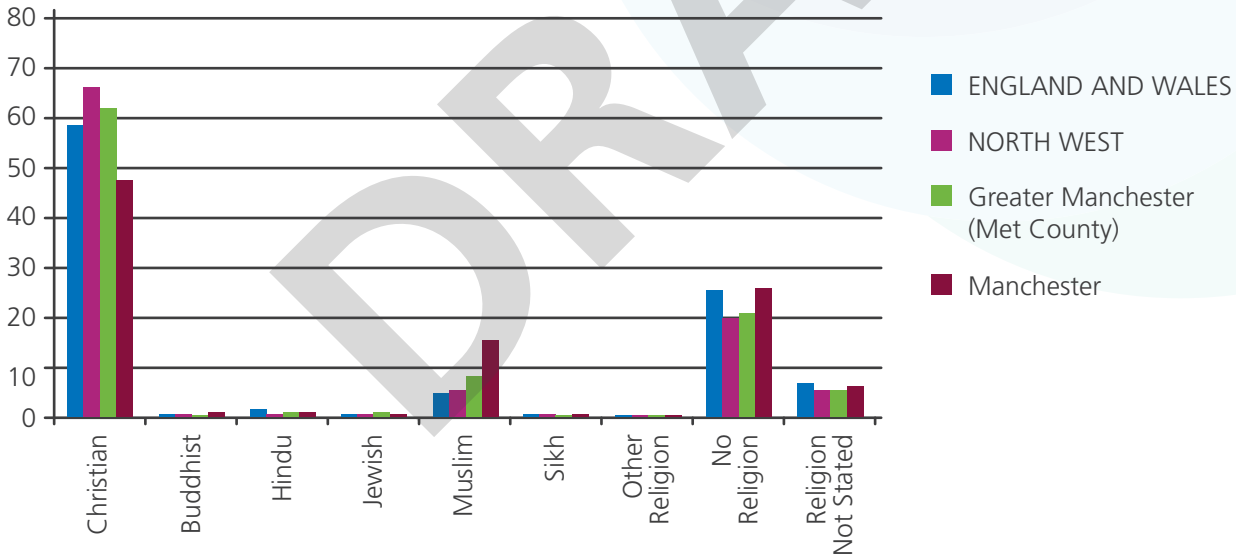
Comparison of gender profiles of England and Wales, North West, Greater Manchester, Manchester and Trafford (Census 2011)



Annex 2: Who We Serve

Religion

The religion demographics for Manchester and Greater Manchester do not follow national trends. Across Greater Manchester there is a larger Muslim population than the national average, and in Manchester (City), this number is higher still. Although the Christian population is the largest group in Manchester, its size is much smaller than regional or national averages. Trafford has a larger Christian population than the England and Wales average but lower than the population for the North West.



This section provides a summary of some of the health inequalities by protected characteristics.

Age

Transitions between child and adult health and care services can be a factor in the experience of care for young people. The age of transition from 'child' to 'adult' status varies across services locally and nationally. Services for care leavers and persons with learning disabilities continue until the age of 25, whilst adult services for substance misuse start at age 19, and mental health at age 18. This staggered movement to adult services itself can be seen as a potential risk factor. Thresholds for service eligibility can vary between child and adult services as well meaning that in some cases support may be discontinued.

Healthy life expectancy in Manchester is 56.1 years for males, and 54.4 years for females, indicating that poor health is likely to begin well before retirement for Manchester residents and with most people over 65 live with a long term condition and most people over 75 live with two or more. National studies find older report receiving poorer levels of care than younger people with the same conditions and report uncertainty, lack of confidence and lack of support on discharge from hospital.

Annex 3: Health Inequalities

Disability

Disabled people can experience significant health inequalities. People with learning disabilities are four times more likely to die of preventable causes. They are also more likely to have hearing loss and sight loss, are at higher risk of diabetes and mental health problems, and have a higher prevalence of dementia.

The life expectancy of people with learning disability, autism and Down's syndrome, on average, is up to twenty years less than the general population, their risk of dying from heart-related diseases is three times higher, and the odds are even greater with respiratory diseases such as pneumonia.

Deaf people are twice as likely to have undiagnosed high blood pressure as hearing people. They are also more likely to have undiagnosed diabetes, high cholesterol and cardiovascular disease.

Gender

The Public Health England, Health Profile for England, report on the state of the nation's health found that whilst life expectancy between the sexes continues to converge, it could take decades before men live as long as women. However, the report also found that the average woman spends nearly a quarter of her life in poor health compared to a fifth for men.

Other studies indicate that conditions that are likely to be prevalent in women than men include asthma, autoimmune disorders and self-reported prevalence for anxiety and depression. Conditions that are more likely to be prevalent in men than women include autistic spectrum disorder, chronic liver disease, chronic obstructive pulmonary disease though mortality rates from COPD, stroke however, death from stroke is more common for women than men.

Gender Reassignment

Trans people are more likely than others to experience mental distress, social isolation and social exclusion. Discrimination can be one of the main issues that can impact on the mental health of trans people, with approximately three quarters having experience some form of harassment in public.

The largest ever UK survey of trans people, Trans Mental Health Study (McNeil 2012), found extremely high levels of previous or current self-reported depression (88%), stress (80%) and anxiety (75%) in trans people. The transgender population is also more likely to be affected by social isolation and depression.

Pregnancy and Maternity

Pregnancy is a normal physiological process, but it increases specific susceptibilities and risks. It is estimated up to 1 in 7 mothers will experience a mental health problem during pregnancy or postnatally. Antenatal maternal stress and poor maternal health are more prevalent in more disadvantaged socio-economic groups. Women with complex social problems, including mental health problems, report discrimination and judgemental behaviour from healthcare staff, which impacts on their on-going engagement with services.

Annex 3: Health Inequalities

Ethnicity

The 2011 Census included two measures of health: limiting long-term illness (LLTI) and general self-reported health. Men from the White Gypsy or Irish Traveller, Mixed White-Black Caribbean, White Irish and Black Caribbean groups had higher rates of reported limiting long term illness than White British men. In contrast, Bangladeshi, Arab and Pakistani men reported lower rates of limiting long-term illness than White British men. White British women had similar rates of illness as White British men. White Gypsy or Irish Traveller women had the highest rates of limiting long term illness, almost twice that of White British women. Pakistani and Bangladeshi women also had worse health than the White British group. In contrast, Chinese, Other White and Black African women had lower rates of limiting long-term illness than White British women.

The British Heart Foundation report the prevalence of cardiovascular disease does not vary considerably by ethnic group for females, and in men, rates were highest in Irish and White British and lowest in Black African men. Black Caribbean, Indian, Bangladeshi and Pakistani men have a considerably higher prevalence of diabetes than the overall population. Cancer research UK report higher mortality rates in White British groups, although survival rates for breast cancer are lower in Asian and Black ethnic groups.

Risk factors also vary across different ethnic groups. Smoking is most prevalent in Bangladeshi men, and binge drinking is much lower across ethnic minority groups.

Sexual Orientation

Despite similar levels of social support and quality of physical health, gay men and lesbians report more psychological distress than heterosexuals. Depression is twice as likely and anxiety 1.5 times more likely in lesbian, gay and bisexual individuals than in heterosexual individuals. Prevalence of suicidal attempts in lesbian, gay and bisexual people are twice as high as in heterosexual people. High levels of social isolation have also been reported among lesbian, gay and bisexual people.

Risk factors such as smoking and alcohol and substance misuse are more common in the lesbian, gay and bisexual population than in the heterosexual population, with alcohol dependence is more than twice as likely and drug dependence almost three times as likely. There is some evidence there are high levels of homelessness among lesbian, gay and bisexual young people.

Annex 3: Health Inequalities

Sources

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Manchester University
NHS Foundation Trust

Diversity Matters

Manchester University NHS Foundation Trust's Equality, Diversity, Inclusion Strategy 2019-2023

Improved patient access, safety and experience	A representative and supported workforce	Inclusive leadership
We will: • Consider how our decisions will affect equality and reduce unfavourable effects. • Know who uses our services by equality and their experiences and reduce any differences that we find. • Carry on working towards the Accessible Information Standard. • Make sure that people with learning disabilities and autism get treatment, care and support. • Be the first Trust in the country to deliver Pride in Practice. This is recognition from the LGBT Foundation. • Make our way-finding and signage easier.	**We will:** • Consider how our decisions will affect equality and reduce unfavourable effects. • Know who our staff are by equality and their experiences and reduce any differences that we find. • Take a zero tolerance approach to bullying, abuse and harassment. • Work towards being a Disability Confident Lead employer. • Increase ethnic diversity at Board and senior management levels.	**We will:** • Board members and senior leaders will champion equality and diversity. Some examples include: > Talk about equality, diversity and inclusion > Engage their staff < Understanding how our decisions will affect equality and reduce unfavourable effects > Have equality, diversity and inclusion objectives in their local delivery plans > Use inclusive leadership competencies in recruitment and appraisal.
The results we are aiming for: • Everyone who needs to can use Trust services. • Individual people's health and care needs are met. • When people use Trust services they are free from harm. • People report positive experiences of Trust services.	**The results we are aiming for:** • Staff are free from harassment, bullying and physical violence. • Staff believe that the Trust provides equal opportunities. • Staff recommend the Trust as a place to work and receive treatment.	**The results we are aiming for:** • Board members and senior leaders demonstrate their commitment to equality, diversity and inclusion. • Board and Committee papers will identify equality-related impacts/ And how unfavourable effect will be reduced.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Cheryl Lenney, Group 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)
Date of paper:	July 2019
Subject:	**Patient Experience Annual Review**: Presentation of mandatory national patient surveys and Friends and Family Test and an update on the Trust Patient Experience Programme "What Matters to Me"
Purpose of Report:	Indicate which by ✓ • Information to Note ✓ • Support ✓ • Accept • Resolution • Approval • Ratify
Consideration of Risk against Key Priorities:	Delivering an excellent experience for patients, their families and their significant others.
Recommendations:	Members of the Board of Directors are asked to note the content of the report and support the actions required to ensure continuous improvement.
Contact:	Name: Debra Armstrong, Assistant Chief Nurse (Quality and Professional Practice) Tel: 0161 276 5061

1. Executive Summary

1.1. Patient Experience is recognised as a core element of Quality[1] (DOH, 2008).

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

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

1.4. This report provides a summary of the MFT results of the mandatory national surveys that have been published in 2019: the Maternity Survey (2018) and the Adult National Inpatient Survey (2018) alongside comparisons with Shelford Group trusts or where applicable specialist hospitals. The surveys are the first surveys conducted since the establishment of MFT in October 2017; therefore exact comparisons cannot be made with previous surveys.

1.5. Overall the National Maternity Services Survey (2018) demonstrates positive experiences of care, with improvements across most aspects of maternity care based on comparison with the survey results for the former Trusts (2017).

1.6. The National Adult Inpatient Survey (2018) demonstrates results that are predominantly 'about the same' as other NHS Trusts, with the exception of 1 question, which is categorised as 'worse'. MFT corporate hospitals/MCS and MLCO improvement plans have been developed with specific focus on the notably low scoring questions as detailed within the report.

1.7. Activity has been undertaken during 2018/19 to capture real time patient feedback including improving the accessibility and response rate to the Friends and Family Test, which includes an electronic mechanism by which patients can feed back about their experience is included in this report.

1.8. Examples from across MFT/ Hospitals/ Managed Clinical Services (MCS's) and Manchester Local Care Organisation (MLCO) of improvement work undertaken following listening to patient and relative feedback are illustrated.

1.9. This report provides an update on the positive progress undertaken during 2018/19 to embed the process and details the planned development in 2019/20 of a new phase of the *WMTM* framework to explore the integration of the approach into the coproduction of services through the Always Events[R] Methodology[2].

[1] DOH (2008) High Quality Care for All

[2] NHSE(2016) Always Events Toolkit

Image 1: Proud to Care on Camera, Patient Choice Winner 2019

2. Introduction

2.1. This is the first Patient Experience Report following the establishment of Manchester University NHS Foundation Trust (MFT) on 1st October 2017 that details the experience of patients cared for within the newly established Trust.

2.2. The NHS Patient Survey Programme is overseen by the Care Quality Commission (CQC) and covers a range of NHS settings on a rolling programme of surveys. The CQC publishes the results of the surveys on its own website. In 2018/19, the CQC published the following surveys:

- Maternity Services 2018 published in January 2019[3]
- Adult Inpatient Survey 2018 published in June 2019[4]

2.3. Triangulation of the results for key questions contained within the National Adult Inpatient Survey (2018) with the Trust's local ***'What Matters to Me'*** Patient Experience survey findings is also presented. The Friends and Family Test (FFT) is a further mechanism by which the Trust receives feedback on Patient Experience; therefore detail is provided of FFT performance and comparisons are provided against other Shelford Group Trusts.

2.4. Many positive elements of patient experience are identified by the both the national and local survey results. The findings of the national surveys demonstrate that the Trust generally falls within the average range for almost all factors that influence patient experience when compared to other Trusts. Areas that persistently receive low scores in previous National Inpatient Surveys, namely food, remain comparatively low and an extensive work programme continues to drive improvement.

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

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

[4] http://www.nhssurveys.org/Filestore/Inpatients_2018/Reports/IP18_R0A.pdf

3. Maternity Services Survey 2018

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

3.2. The survey involved a postal questionnaire being sent to eligible women, aged 16 and over, who had a live birth during February 2018. The CQC published the National Maternity Survey, 'Women's Experience of Maternity Care' (2018) in January 2019. Since the 2017 survey the report format has been published in three separate reports aligning to different aspects of the maternity pathway, namely: antenatal care, labour and birth and postnatal care. Previous surveys were undertaken in 2007, 2010, 2013, 2015 and 2017. It was agreed in 2018 that the Maternity Survey would be undertaken annually.

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

- Antenatal Care
    - The start of your pregnancy
    - Antenatal check ups
    - During your pregnancy
- Labour and Birth
    - Labour and birth
    - Staff
    - Care in hospital after birth
- Post-natal care
    - Feeding
    - Care at home after the birth

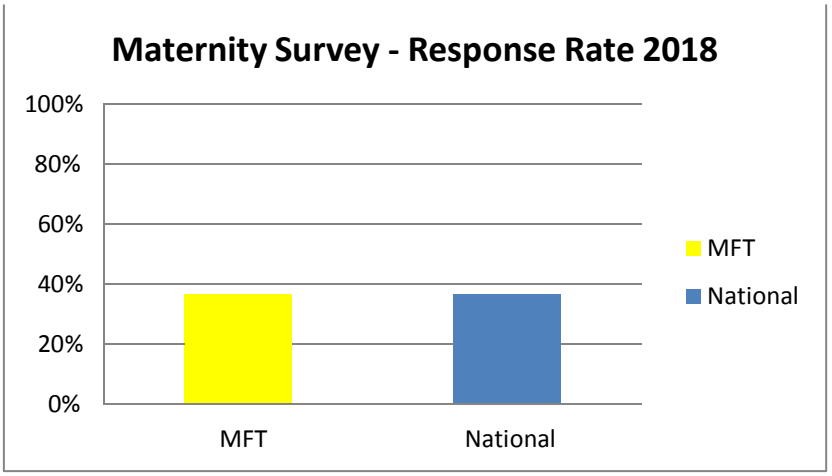
3.4. There have been minor changes to the 2018 survey compared to the 2017 version. These include; one question being reworded, the moving of one question to a different section, one question added and one question removed. In total there are 81 questions.

3.5. Maternity Services Survey Results

3.5.1 Response rate

Graph 1 compares the MFT response rate to the national average. The response rate for the Maternity Survey (2018) was 36% (330 respondents), this compares to a national average of 37%.

Graph 1: MFT response rate (2018) compared to national average



3.5.2 Survey Analysis

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

This is the first national maternity survey for the organisation since MFT was formed and as such exact comparisons cannot be made with previous surveys.

3.5.3 Notably High Scores

Twelve questions indicated specifically high scores (a score 9.0 and above), which are presented in **Table 1**. Three of these questions have improved compared to the scores in the Maternity Surveys (2017) for both legacy organisations. These high scores provide a level of validation about the impact of activity undertaken by the Trust in relation to the ***'What Matters to Me'*** patient experience programme which involves staff at all levels to provide care delivery which is personalised to individual's needs.

Building on the service improvement methodology used in 2015 and 2016 Saint Marys Managed Clinical Service (MCS) has continued to take actions aimed at improving patient safety and overall patient experience. In 2017 there was investment in the midwifery workforce to specifically support care during the Antenatal period and during a woman's Labour. The increased scores in the 2018 Maternity Survey are reflective of improvements to the

elements of the maternity pathway that this investment has supported. This is further reflected in respect of the Antenatal check-up when compared with the Shelford Group Trusts St Marys MCS was the best performing Trust.

Table 1: Maternity Survey Questions with Scores over 9 out of 10

Question	MFT Score 2018	Legacy CMFT 2017	Legacy UHSM 2017	National Range 2018
During your antenatal check-ups, did the midwives listen to you?	9.2	9.5	8.9	8.3-9.7
Thinking about your antenatal care, were you spoken to in a way you could understand?	9.5	9.3	8.9	8.6-9.9
Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?	9.2	8.7	9.6	7.0-10.0
If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?	9.7	9.4	9.7	8.9-10.0
Did the staff treating and examining you introduce themselves?	9.3	9.2	9.6	8.5-9.8
Thinking about your care during labour and birth, were you spoken to in a way you could understand?	9.5	9.3	9.6	8.7-9.7
Thinking about your care during labour and birth, were you involved enough in decisions about your care?	9.0	8.5	8.8	7.6-9.2
Thinking about your care during labour and birth, were you treated with respect and dignity?	9.4	9.3	9.6	8.5-9.8
When you were at home after the birth of your baby, did you have a telephone number for a midwife or midwifery team that you could contact?	9.9	9.4	10.0	8.6-10.0
Did a midwife or health visitor ask you how you were feeling emotionally?	9.8	9.7	9.8	8.5-10.0
Were you given information or offered advice from a health professional about contraception?	9.2	9.0	8.7	7.3-9.8
Did a midwife tell you that you would need to arrange a postnatal check-up of your own health with your GP? (Around 6-8 weeks after the birth)	9.1	9.0	9.8	7.1-10.0

3.5.4 Notably Low Scores

Three questions results indicated specifically low scores (a score 5.0 and below) which are presented in **Table 2**. The three questions have a similar theme in that all ask about choice of care provision. As Saint Marys MCS is a tertiary centre many patients may not have had the option to select their preferred choice of care provision due to the specialist nature of services.

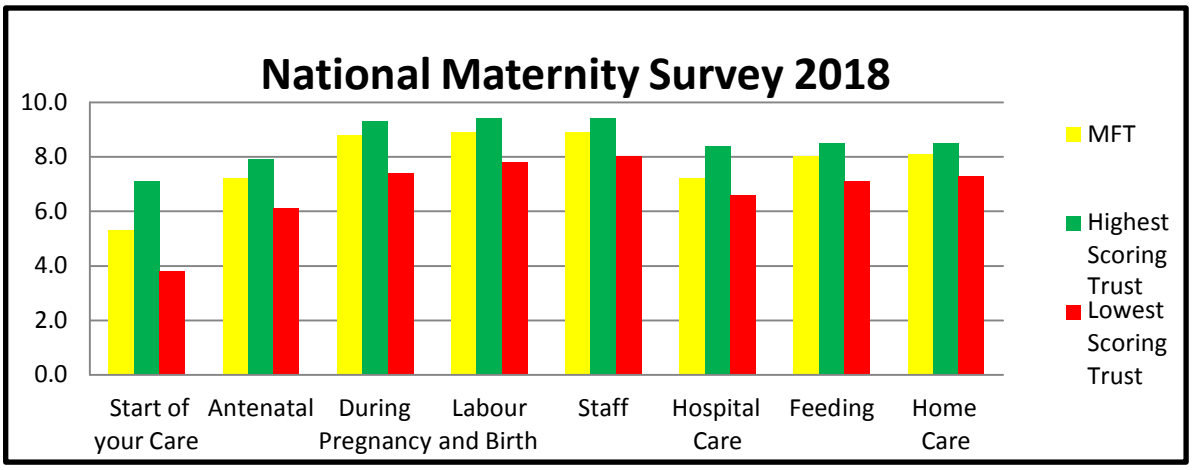
Table 2: Maternity Survey Questions with Under 5 score out of 10

Question	MFT Score 2018	Legacy CMFT 2017	Legacy UHSM 2017	National Range 2018
Were you offered any of the following choices about where to have your baby?	3.2	3.0	3.5	1.3-5.1
During your pregnancy were you given a choice about where your antenatal check-ups would take place?	3.5	3.6	3.9	1.3-5.4
Were you given a choice about where your postnatal care would take place?	3.7	5.9	3.9	2.1-6.3

3.5.5 National Benchmarking

Graph 2 compares the Trusts results for each of the eight key themes alongside the highest and lowest scores achieved nationally.

Graph 2: MFT scores compared to highest and lowest scoring trusts nationally



3.5.6 Comparison with Shelford Trusts

The response rates for the Shelford Group Trusts range between 26% (Imperial College) and 51% (Cambridge University Hospitals). The Trust's response rate of 36% places MFT in sixth position, alongside Kings College.

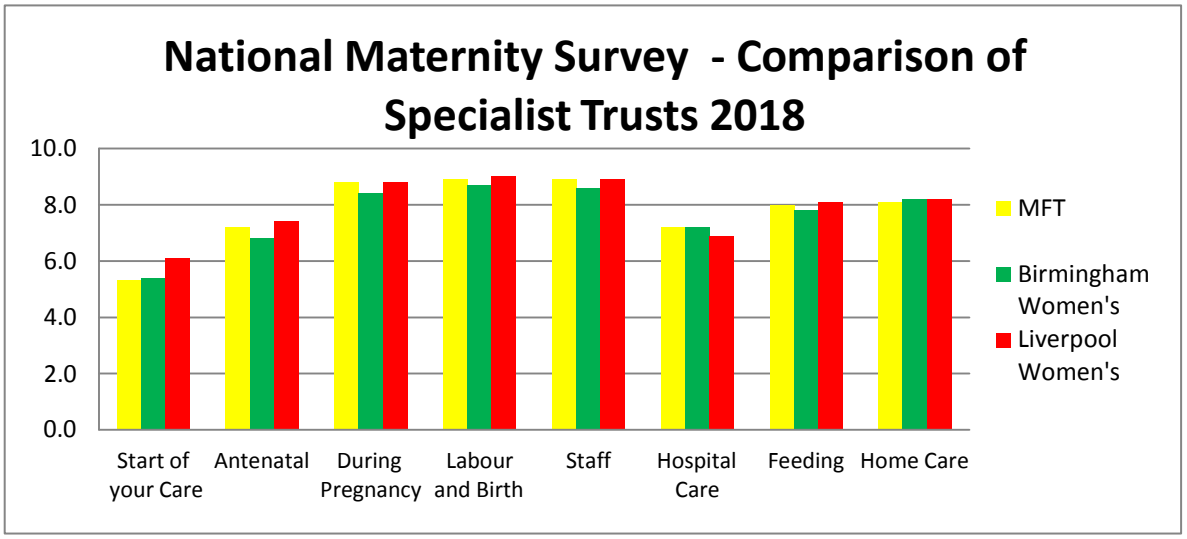
The Maternity Services Survey does not include an overall question relating to patient experience which precludes comparison with the other Shelford Group Trusts. In the 8 categories Saint Marys MCS was placed in the top three trusts for 5 categories, in the average range for 1 category and at the lower scoring Shelford Trust in 2 categories ('The start of your pregnancy' and 'Care in hospital after birth). **Appendix 1** provides the comparison of MFT with the Shelford Group Trust for all eight overall categories.

When compared with the Shelford Group Trusts St Marys MCS was equal as the best performing Trust, alongside Oxford for the question relating to Antenatal check-up.

3.5.7 Comparison with other Specialist Women's Hospitals

There are 3 specialist Women's Hospitals in England; St Marys Hospital, Liverpool Women's Hospital and Birmingham Women's Hospital. When compared with Liverpool Women's and Birmingham Women's Hospitals, Saint Marys MCS was placed in joint first for 3 categories, 2nd for 3 categories and 3rd for 2 categories across the eight survey categories. The categories where St Marys scored 3rd out of the 3 specialist women's Hospitals were the same lower scoring categories when compared to the Shelford Trusts; 'The start of your pregnancy' and 'Care in hospital after birth'. **Graph 3** compares the Trusts results for each of the eight key themes with Liverpool Women's and Birmingham.

Graph 3: MFT scores compared to Liverpool Women's and Birmingham Women's Trusts



3.5.8 St Mary's Maternity Services Improvement Programme

The results of the Maternity Services Survey are utilised to improve maternity care throughout St Mary's Managed Clinical Service (MCS) and specifically inform St Mary's Maternity Service Improvement Programme. Based on the notably low scores from the Maternity Services Survey 2018 St Mary's MCS team have implemented the following improvements:

- All women, at their Antenatal Booking Appointment, are advised of the choices of where to birth their baby and women's preference of the location of antenatal checks is discussed and agreed
- Midwives ensured that the women are signposted to the leaflet 'Choosing where to have your baby' on the Saint Mary's Hospital website.
- Community midwives offer the choice of postnatal visits in the home or at the postnatal clinic

Future priorities and work stream to continually improve maternity care across St Marys MCS are already well advanced and include:

- The Manchester Birth Centre will be launched at the Wythenshawe Hospital which will provide women four options for place of birth:
    - The Delivery Unit and Midwifery Led Care at Oxford Road Campus
    - Manchester Birth Centre Saint Mary's at Wythenshawe
    - Home birth.
- In addition the community midwifery team are also planning to in-reach into Ingleside which is based in Salford to offer women a further choice of birth in a standalone midwifery unit.
- All women will be provided with a personalised care plan which in partnership with her midwife and other health professionals sets out decisions about her care. This plan will be kept up to date as the woman's pregnancy progresses.
- Saint Mary's MCS has been working with Greater Manchester and East Cheshire Local Maternity System (GM&EC LMS) to launch the Choice website. All women will be able to access this website where they have genuine choice, informed by unbiased information.
- Harmonisation of community midwifery services across the MCS will offer improved Continuity of Carer for women. The aim is for every woman to have a midwife, who is part of a small team of 4 to 6 midwives, who knows the women and family and can provide continuity throughout the pregnancy, birth and postnatally. In implementing Better Births, there is a national guidance that 20% of women should be booked on a Continuity of Carer pathway by March 2019. In March 2019 MFT reported to the GM &EC LMS that 23% of women were booked on to a Continuity of Carer pathway.

3.6 Summary

Overall women reported positive experiences of care based on the results of the Maternity Services Survey (2018) with improvements across most aspects of maternity care based on comparison with the survey results for the former Trusts (2017).

Image 2: Proud to Care on Camera, winner 2019

4. Adult National Inpatient Survey 2018

4.1 Background and Methodology

The annual Adult National Inpatient Survey is a CQC requirement to obtain feedback to improve local services for the benefit of patients and the public based on adult inpatient patient experience. Survey results are reported to the CQC, results contribute to the Trust Quality & Risk Profile outcomes and form the basis of quality improvements which are monitored through the Trust's contracts with its commissioners. The CQC published the results of the Adult National Inpatient Survey (2018) on the 20th June 2019.

The survey of inpatient services is part of the National Patient Survey Programme and is undertaken on behalf of the Trust by an independent provider, who administers a postal survey, observing nationally approved methodology. The 2018 survey involved a postal questionnaire being sent to 1,250 patients who had been an inpatient and had at least one overnight stay in the Trust during July 2018.

This is the first national inpatient survey for the organisation since MFT was formed and as such direct comparisons cannot be made with the legacy organisations.

The 2018 survey has been kept as similar as possible to the 2017 survey, with only minor changes. The changes include the addition of two new questions and the removal of one question. The questions added were '**Was the care and support you expected available when you needed it?'** and **'During this hospital stay, did anyone discuss with you whether you would like to take part in a research study?'**

The survey involved 81 questions, of which 63 require respondents to indicate the standard of care they received, with 18 questions relating to demographic information or routing questions. Routing questions are not scored; the questions are designed to filter respondents to whom the following questions apply/ do not apply.

Each question receives a score out of 10 based on the responses provided by the respondents. A higher score is a more positive response and a lower score is the least positive score. Each question is categorised based on comparison to other organisations' scores as ***'better'***, ***'about the same'*** or ***'worse'***.

The survey is arranged into the following categories relating to the patient pathway.

- The Accident and Emergency Department (answered by emergency patients only)
- Waiting list or planned admission (answered by those referred to hospital)

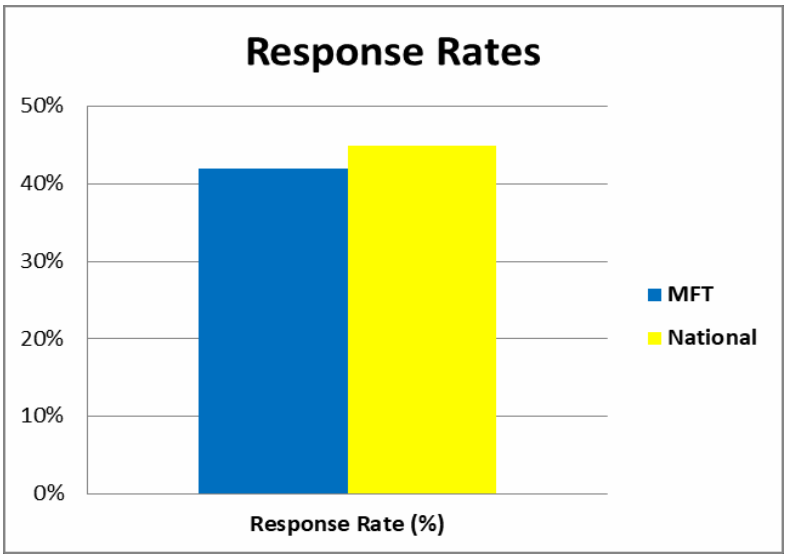
- Waiting to get to a bed on a ward
- The hospital and ward
- Doctors
- Nurses
- Your care and treatment
- Operations and procedures (answered by patients who had an operation or procedure)
- Leaving hospital
- Overall views of care and services
- Overall experience

4.2 Adult Inpatient Survey results

4.2.1 Response Rates:

Graph 4 compares the MFT response rate for the Adult Inpatient Survey (2018) to the national average. The MFT response rate was 42% (505 respondents), this compares to the national average of 45% (2018). This compares to both legacy organisations response rate of 33% compared to the national average of 41% in 2017; demonstrating a significant improvement in response rate in 2018 when compared to 2017.

Graph 4: MFT response rate compared to national average

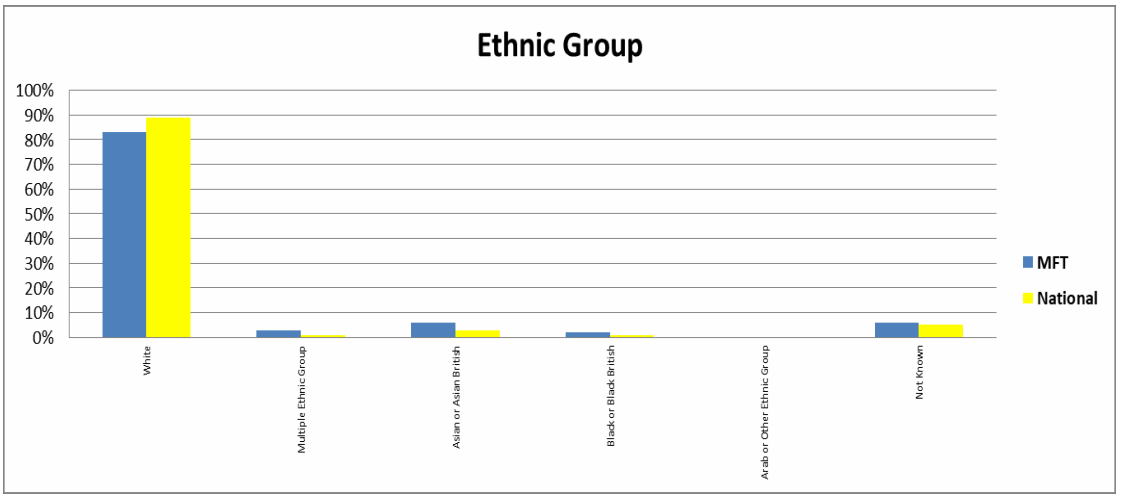


4.2.2 Patient Demographics

The results for MFT show that the proportion of female to male respondents is comparable to the national average. The MFT responses for males was 47% compared to the national average of 48% and the MFT responses for females was 53% compared to the national average of 52%.

The results also demonstrate that we treat a more diverse group of people from different ethnic backgrounds when compared to the national profile, which reflects our population, as demonstrated in **Graph 5**.

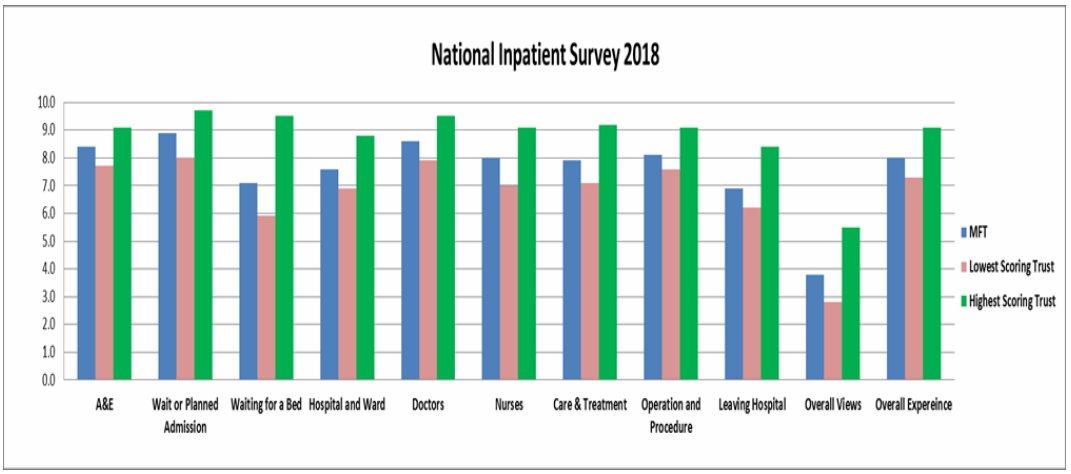
Graph 5: MFT Ethnic group compared to national average



4.2.3 Themes

Graph 6, below, shows the results for MFT for each of the eleven themes; the highest and lowest scores achieved nationally are also presented. This chart highlights that the Trust's scores are generally midway between the highest and lowest scoring trusts for most key themes.

Graph 6: MFT scores compared to the highest and lowest scoring trusts



4.2.4 Site Results – Manchester Royal Infirmary (MRI) and Wythenshawe Hospital

Detailed results are provided at **Appendix 2** for each of the two hospital sites (MRI and Wythenshawe Hospital) and compare each site with the overall Trust Score for 2018.

The results for individual hospitals are only available when questions have received 30 responses or more. According to the CQC this is because the uncertainty around the result is too great.

Results for MRI and Wythenshawe are available for all of the 63 questions that require respondents to indicate the standard of care they received. There are no specific site results for any other Hospital/ MCS within MFT.

The overall quality score for MRI was 7.57 and for Wythenshawe Hospital was 8.19 compared to the Trust overall MFT quality score of 8.0

When compared to the MFT overall results, MRI scored better in 4 questions, worse in 58 questions, and the same in 1 question.

When compared to the MFT overall results, Wythenshawe Hospital scored better in 51 questions, worse in 5 questions, and the same in 7 questions.

The available site results have been shared with the MRI and Wythenshawe Hospitals Senior Leadership Teams and action plans for improvement are being developed with specific focus on those scores that rated below 5. Additionally, in recognition that there have been more improvements noted at Wythenshawe Hospital and part of the benefits of working as in a group model the team at Wythenshawe Hospital will support the team at MRI and share their strategy for improvement. The MFT Report has been shared with all Hospitals/ MCS's/MLCO to enable the development of action plans to inform improvement work across the group in all hospitals /MCS and MLCO on the issues raised within the National Inpatient Survey Trust wide.

Specifically, the Senior Leadership team at Wythenshawe Hospital plan to introduce a multi-professional National Inpatient Survey Improvement Group, involving Hospitals/MCS and external partners to develop a site wide action plan for improvement based upon the 2018 National Inpatient Survey. The group will be chaired by the Deputy Director of Nursing, Wythenshawe, Trafford, Withington and Altrincham, (WTWA) and meet bi-monthly. Action planning will focus on any survey scores below 7, and the 5 scores noted to have deteriorated since the 2017 survey.

A quarterly progress report will be provided to the WTWA Quality and Governance Operational Group, biannual report to WTWA Quality and Patient Safety Committee and annual report to WTWA Hospital Management Board.
Managed Clinical Services on the Wythenshawe site will be requested to

establish governance arrangements to monitor progress against the improvement plan.

The MRI has an established governance framework in place within which the National Inpatient Survey action plan will be monitored and progressed. The MRI Quality and Safety Committee will have oversight of the progress, with established work streams undertaking the activity and improvements. This framework will be utilised to manage the improvement plan for the MRI Inpatient Survey results. An annual progress report will be provided to the MRI Hospital Management Board.

The Senior Leadership team at MRI are planning to develop a patient experience framework to support the existing governance arrangements and this will include the triangulation of data from patient safety incidents, complaints, survey and engagement work, to ensure that work-streams are focused on the appropriate areas for improvement. This will be led by the Lead Nurse for Quality and the Clinical Governance Teams, supported by the ward based teams, and will be reported via the Quality and Safety Committee.

4.2.5 National Benchmarking

Each question receives a score out of 10 based on the responses provided by the respondents. A higher score is a more positive response and a lower score is the least positive score. Each question is categorised based on comparison to other organisations' scores as ***'better'***, ***'about the same'*** or ***'worse'***.

When compared nationally to the Trusts who took part in the survey the responses for MFT are categorised as ***'about the same'*** for all questions with the exception of 1 question, which is categorised as ***'worse'***. In accordance with the survey methodology ***'about the same'*** reflects ***'the expected range'*** based on the survey analysis technique. The question that was categorised as ***'worse' 'How would you rate the hospital food?'*** The MFT recorded score was 4.7 this compares nationally to the lowest trust score reported of 4.4 and the highest reported score of 7.9. Both CMFT and UHSM scored 4.9 in the 2017 survey this therefore demonstrates a deterioration of satisfaction with food for both former Trusts.

4.2.6 Notably High Scores

Notably high scores 9.0 and above were attained in 2018 for 8 questions. The notable high scores are presented in **Table 3**. As this is the first MFT Adult Inpatient Survey Report, statistical direct comparisons cannot be made with previous results from the legacy organisations, however the table below includes this data for information from the legacy organisational results for 2017 and the national range for 2018.

Table 3: Adult Inpatient Survey Questions with Scores over 9 out of 10

Question	MFT Score 2018	Legacy CMFT Score 2017	Legacy UHSM Score 2017	National Range 2018
Were you given enough privacy when being examined or treated in the A&E Department?	9.0	9.0	8.9	7.7-9.5
Was your admission date changed by the hospital?	9.2	9.0	9.1	8.3-9.9
Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?	9.2	9.0	9.3	7.9-9.6
During your time in hospital, did you get enough to drink?	9.0	8.9	9.5	8.6-9.9
Did you have confidence and trust in the doctors treating you?	9.0	8.9	9.0	8.4-9.7
Did nurses talk in front of you as if you weren't there?	9.0	9.2	9.2	7.8-9.6
Were you given enough privacy when being examined or treated?	9.6	9.4	9.6	9.1-9.9
Overall, did you feel you were treated with respect and dignity while you were in the hospital?	9.1	9.2	9.1	8.2-9.8

4.2.7 Notably Low Scores

Notably low scores below 5.0 were attained in 5 questions. The notably low scores are presented in Table 4 As this is the first MFT Adult Inpatient Survey Report, statistically direct comparisons cannot be made with previous results from the legacy organisations, however the table below includes this data for information from the legacy organisational results for 2017 and the national range for 2018. Worthy of note is that 4 of the 5 notably low scores attained less than 5.0 for both legacy organisations and the 5th low score related to research is a new question for the 2018 survey.

Table 4: Adult Inpatient Survey Questions with Scores under 5 score out of 10

Question	MFT Score 2018	Legacy CMFT Score 2017	Legacy UHSM Score 2017	National Range 2018
How would you rate the hospital food?	4.7	4.9	4.9	4.4-7.9
Did a member of staff tell you about medication side effects to watch for when you went home?	4.3	4.7	4.4	3.4-7.4
During this hospital stay, did anyone	1.7	n/a	n/a	1.1-4.6

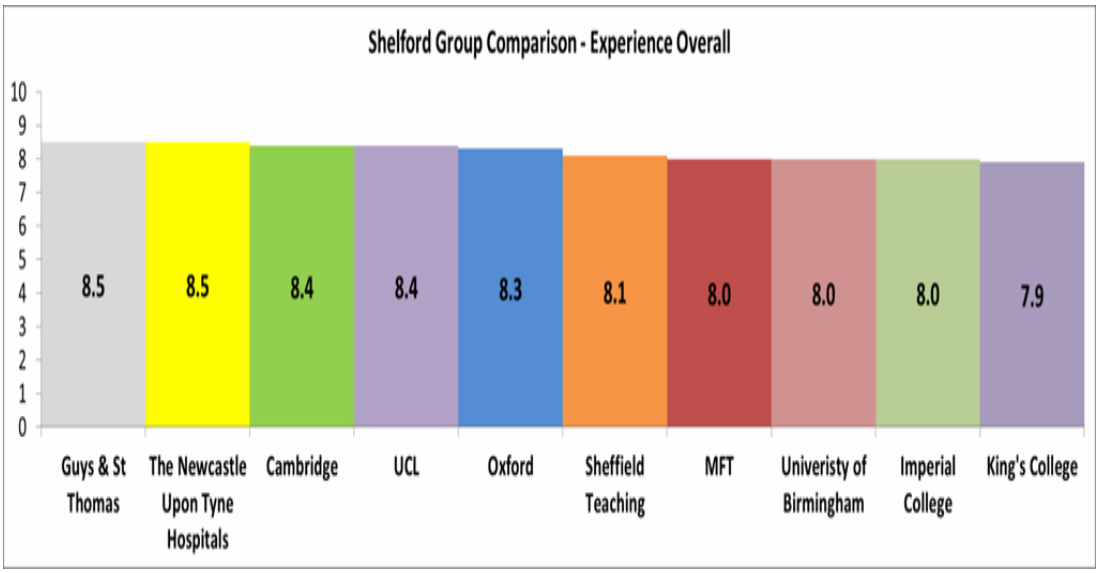
discuss with you whether you would like to take part in a research study?				
During your hospital stay, were you ever asked to give your views on the quality of your care?	2.0	2.5	2.2	0.6-4.8
Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	2.2	2.7	1.8	0.5-3.7

4.2.8 Comparison with other Shelford Trusts

The response rates for the Shelford Group Trust ranged from 30% (Birmingham) to 58% (Cambridge). The response rate of 42% for MFT places the Trust in equal fourth position when compared to the other Shelford Group Trusts.

The overall experience score for MFT was 8.0 (2018); placing the trust in equal 7th position with 3 other Trusts when compared to the other Trusts within the Shelford Group (**Graph 7**). The overall experience score has deteriorated compared to the 2017 position, when both legacy organisations scored 8.2 for overall experience. Nationally the lowest trust score for overall experience was 7.3 and the highest trust score 9.1.

Graph 7: Overall Experience Scores 2018 – Shelford Group



4.3 Summary

The Adult Inpatient Survey (2018) results demonstrate the results are predominantly ***'about the same'*** as other NHS Trusts, with the exception of 1 question, which is categorised as ***'worse'***. Group and local improvement plans have been developed with specific focus on the notably low scoring questions as detailed within the report.

The results and identified improvements will be shared at relevant Patient Experience Forums, which will include Group Quality and Safety Committee, Quality and Patient Experience Forum, which has reporting lines to Nursing Midwifery and Allied Health Professional Board and the Governor Patient Experience Group.

The King's Fund and Picker Institute Europe recently analysed longitudinal inpatient survey data for acute trusts over a nine-year period (from 2005 to 2013)[5] identifying that significant improvements have typically been driven by national initiatives and policies to tackle widespread or high-profile problems, for example infection prevention. It is recognised that to make improvement the support from National Campaigns increases the sustainability of positive action. With appropriate data analysis useful insights into patient experience can be yielded and initiatives identified, especially when complemented by detailed local knowledge. Therefore specific focus on the notably low scores from the 2018 survey will be prioritised at a Group, Hospitals and MCSs during 2019/20.

[5] https://www.kingsfund.org.uk/sites/default/files/2017-05/Patients-experience-summary-Kings-Fund-Dec-2015.pdf

Image 3: Proud to Care on Camera, runner-up

5. Real Time Patient Feedback

It is valuable to cross reference the snap shot provided by the National Survey results with real time feedback from the Trust's electronic ***'What Matters to Me'*** patient experience surveys. These MFT surveys are locally developed based on the questions in the national patient experience surveys. The surveys ask patients about their experiences in the following themed categories:

- **Communication**
- **Involving patients/ carers**
- **Privacy and Dignity**
- **Clean**
- **Hygiene and Personal Care**
- **Infection Prevention Control**
- **Nutrition and Hydration**
- **Pain**
- **Patient Safety**
- **Equality and Diversity**

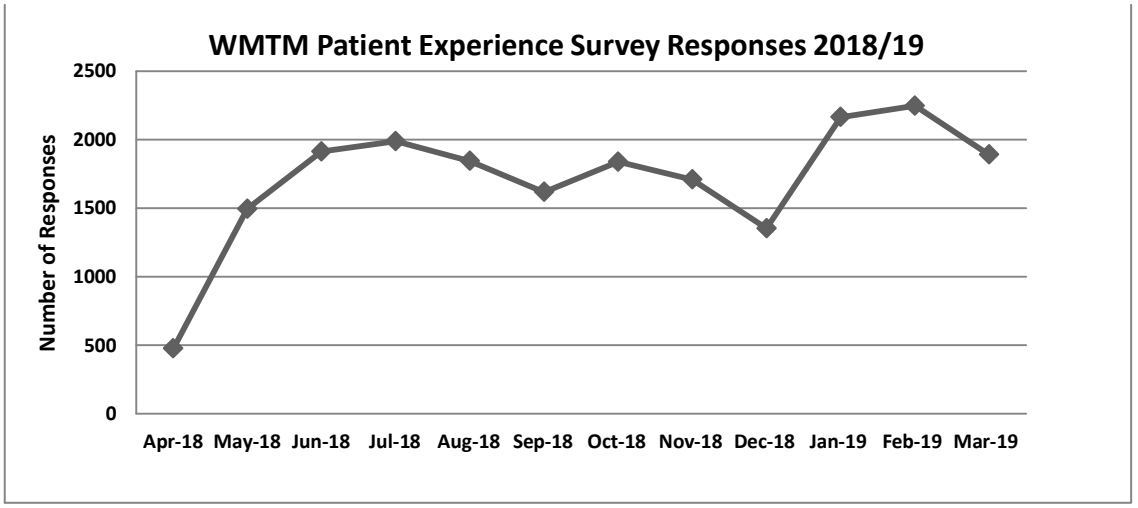
The feedback received informs quality improvement activity which subsequently informs the MFT Accreditation process.

The trust has developed specific surveys for patients being cared for in Adult and Children & Young People's inpatient areas, day-case, Emergency Departments and Outpatient Department with specific surveys for Maternity Services and Child and Adolescent Mental Health Services (CAMHS).

Each year the surveys are reviewed to ensure they reflect any changes to the national patient surveys, national guidance and best practice.

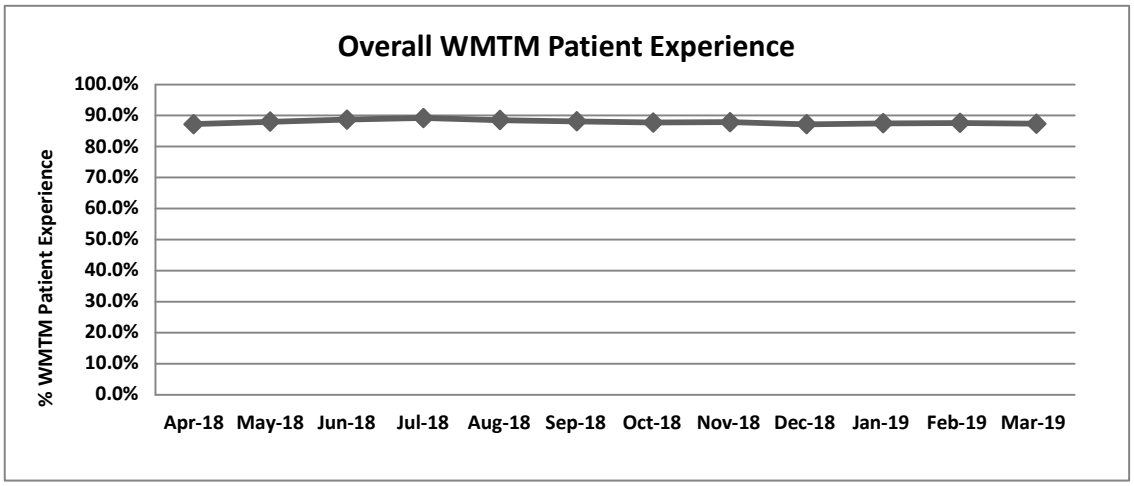
Following the introduction of a newly procured electronic system on 1st April 2018 to capture and report the MFT ***'What Matter to Me'*** patient experience data, frontline teams have had real-time access to patient experience feedback, inclusive of qualitative comments provided by patients for each of the themed categories. **Graph 8** demonstrates that between April 2018 and March 2019 a total of 20,539 questionnaires were completed by our patients.

Graph 8: WMTM Patient Experience Survey Responses



The electronic system allows analysis to be undertaken at ward, Hospital/ MCS and Trust Level for overall patient experience satisfaction and each of the themed categories. Analysis of the ***'What Matters to Me'*** survey data shows an average overall patient experience score of 87.9%. There has been month by month variation, with the lowest score of 87.2% in December 2018 compared to the highest score 89.2% in July 2018. Comparison with previous years is not possible due to the changes to the system and questions contained within the surveys. Data collected in 2018/19 will therefore provide a baseline position for MFT **(Graph 9**).

Graph 9: MFT Overall Patient Experience Score April 2018 –March 2019



The National Survey results (2018) for MFT for overall experience score was 8.0.

As noted in Section 4 of this report, the Adult National Inpatient Survey (2018) indicates specifically low scores for MFT in the following areas:

- Quality of Food
- Whether patients were told about the medication side effects to watch out for when they went home?
- Whether staff discussed with patients whether they would like to take part in a research study
- Whether patients were asked to give views on the quality of care they received?
- Whether patients were given, any information about how to complain to the hospital about the care they received?

These areas are therefore considered in further detail below

5.1 Quality of Food

The score for this question is 4.7 in the Adult National Inpatient Survey (2018). This compares to a score of 4.9 in the 2017 survey for both legacy organisations. Based upon the analysis of ***'What Matters to Me'*** survey data for satisfaction rate with the quality of food between April 2018 and March 2019 averaged 67.1%.

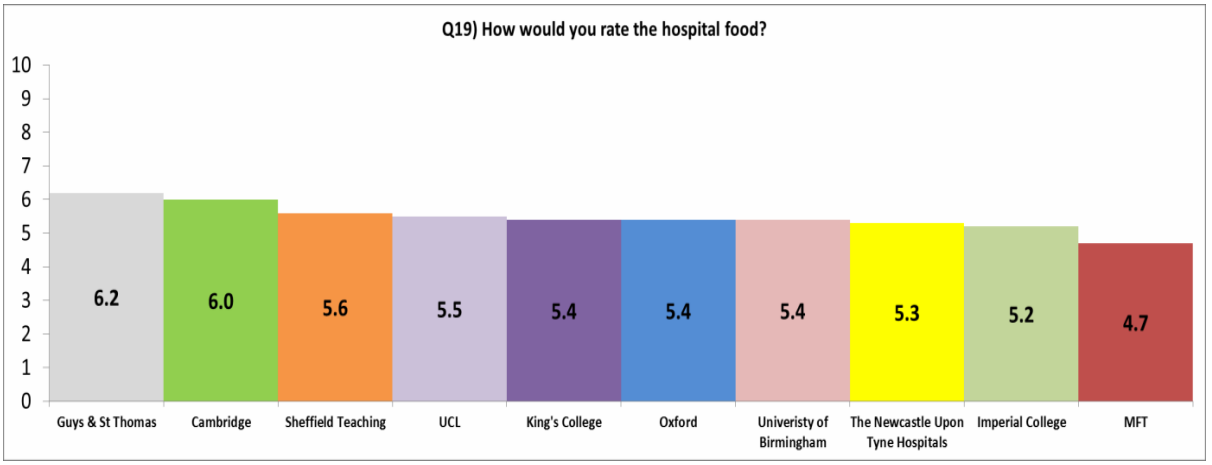
Graph 10 compares the Trust scores for April 2018 – March 2019. The lowest score for the Trust during this period was 66.4% and the highest was 69.5%.compared to a minimum target of 85%.

Graph 10: Quality of Food Score April 2018 – March 2019

In recognition of the need to further improve the quality of food a designated work programme in collaboration between Nursing, Estates and Facilities and the Trust's PFI Partners, Sodexo was established on the Oxford Road Campus. Funding was identified for a Matron for Dining to support this work during 2017.

The Trust has placed significant focus on improving the quality of food and through a process of wide engagement during 2017/18 a detailed action plan for improvement was developed. Work commenced to replicate the improvement programme at Wythenshawe and Trafford Hospitals. However, despite some initial work in 2017/18 on the Oxford Road Campus this did not translate into the transformational improvement in the quality of food score for MFT in 2018 National Survey, with MFT placed 10th when compared to other Trusts within the Shelford Group. **Graph 11** compares the MFT score to the Shelford Group.

Graph 11: Quality of Food Scores 2018 – Shelford Group



Since July 2018, significant progress against the milestones within the action plan on the Oxford Road Campus have been made and the improvement

programme at Wythenshawe and Trafford Hospitals has been developed and commenced led by a newly appointed Matron for Estates and Facilities. A specific focus for the Matron will be working with the Quality Improvement Team to continue to roll out Improving Quality Programme (IQP) at Wythenshawe Hospital in relation Meal Time Standards. Delivery of the action plans will continue in 2019/20.

A key work stream in 2019/20 is the **'Model Ward'**, with Manchester Vascular Centre identified as the pilot ward. Model Ward is a programme of work to develop an exemplar ward relating to Facilities Management services with concentration on Catering and Domestic Service provision. The programme is currently being finalised. The highlights proposed for catering include an 'end to end' catering service by dedicated catering professionals across all patient catering provision. Other benefits to patients include developments around Social Dining, with the inclusion of relatives also within the various food outlets across site.

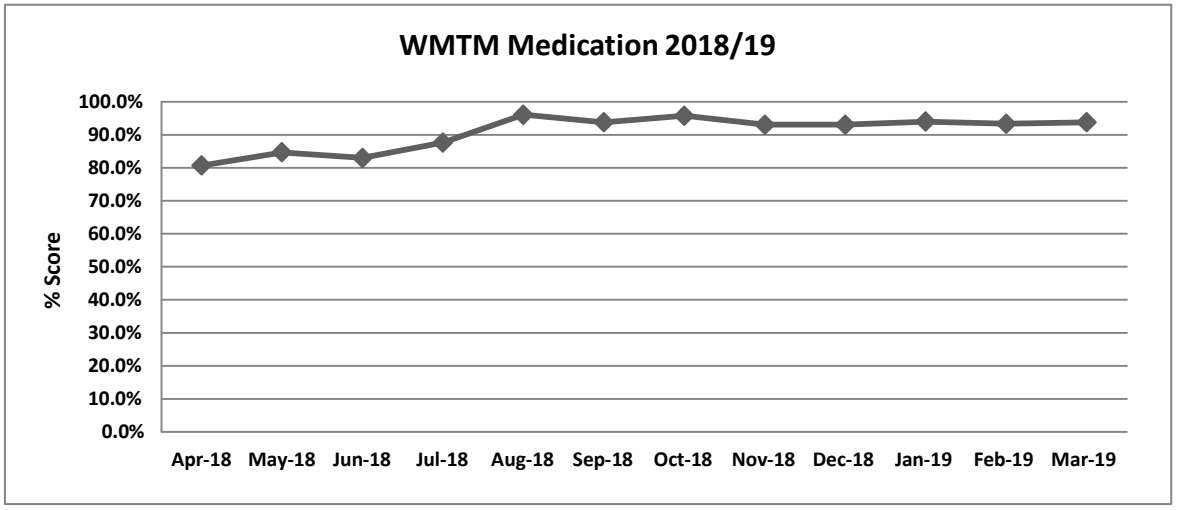
In recognition that a fundamental analysis and change is required to deliver significant improvements a Food Summit will be convened between nursing, Estates and Facilities and the Trusts PFI Partners to identify a number of high impact changes. Initial analysis of the Shelford Group Trust has identified that Guy's & St Thomas NHS Foundation Trust both score the highest and have demonstrated the most significant improvement when 2017 results are compared to 2018 results and the intention is to engage with the Trust to understand if lessons can be learnt to inform improvement at MFT. This work will then lead to a comprehensive action plan for 2019/20. It is however recognised that significant improvements will be challenging without transformational changes to the provision of food for patients, including the quality of food available for patients and the food delivery methods. As such the outputs from the Food Summit are required before the impact of any changes can be quantified.

5.2 Information about Medication

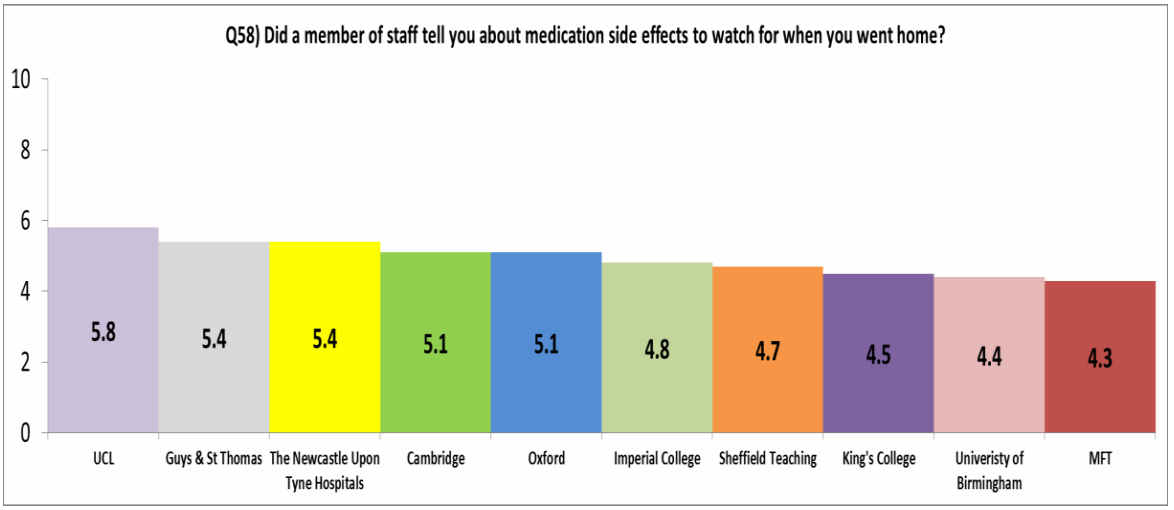
The ***'What Matters to Me'*** survey does not specifically ask whether staff advise patients about medication side effects to watch for when they go home; the survey asks 'Did a member of staff detail the medications you were taking home in a way you could understand?'

Analysis of the ***'What Matters to Me'*** survey data for inpatient respondents between April 2018 and March 2019, shows that on average 90.8% of respondents across the Trust reported that they had received information explaining their medication in a way that they could understand. This result exceeds the Trust's minimum target of 85% but highlights the need for continued focus on this aspect of patient experience. **Graph 12** compares the Trust scores for April 2018 – March 2019.

Graph 12: Medication Score April – March 2019



Graph 13: Medication Side Effects Scores 2018 – Shelford Group. The MFT score of 4.3 places the trust in 10th position.

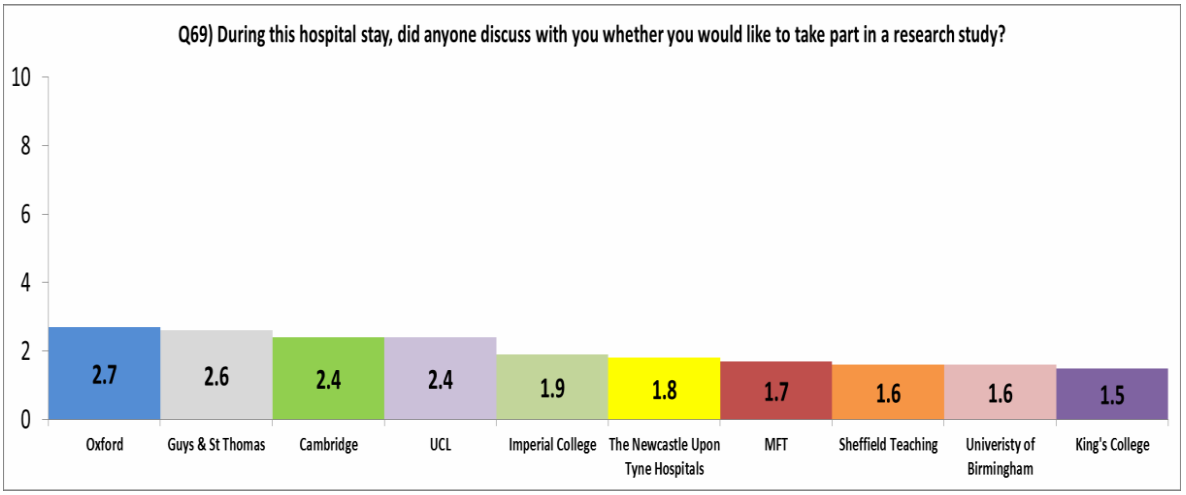


In collaboration with Pharmacy colleagues a Task and Finish Group will be established to map current processes for discussing medication side effects with patients and identify areas for improvement.

5.3 Research Involvement

Asking patients whether anyone discussed with them whether they would like to take part in research study is a new question for the 2018 survey. **Graph 14** compares the MFT score compared to the other Shelford Group Trusts, the MFT score 1.7 places the trust in 7th place.

Graph 14: Research Involvement Scores 2018 – Shelford Group



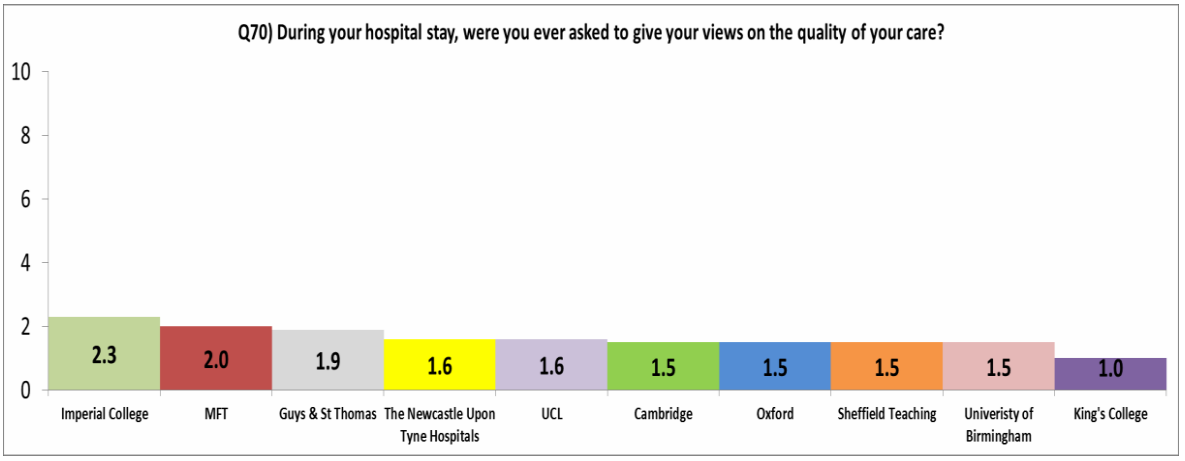
Last year at MFT 20,405 patients were recruited into research studies the 5th highest recruiting Trust Nationally. The question of whether anyone discussed with inpatients if they would take part in a research study could be problematic as the research team would only approach patients who have been pre-screened to fit into the inclusion or exclusion categories for the particular research studies. The baseline data for this question will be utilised to engage with colleagues in Research and Innovation to understand how involvement in research is offered and identify areas for improvement.

5.4 Quality of Care

The Trust's electronic ***'What Matters to Me'*** patient experience surveys, which are MFT surveys that have been locally developed based on the questions in the national patient experience surveys have been rolled out across MFT since April 2018. The survey includes question about specific and the overall patient experience. During 2018/19 20,539 surveys were completed. Whilst the survey relate to the quality of care a patient has experienced, the survey does not specifically use the terminology 'quality of care' and therefore despite patients completing the questionnaire they may not associate the questions with 'quality of care'.

Graph 15 compares **the** MFT quality of care score compared to the Shelford Group Trusts. The MFT score of 2.0 places the trust in 2nd position when compared to the other Shelford Group Trusts.

Graph 15: Quality of Care Scores 2018 – Shelford Group



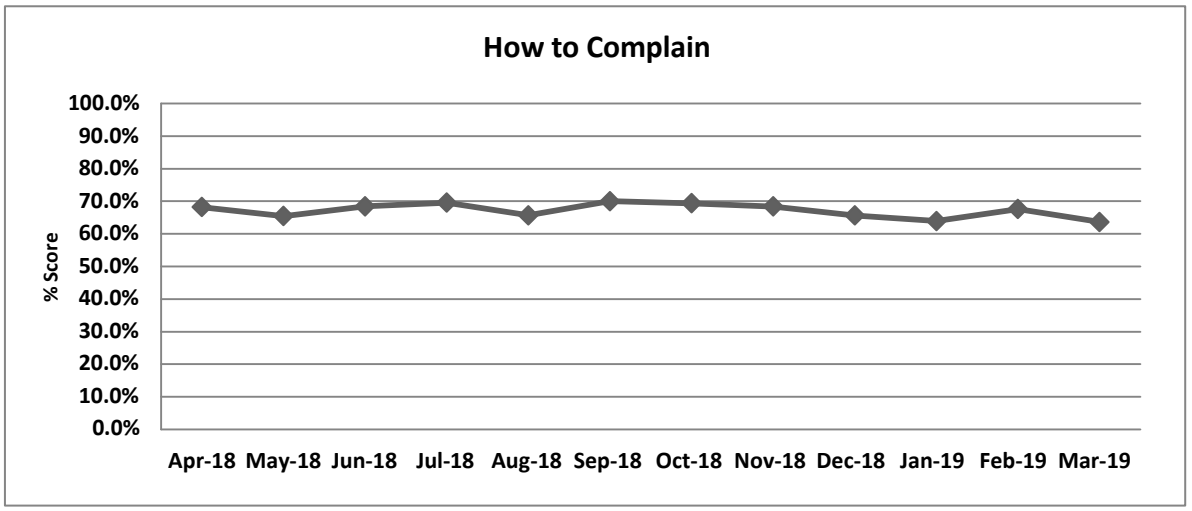
During 2019/20 the introductory on the screen for the WMTM patient experience survey will be amended to include the terminology 'quality of care' and explain to patients completing the survey that the survey is seeking feedback about the 'quality of care' the patient has received.

5.5 Information about Complaints

The Adult National Inpatient Survey (2018) MFT score for the question about knowing how to complain was 2.2. This compares to a score of 2.8 for legacy CMFT and 1.8 for legacy UHSM in the 2017 survey

The (2018) Analysis of the ***'What Matters to Me'*** survey data between April 2018 and March 2019 indicates that when asked 63.6% - 70.0% of patients in 2018/19 were aware how to complain.
The monthly data refelcts a downward trend, with an average score of 67.2% satisfaction rate across the Trust in relation to being given any information explaining how to complain to the hospital about the care received. **Graph 16** compares the Trust scores for April 2018- March 2019.

Graph 16: How to Complain Score April 2018 – March 2019



Based on feedback from previous surveys indicating information about complaints as an area for improvement during 2018/19 the following resources have been developed and made available to explain how to provide feedback, including how to complain:

- Patient Experience pop-up posters for each hospital
- Patient Experience Posters for display (Figure 1)
- Patient Experience Leaflet

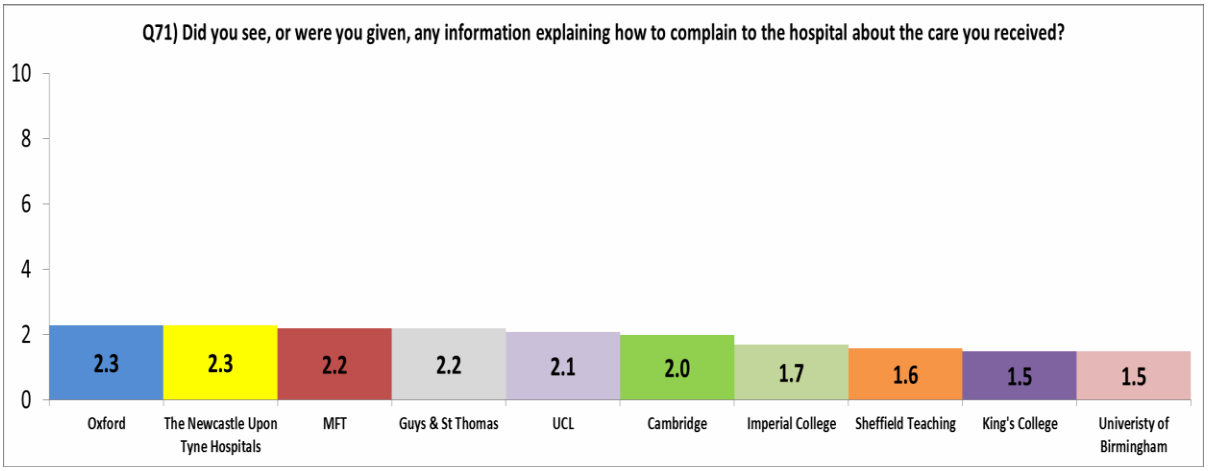
These resources will continue to be promoted during 2019/20.

The Easy Read Patient Experience Leaflet has been reviewed and approved by the Learning and Disability Patient, Parent and Carer Forum.

Figure 1: Patient Experience Feedback Poster

Graph 17 compares the MFT score of 2.2 which places the trust in joint 3rd position when compared to the other Shelford Group Trusts.

Graph 17: Information about Complaints Scores 2018 – Shelford Group



5.6 Next Steps: Information about Complaints

During 2019/20 we will continue to explore opportunities to ensure the trust is responsive to concerns raised and learn from patient feedback when accessing services or raising complaints.

Following the relocation of front of house PALS service on the Oxford Road Campus in 2017, the PALS Service at Wythenshawe Hospital is scheduled to move to a larger, more visible location in 2019/20.

5.7 Response to National Survey Results

Overall MFT was categorised as ***'about the same'*** as other organisations for responses to the Patient Surveys outlined within this report. Recognising that when comparing results over time[6], the 2018 survey results alongside real time MFT feedback, provide a baseline and real-time information for the organisation, enabling priorities to be identified and improvements realised

The survey results have been shared through Hospital/MCS structures and actions identified as required, to build on existing improvement work. Additionally, Trust-wide work continues through the Patient Environment of Care Group in order to address the persistently low scoring areas of food.

The Trust's ***'What Matters to Me'*** Patient Experience Programme, continues to be fundamental to achieving continued improvement in the Trust's annual National Survey scores. This programme of work aims to engage staff at all levels, creating individual ownership for the delivery of personalised care. Further detail of this programme is provided in Section 7 of this report.

[6] https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2019/06/Bulletin_2018_IP_FINAL.pdf

6. Friends and Family Test (FFT)

Figure 2: FFT Card

The FFT is a single question survey, which asks patients whether they would recommend the NHS service they experienced to friends and family who need similar treatment or care[7]. FFT results are published monthly on the NHS England website and the NHS Choices website and are monitored by the CQC as part of their inspection process. The Trust's FFT results are also included in the Board Assurance Report and Performance is manged via the Accountability Oversight Framework (AOF). FFT performance including qualitative comments provided by patients is accessible via the Meridian Patient Experience Portal – the Trust's electronic patient experience system, which is used locally to inform and support service improvements.

The FFT is an important source of information that provides information about ***What Matters to Patients*** about the care and treatment they receive. It is important that patients are given the opportunity to complete the FFT question and that they are able to add comments about their experience. The feedback informs continuous improvements and transformation of services to provide a high quality patient experience.

To maximise feedback from the FFT responses are captured through a variety of different methods including; FFT postcards, electronic devices, kiosks, the bedside entertainment system, online surveys and SMS text messaging

[7] NHS, England (2014, updated March 2015) **The Friends and Family Test.** Available from: http://www.england.nhs.uk/ourwork/pe/fft/

6.1 FFT Performance

Following the launch of FFT in April 2013 and up until March 2015 there was a CQUIN target of a 40% response rate for inpatient areas and 20% response rate for Emergency Departments. Reporting response rates is only a requirement for Inpatients and Emergency Departments and not the other categories. Post April 2015 there have been no CQUIN targets, however the Trust has continued to seek to achieve the previous targets. In recognition and agreement with local commissioners the Quality Schedule includes targets that the Trust will be expected to improve the FFT response rates year on year.

The MFT FFT response rates and results in 2018/19 are detailed in **Table 5**

Table 5: MFT FFT response rates and results in 2018/19

Friends and Family Test Response and Results: MFT 2018/19		
Area	**Response Rate**	**Percentage of patients who were 'extremely likely' and 'likely' to recommend our services**
Inpatients	21%	97%
Emergency Departments	16%	86%
Outpatients	N/A	96%
Community	N/A	99%
Maternity	N/A	97%

6.2 Shelford Group Comparison

The overall inpatient FFT response rates for the Shelford Group for the period of April 2018 to March 2019 range from 9% to 31% as demonstrated in **Table 6.** The MFT response rate was 21%, which places MFT in third position in the Shelford group. This compares to the MFT response rate of 27.5% between October 2017 and March 2018, which also placed MFT in third position in the Shelford group.

The percentage of patients who were extremely likely/ likely to recommend MFT to friends and family who need similar treatment or care was 97%, for this period, which compares favourably to a range from 94% to 98% across Shelford Group trusts. This compares to 96.9% of patients who were

extremely likely/ likely to recommend the MFT to friends and family who need similar treatment or care between October 2017 and March 2018.

The comparison of MFT Inpatient FFT response rate and responses compared to Shelford Group Trusts 2018/19 in detailed in **Table 6**.

Table 6: MFT Inpatient FFT response rate and responses compared to Shelford Group Trusts 2018/19

Friends and Family Test Response and Results: Inpatients 2018/19		
Trust	**Response Rate**	**Percentage of patients who were 'extremely likely' and 'likely' to recommend our services**
Cambridge University Hospitals NHS Foundation Trust	9%	96%
Guy's and St Thomas' NHS Foundation Trust	20%	95%
Imperial College Healthcare NHS Trust	31%	98%
Kings College Hospital NHS Foundation Trust	13%	94%
Manchester University Hospitals NHS Foundation Trust	21%	97%
Newcastle upon Tyne Hospitals NHS Foundation Trust	20%	96%
Oxford University Hospitals NHS Foundation Trust	29%	96%
Sheffield Teaching Hospitals NHS Foundation Trust	12%	97%
University College London Hospitals NHS Foundation Trust	20%	94%
University Hospitals Birmingham NHS Foundation Trust	19%	95%

The overall Emergency Department FFT response rates for Shelford Group trusts for the period April 2018 to March 2019 range from 1% to 23% as demonstrated in **Table 7.**

The MFT response rate was 16%, which places the trust in sixth position in the Shelford Group. The percentage of patients who were extremely likely/ likely to recommend the MFT Emergency Department services is 86%, which again places MFT in sixth position compared to other Shelford trusts.

Table 7: Comparison of MFT Emergency Department FFT response rate and responses compared to Shelford Group Trusts in 2018/19.

Friends and Family Test Response and Results: Emergency Departments		
Trust	**Response Rate 2018/19**	**Percentage of patients who were 'extremely likely' and 'likely' to recommend our services**
Cambridge University Hospitals NHS Foundation Trust	21%	92%
Guy's and St Thomas' NHS Foundation Trust	20%	85%
Imperial College Healthcare NHS Trust	14%	94%
Kings College Hospital NHS Foundation Trust	7%	79%
Manchester University Hospitals NHS Foundation Trust	16%	86%
Newcastle upon Tyne Hospitals NHS Foundation Trust	23%	88%
Oxford University Hospitals NHS Foundation Trust	21%	87%
Sheffield Teaching Hospitals NHS Foundation Trust	1%	93%
University College London Hospitals NHS Foundation Trust	19%	85%
University Hospitals Birmingham NHS Foundation Trust	11%	76%

6.3 FFT Improvement plan

The initiatives implemented and undertaken during 2018/19 to improve FFT are detailed in **Table 8** below

Table 8: Initiatives implemented during 2018/19 to improve FFT

FFT Improvements during 2018/19
In April 2018, the electronic system which was implemented across our wards and departments allows teams to review their FFT feedback and specifically individual comments in real time
The provision of the FFT question as a separate icon on the hand held electronic devices, making it easier for our patients to complete the FFT question on their discharge
The FFT question on the hand held devices and the Trust website is available in the top ten most used languages across MFT
Monthly FFT data reports have been updated to reflect the changes across the Trust and are prepared for each Hospital/ MCS/ MLCO
The Quality Improvement and Patient Experience teams have worked collaboratively with Hospitals/Managed Clinical Services/MCLO to: • Continue to promote the FFT survey • Support processes for collecting FFT • Support use of the Patient Experience Portal 'Meridian'
A designated FFT and NHS Website Lead post was authorised, the post holder commenced in April 2019.

6.4 Future development of FFT

During 2018/19 NHS England undertook a review of the patient focused FFT. In his announcement on 10th June 2019, Dr. Neil Churchill, Director of Patient Experience, NHSE informed NHS Provider Organisations that from April 2020 there will be significant changes to the way FFT is carried out across England. The Trust awaits the pending release (anticipated September 2019) of the changes to ensure preparedness for the new model.

In order to continue to improve the response rate, the following further actions are planned for 2019/20:

- Upon publication of revised national guidance from NHS England a full review will be carried out of the FFT materials used across the Trust
- Continue to publicise the importance of FFT to staff and patients.
- Continued work in collaboration with Hospital/ MCS/ MCLO teams to increase FFT response rates and promote the FFT survey.

- Continue to refine FFT capture processes across the Trust.
- Raise awareness of the availability of the FFT survey from the trust website. The FFT survey can be accessed on any device with the internet, trust or personal; this capability is currently underutilised.
- A bespoke FFT Card for children and young people is being developed in order to make them more user friendly.

Whilst it is recognised that the feedback received through FFT is valuable we will continue to triangulate this feedback with other available data to ensure focused quality improvement.

7 What Matters to Me: Trust Patient Experience Programme

7.1 Background

Patient experience is one of the three dimensions of quality[8] alongside patient safety and clinical outcomes. There is a body of research[9][10][11][12] to indicate that delivering excellent Patient Experience can support a number of benefits for patients and healthcare organisations, including lower staff turnover and absenteeism, enhanced recovery, improved productivity and efficiency and informed choice by patients. Improving the experience for patients, carers and their families is a strategic aim of the Trust and this is influenced by every member of staff, in every staff group in the organisation.

The Trust's Quality and Safety Strategy (2018-2021) sets out a commitment to provide the quality of care that matters to patients and their families and caring for the wellbeing of staff. The strategy is underpinned by the Trust Vision, Values Statement that ***'Together Care Matters'*** and a values and behaviours framework

The ***'What Matters to Me'*** Patient Experience Programme is underpinned by the Trusts values with the overarching principle of the programme being to treat every patient as an individual, to encourage staff to ask patients 'what matters' to them as they travel through services, to listen, and to respond to those needs.

Following the initial phases of the work in 2016 and 2017 at former CMFT, a programme to roll out the programme across the entire newly formed Trust commenced in February 2018 with the first of a series of ***'What Matters to Me'*** staff and patient engagement sessions

[8] NHS England. https://www.england.nhs.uk/about/our-vision-and-purpose/imp-our-mission/high-quality-care/

[9] NHS Confederation, http://www.nhsconfed.org/Publications/Documents/Feeling better Improving patient experience in hospital. Report.pdf

[10] The King's Fund, Seeing the Person in the Patient, The Point of Care Review, 2008

[11] The Beryl Institute (2011), Return on Service, The Financial Impact of Patient Experience and HFM, Building the Business Case for Patient-Centred Care

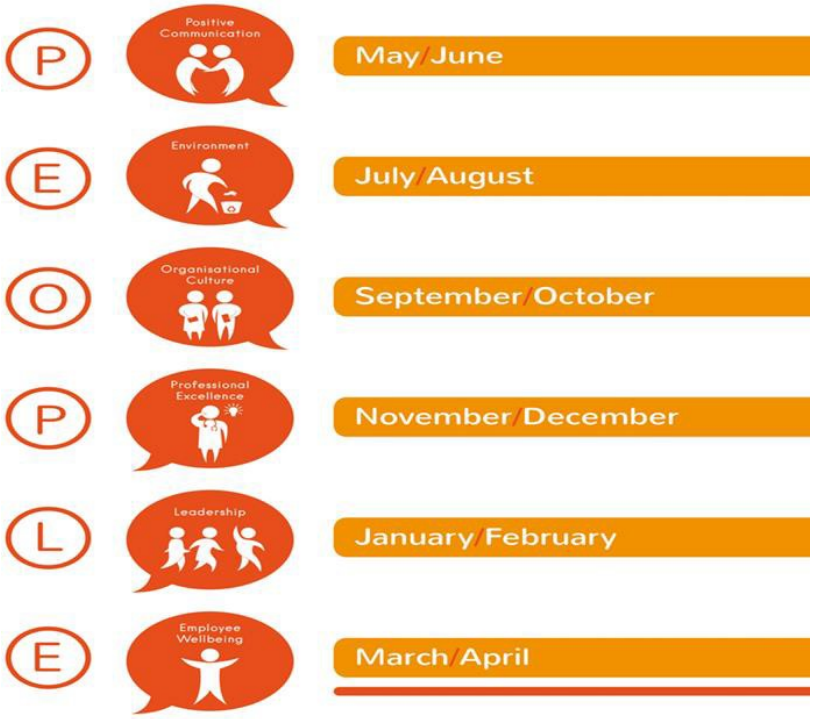
[12] Charmel PA, Frampton SB (2008) Building the business case for patient-centered care. Healthcare Financial Management. March, vol 62(3), pp.80-5

During April to August 2018 further patient, service user and staff engagement sessions took place across all MFT Hospitals/ MCS and the MLCO. Collation and analysis of the feedback from the additional engagement sessions revealed that whilst some contrast in WMTM sub-themes existed which are representative of individual hospitals, (their services and the populations which they represent), the main overarching themes remained consistent with those identified at former CMFT, with no independent themes emerging.

7.2 What Matters to Me (WMTM)

The overarching principle of the ***'What Matters to Me'*** programme is to treat every patient as an individual, to encourage staff to ask patients 'what matters' to them as they travel through services, to listen, and to respond to those **personal** needs. The six key elements of the programme are identified in **Figure 3** below, along with the months upon which the programme has a specific focus on each element.

Figure 3: Overarching elements of excellent personalised patient experience



7.3 WMTM Programme Update

Supported by the investment of Charitable Funds, a dedicated Programme Manager was recruited for one year commencing in February 2018, to expedite the pace and spread of the ***'What Matters to Me'*** programme across all MFT Hospitals/ MCS/ MLCO. The Programme Manager established networks throughout the organisation and worked in partnership with a variety of multi-disciplinary professionals to integrate WMTM into strategies, policies and educational programmes.

In line with the NHS Identity Guidelines the **'*What Matters to Me'*** visual identity and all associated resources were updated in Quarter 2 of 2018/19 (**Figure 4**).

Figure 4: ***'What Matters to Me'*** visual identity

The recruitment of two '**What Matters to Me'** Educators, supported by Charitable Funding, launched the co-designed the 'First Impressions Training Programme' for Administrative and Clerical Staff. This programme which recognises the key interface that Administrative and Clerical staff have with patients at their first point of contact with the organisation was piloted in September 2018 and rolled out across the trust in October 2018 following feedback from comprehensive staff engagement sessions and focus groups. The achievements of the programme have included:

- Around 300 Administration & Clerical staff have attended the trained since October 2018.
- The First Impressions Staff and Managers Modules of the Programme have been well received with approximately 92% of the learners indicating substantial understanding of the Trust Vision and Values, the importance of patient experience and ways to reduce the barriers to and improve the ***First Impressions*** for our patients.
- There has been significant feedback from learners expressing, they felt valued and understood that they are pivotal to patient experience and that they felt empowered to make improvements in their areas of work which can positively impact patient experience.
- The training resources, including the telephone and email etiquette have been welcomed and well received by learners.
- The First Impression training programme was a recognised 'Finalist' of the Patient Experience Network National awards (PENNA) 2018.

Image 4: First Impressions Training cohort

7.4 Sustaining Momentum

Momentum for the programme has been maintained through an extensive engagement and communication approach, which involves staff and encourages a personal commitment to introduce ***'What Matters to Me'*** conversations into interactions with patients at all levels. Regular communication and engagement across a range of channels includes:

- A weekly WMTM update in the organisational staff newsletter; MFT iNEWS.
- Social media has been extensively utilised to communicate and publicise the WMTM programme to promote local ownership. Within the financial year 2018-2019 there was significant activity on twitter which continued to raise the profile of the WMTM programme. During this period the Patient Experience Team published 1479 tweets and gained 3095 likes and have 1081 followers. This activity demonstrates the continued high profile of the WMTM programme.
- WMTM patient stories at the commencement of the MFT Board of Director Meetings and other Group-wide meetings including the Cancer Board.
- Regular screensavers, e-shots and communication bulletins that provide publicity for key training and events related to WMTM.
- Promotion of the enhanced electronic resource pack available on the MFT Learning and Resource hub, including resources for use with Children and Young People and resources for those who converse in the languages most commonly used across Greater Manchester: English, Urdu, Punjabi, Cantonese, Arabic and Polish.
- WMTM has been embedded into the Accreditation process and Senior Leadership Walk Rounds (SLWR), with senior leaders asking staff and patients about ***'What Matters to Them'*** as part of the Walk Rounds. During SLWR, staff are asked about their knowledge of the WMTM

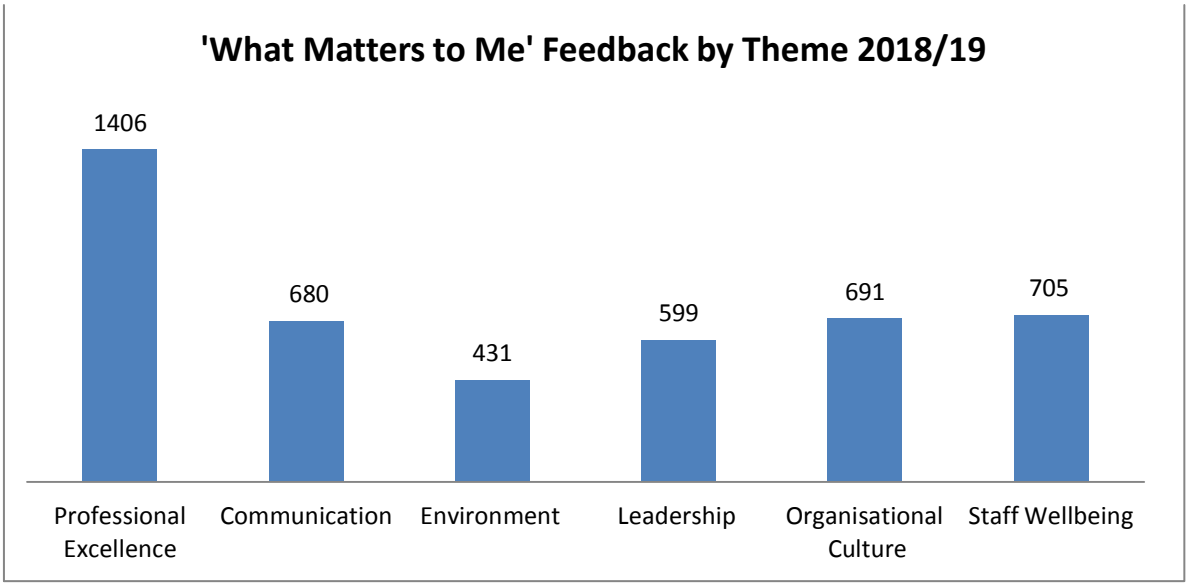
programme, in order to support them in embedding WMTM within their own service.

- A programme of WMTM events have been held across the Trust, including in Mental Health Awareness week in May 2018 and on International WMTM day in June 2018.
- There have been engagement events held with staff, for example, a theatre staff engagement event was held in June 2018 across the Oxford Road Campus, Wythenshawe and Trafford involving over 180 theatre staff.

7.5 Feedback

The feedback from patients, gathered since the launch of the programme is used to provide local insights regarding how care can be more patient centred. This has allowed real time changes and adjustments to be made based upon the feedback received, to essentially respond to ***'What Matters'*** to patients. In addition, the Patient Experience Team have developed a database, which allows feedback to be themed against the 6 key elements of the programme. **Graph 18** demonstrates the percentage of feedback currently mapped against each theme. This highlights the importance of positive communication, professional excellence, organisational culture and staff wellbeing to staff and patients.

Graph 18: Patient feedback mapped to each key theme, 2018-2019



7.6 Examples from across MFT/ Hospitals/ MCS's/ MLCO of improvement work undertaken following listening to patient and relative feedback

MFT's '***Getting to know me'*** cards have been revised to increase the focus on getting to know the person and to help identify if a person is in pain

The cards (**Figure 5**) are used across the trust to compliment the patients care Plan

Figure 5: 'Getting to know me' cards

7.7 **The Royal Manchester Children's Hospital (RMCH)** is one of three highly specialised nationally commissioned paediatric services for LSD (Lysosomal storage disorders) in the UK. In response to feedback from a child's family about their experience of attending Accident and Emergency in a general hospital where the medical staff were unfamiliar with the child's rare genetic condition a specialist physiotherapist has created information cards (**Figure 6**) for patients with rare genetic conditions. The cards provide diagnosis information as well as details of their medical team/s and medication.

Figure 6: Information card for patients with rare genetic conditions, RMCH

NHS Manchester University NHS Foundation Trust — MPS I (Hurlers disease)	Joe Bloggs MPS I Post HSCT 2008 (as of 25/7/18)
MPS I (a Lysosomal storage disorder) is a Genetic metabolic disorder affecting all body systems. A missing enzyme results in the build-up of glycosaminoglycan's (GAGS). Without this enzyme, a build-up of heparin sulphate and dermatan sulphate occurs in the body. MPS I comprises a wide spectrum of severity and the traditional classification of Hurler, Hurler Scheie and Scheie does not adequately reflect the wide spectrum. Although there is no cure for MPS diseases, there are ways of managing and treating the problems they cause. Symptoms are progressive appearing during childhood causing progressive organ and skeletal damage which may affect the heart and airway.	**Medication** Ibuprofen Paracetamol Melatonin Penicillin **RMCH 0161 276 1234** **Allergies Emla cream / bee stings**

Endocrine	Prof Clayton	**Hands**	Mr Nixon
Metabolic	Dr Jones	**ENT**	Prof Bruce
Spinal	Mr Oxborrow	**Cardiac**	Dr Ciotti
Orthopaedic	Mr Morakis	**Eye**	Miss Ashworth
Neurosurgeon	Mr Ramirez	**Dental**	Miss Hood

The RMCH Youth Forum was established in October 2008, as part of Youth Engagement Structure. The aim of the Youth Forum is to provide youngpeople with the opportunity to express their views and to contribute to the ways in which the Trust delivers health care services for young people. The Youth Forum is run by its youth members with representation and support from a member of the senior management team at RMCH who has a remit to working across the Trust. Membership of the Youth Forum is open to young people aged between 11-25 years who feel passionately about improving the services for young people in the hospital setting. Current membership reflects young people who are service users, volunteers and those pursuing careers in health care or medicine**.** The Youth Forum Poster has been redesigned by the Youth Forum (**Figure 7**).

Figure 7: Youth Forum Poster, RMCH

During Mental Health Awareness Week Ward 77, RMCH raised awareness with a display at the front of Ward 77 with information on how to deal with work related stress and mental health and social media. There were advice leaflets and staff were provide with a stress ball and contact numbers of who to contact if they were struggling, including the Trusts Employee Health and Wellbeing Service (**Image 6**). They planned a daily activity to promote positive communication between staff to help open up lines of communication for them to be able to talk to each other if they need support. They did this recognising the general increase in mental health illnesses and the impact of staff not looking after themselves can have on our patients.

Image 6: Gifts for staff including stress ball and details of the employee health and well-being service, Ward 77, RMCH

Following feedback from patients that they worried when being admitted to hospital the team on Ward 77, RMCH have introduced a 'Worry Tree' at the front the ward, opposite their staff WMTM tree (**Image 7**). The purpose of this tree is for patients to express their worries to the tree on admission, for example if they are worried about their operation. There is worry plague attached to the tree with a hand print on it. The patient places their hand on the hand print and it turns red. They say their worry and the hand print then turns green. The worry is turned into a wish and the patient is given a wish bracelet (a little acorn bracelet) on discharge to celebrate their achievements of being brave.

Image 7: Worry Tree, Ward 77, RMCH

7.8 At **St Marys MCS**, the Matron for inpatients Services has developed the role of disability advocate for women and has developed a referral pathway for any woman with a physical disability. Staff are able to refer women to the service for either a face to face or a telephone meeting to discuss the #WMTM for their disability while they will be in our inpatient areas.

Facilities and equipment are explored to ensure the woman is provided with personalized disability care. The Care Quality Commission hashighlighted this role as an area of outstanding practice.

At **St Marys MCS** the Emergency Gynaecology Unit Team have developed Dignity Packs (Image 8) for women. The packs include items of clothing which support the women to respect their dignity and provide comfort, and improve their patient experience. Prior to the availability of dignity packs, women were provided with a change of emergency clothing including disposable underwear and theatre scrub trousers as an alternative. The team embarked upon a series of fundraising events to raise funds to support developing the packs.

Image 8: Dignity Packs, Gynaecology, SMH

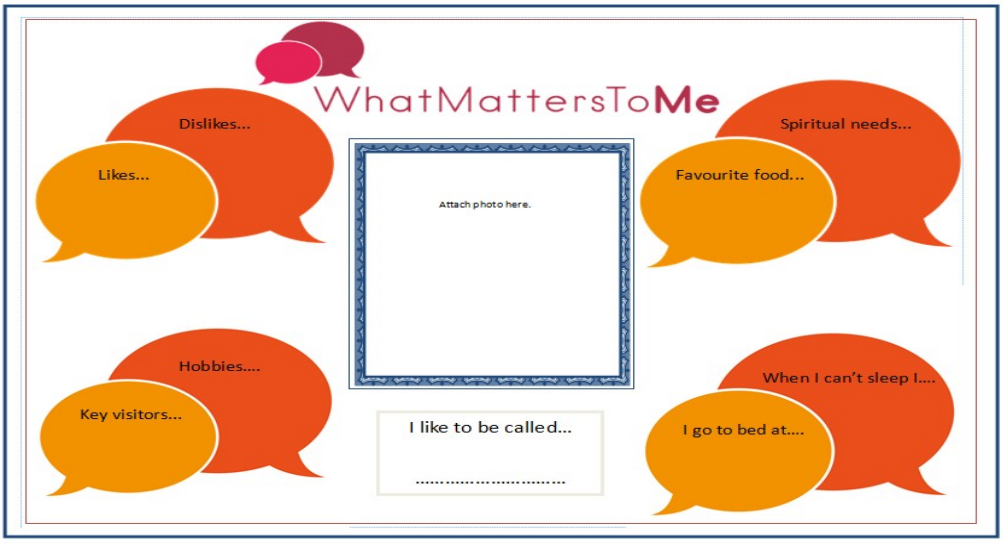
The **St Marys** Rainbow Clinic Team have shared information with representatives from other Trusts to support the introduction of Rainbow Clinics both regionally and nationally. The aim is to support all women that have experienced baby loss and reduce variation in practice. This will ensure that care is individualised in the next and subsequent pregnancies. A patient questionnaire is used to ask all women WMTM and they consistently recommend that the service should be available to all women who need it.

A **St Marys** Clinical Research Midwife (**Image 9**) has been highly commended at the Mariposa Awards for making a real difference in the lives of people who have experienced baby loss

Image 9: Clinical Research Midwife with her Award, SMH

7.9 Within **Clinical and Scientific Services MCS** the Critical Care Team have introduced a WMTM Bedside poster (**Figure 8**) this allows the staff to understand more about the person prior to their admission. Who they are as an individual and what really matters to them.

Figure 8: WMTM Bedside poster, Critical Care



The Critical Care team have also embedded WMTM questions into the documentation system, including mandatory daily questions for visitors & patients

- What would you like to ask the Dr Today?
- 'What Matters To You, Right Here Right Now?'

Trust volunteers spend time with visitors in the Critical Care unit relatives waiting area. They provide 'a brew and a biscuit' and the informal opportunity for relatives to talk and come together to chat about their experiences.

What Matters to Me Comments cards are also available within the Critical Care Unit to provide visitors with the opportunity to inform staff about their experiences to support further improvements?

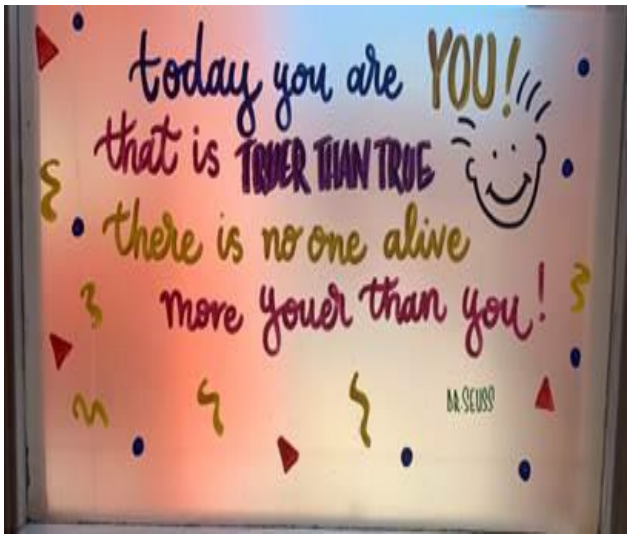
7.10 The **Manchester Royal Eye Hospital** team received feedback from patients that the colour of the door frames and the walls on Ward 55. Manchester Royal Eye Hospital (MREH) needed to be more contrasting. Advice was sought from Ophthalmologists to ensure suitable best contrast to meet the needs of visually impaired patients.

Using this advice, patients were involved in the decision to decorate the walks in lemon and the doorframes in gun metal

7.11 With the **University Dental Hospital of Manchester** art work has brightened up the Orthodontic Department and First Floor Restorative clinic

The art work (**Images 10 and 11**) consists of motivational quotes for teenagers and 'welcome' in the many languages used by our patients that attend the hospital. This has been very well received by staff and patients and had lots of positive feedback.

Images 10 & 11: Art Work, Orthodontic Department and First Floor Restorative clinic, UDHM



7.12 The **Clinical Research Facility** uses contrasting colours on flooring and sign boards to facilitate accessibility for people with a visual impairment (**Figure 13**). Additionally the facility has a variety of Visual impairment information leaflets to support people with a visual impairment.

Image 12: Contrasting colours on stair flooring, Clinical Research Facility

7.13 Within **Wythenshawe, Trafford, Withington and Altrincham (WTWA)** the Elective Orthopaedic and Speciality Surgery unit at Trafford General Hospital is a very busy inpatient and day case facility. Following feedback from patients regarding the waiting time to be taken to the operating theatre the team embarked on a programme of work which included a patient questionnaire and a focus group to identify feedback from patients to inform improvements. The work was multi-disciplinary and was supported by Healthwatch Trafford.
As a result of the feedback changes were introduced including identifying and informing the patient of their 'Estimated time to theatre'. The MFT website Ward 12 page and patient admission letters communicate this process. Patients are now given one of two admission times, depending on their time to theatre. Following the improvements verbal concerns and negative FFT comments regarding delays have significantly reduced.

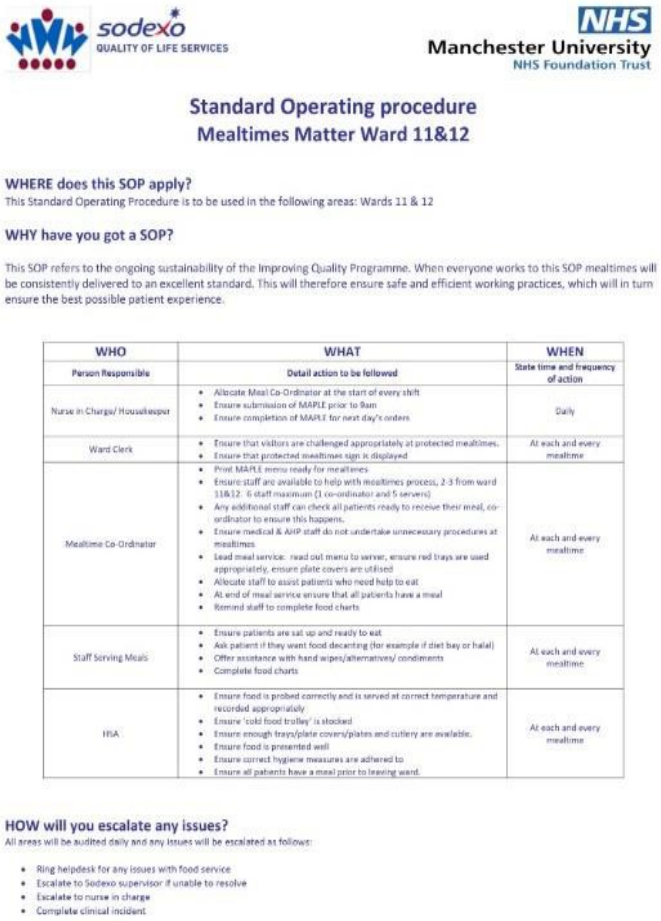
Ward F3, Wythenshawe Hospital have made improvements to the garden adjacent to the ward to provide a quiet peaceful area for their patients to relax and enjoy the open air. New seating has been purchased and the hospital gardeners have helped to improve the trees and large plants whilst ward staff are helping with the weeding. The ward staff are grateful to local garden centres who have supplied plants, bird feeders and nuts to further improve the area.

The majority of patients on Ward 11/12 undergo gastro-intestinal surgery and often feel nauseous with a reduced appetite. The wards WMTM data consistently demonstrated that patients were very unhappy with the nutritional aspects of the hospital experience. Prior to the improvements a large prepacked meal which was reheated in the microwave and served to patients. Patients complained about the size of the portion and that the food was bland tasting. The ward team devised a Standard Operation Procedure (**Figure 11**) and transformed the service, with the re-introduction of the trolley where patients are able now to choose portion size and create their own meal.

The team also improved on the meal service, ensuring this was patient centred and individualised.

7.14 Within **Manchester Royal Infirmary (MRI)** the WMTM data regarding nutrition on Wards 11/12 has consistently and significantly improved, and the team were recently accredited and received GOLD standard in all aspects of the meal process. The Trust Improving Quality Programme (IQP) methodology has been used to achieve the improvements and has resulted in the team developing a Standard Operating Procedure of Meal Times **(Figure 9)**.

Figure 9: Mealtime Standard Operating Procedure, Wards 11/12, MRI



sodexo QUALITY OF LIFE SERVICES

NHS Manchester University NHS Foundation Trust

Standard Operating procedure
Mealtimes Matter Ward 11&12

WHERE does this SOP apply?
This Standard Operating Procedure is to be used in the following areas: Wards 11 & 12

WHY have you got a SOP?

This SOP refers to the ongoing sustainability of the Improving Quality Programme. When everyone works to this SOP mealtimes will be consistently delivered to an excellent standard. This will therefore ensure safe and efficient working practices, which will in turn ensure the best possible patient experience.

WHO	WHAT	WHEN
Person Responsible	Detail action to be followed	State time and frequency of action
Nurse in Charge/ Housekeeper	• Allocate Meal Co-Ordinator at the start of every shift • Ensure submission of MAPLE prior to 9am • Ensure completion of MAPLE for next day's orders	Daily
Ward Clerk	• Ensure that visitors are challenged appropriately at protected mealtimes. • Ensure that protected mealtimes sign is displayed	At each and every mealtime
Mealtime Co-Ordinator	• Print MAPLE menu ready for mealtimes • Ensure staff are available to help with mealtimes process, 2-3 from ward 11&12. 6 staff maximum (1 co-ordinator and 5 servers) • Any additional staff can check all patients ready to receive their meal, co-ordinator to ensure this happens. • Ensure medical & AHP staff do not undertake unnecessary procedures at mealtimes • Lead meal service: read out menu to server, ensure red trays are used appropriately, ensure plate covers are utilised • Allocate staff to assist patients who need help to eat • At end of meal service ensure that all patients have a meal • Remind staff to complete food charts	At each and every mealtime
Staff Serving Meals	• Ensure patients are sat up and ready to eat • Ask patient if they want food decanting (for example if diet bay or halal) • Offer assistance with hand wipes/alternatives/ condiments • Complete food charts	At each and every mealtime
HSA	• Ensure food is probed correctly and is served at correct temperature and recorded appropriately • Ensure 'cold food trolley' is stocked • Ensure enough trays/plate covers/plates and cutlery are available. • Ensure food is presented well • Ensure correct hygiene measures are adhered to • Ensure all patients have a meal prior to leaving ward.	At each and every mealtime

HOW will you escalate any issues?
All areas will be audited daily and any issues will be escalated as follows:

- Ring helpdesk for any issues with food service
- Escalate to Sodexo supervisor if unable to resolve
- Escalate to nurse in charge
- Complete clinical incident

The MRI Older Person's Fellowship Project '5 things about me' was inspired by WMTM. The project aim was to make care person-centred by supporting staff to get to know their patients better as people (**Figure 10**).

Figure 10: *5 Things about Me* Bedside Poster

7.15 In 2018, collaboration across Clinical and Scientific Services MCS and Royal Manchester Children's Hospital (RMCH) introduced the ***Harvey's Gang*** initiative. The objective of the initiative is to provide children the opportunity to visit the laboratories and ask questions about where their samples go to be tested (https://harveysgang.com/).

The laboratory staff work closely with play specialists from RMCH. Visitors are selected due to their fear of needles and apprehension about having their blood taken. Over the past year the service has seen 13 patients in the Blood Sciences Laboratories. Visitors have asked questions such as 'why does it take so long for my blood to arrive on the ward?', 'how do we know the blood is the right type for me?' and 'What training do the laboratory staff have?' The visits give parents an opportunity to ask questions and feel reassured that their child's samples are being treated with care and compassion. The initiative also gives laboratory staff the opportunity to meet and chat to the patients (**Image 13**).

Image 13: Harvey's Gang visitors to the laboratories

7.16 Following feedback from patients and relatives regarding end of life care Community Nurses in the MLCO have worked in partnership with the Macmillan Care Team to ensure they provide dignified and respectful personalised care. Patients and relatives are offered the opportunity to have hand casts (**Image 14**) which provide a positive lasting memory for bereaved loved ones.

Image 14 Picture of hand cast provided to a patient and relative by the Community Nursing Team in partnership with Macmillan Care.

7.2 Future Development for What Matters to Me

'What Matters to Me' will continue to be embedded in Trust strategies, policies and education programmes

Wall art will be developed to display the unique graphics produced during the engagement process, at both MFT and Hospital level.

There will be development in 2019/20 of a new phase of the *WMTM* framework to explore the integration of the approach into the coproduction of services through the Always Events^{R} Methodology[13].

8 Conclusion and Recommendation

8.1 The patient feedback received through the National Surveys identifies that MFT, was categorised as ***'about the same'*** as other organisations, with some positive high scores and some identified areas where there is recognition a fundamental analysis and change is required to deliver significant improvements

8.2 Overall real time patient experience feedback from the ***'What Matters to Me'*** Patient Experience Survey shows more positive results, demonstrating that progress continues to be made to deliver improvements in some key areas, whilst highlighting the continued activity that must be undertaken to drive a shift from 'average' to 'excellent'.

8.3 The Trust's approach to Patient Experience, ***'What Matters to Me',*** continues to places the focus on delivering a **personalised** approach to care. This Programme has gained momentum and has maintained the commitment and enthusiasm of a wide range of staff across many disciplines with significant progress to roll out the approach across the organisation and embed the approach into all activities across the Trust. There continues to be emerging evidence that ***'What Matters to Me'*** can be used to effectively support clinical and non-clinical improvement in order to improve the quality of staff experience and the experience provided to patients and their families and carers and ultimately to impact on care outcomes. Examples of ***'What Matters to Me'*** initiatives across the Trust are highlighted within the report.

8.4 The Board of Directors are asked to note the content of the report and support the actions required to ensure continuous improvement.

[13] NHSE(2016) Always Events Toolkit

Appendix 1

Maternity Services Survey (2018) comparison of MFT scores by category to the Shelford group Trusts

Antenatal Care

Note: Queen Charlotte's and Chelsea Hospital (Imperial College Hospital Healthcare NHS Trust) does not provide Antenatal Care

Chart A: Overall Scores for 'The start of your pregnancy'

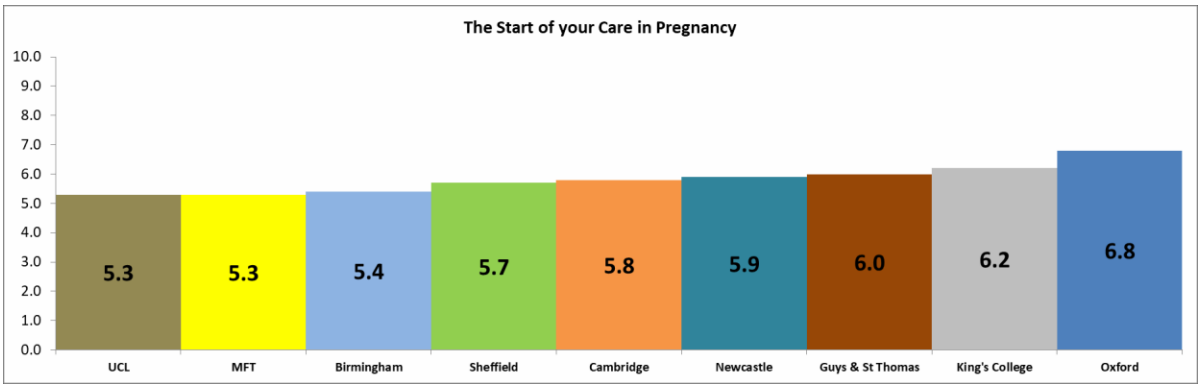


Chart B: Overall Scores for 'Antenatal check ups'

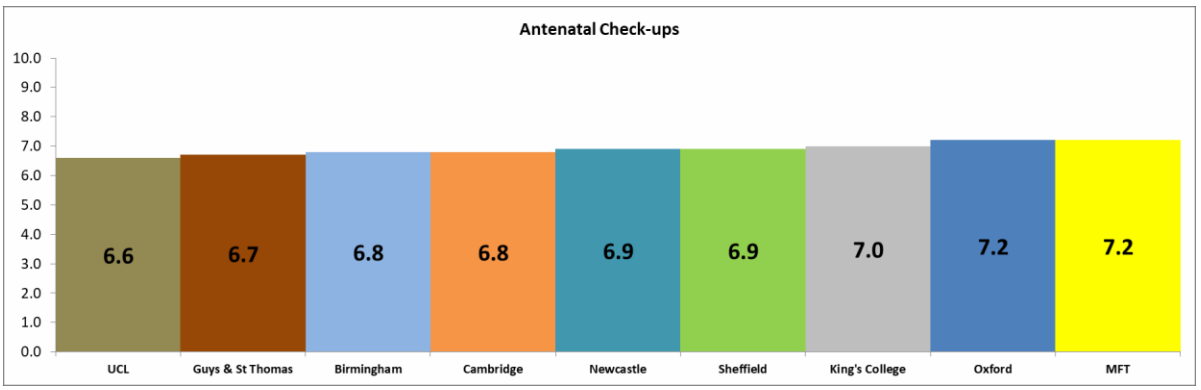
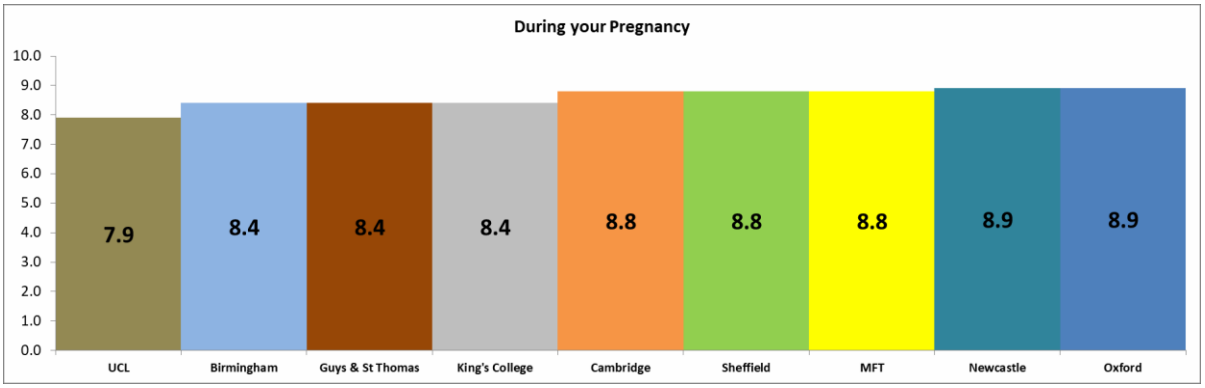


Chart C: Overall Scores for 'During your Pregnancy'



Labour and Birth

Chart D: Overall Scores for 'Labour and Birth'

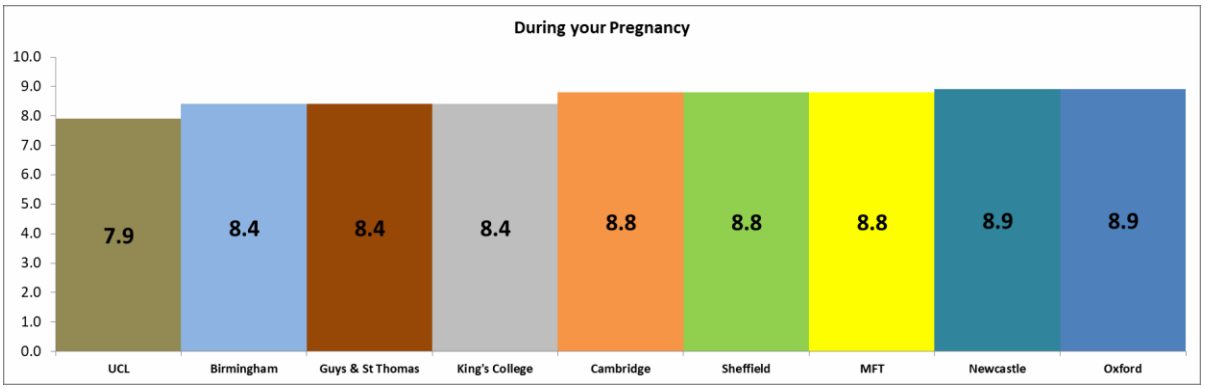
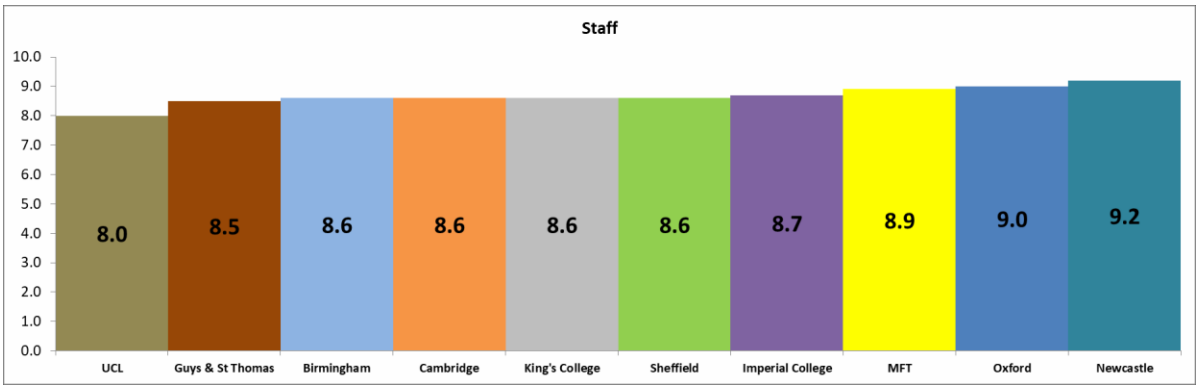


Chart E: Overall Scores for 'Staff'



Postnatal Care

Note: Queen Charlotte's and Chelsea Hospital (Imperial College Hospital Healthcare NHS Trust) and Kings College Hospital NHS FT DO not provide Postnatal Care

UCL Hospital NHS FT did not have a Section Score for 'Care at Home after Birth'

Chart F: Overall Scores for 'Care in Hospital after Birth'

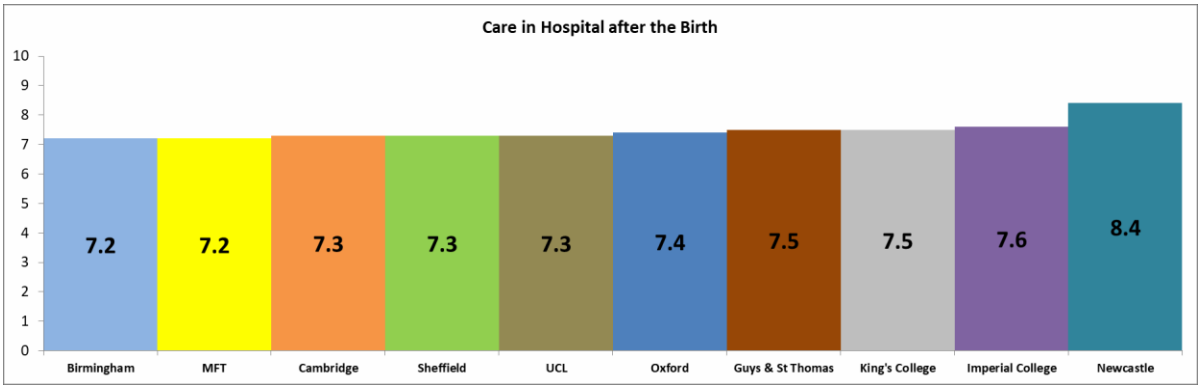


Chart G: Overall Scores for 'Feeding'

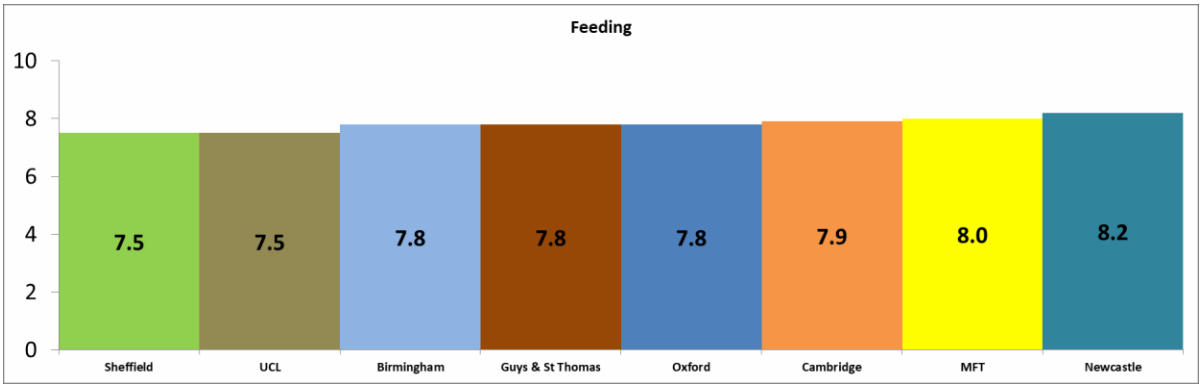
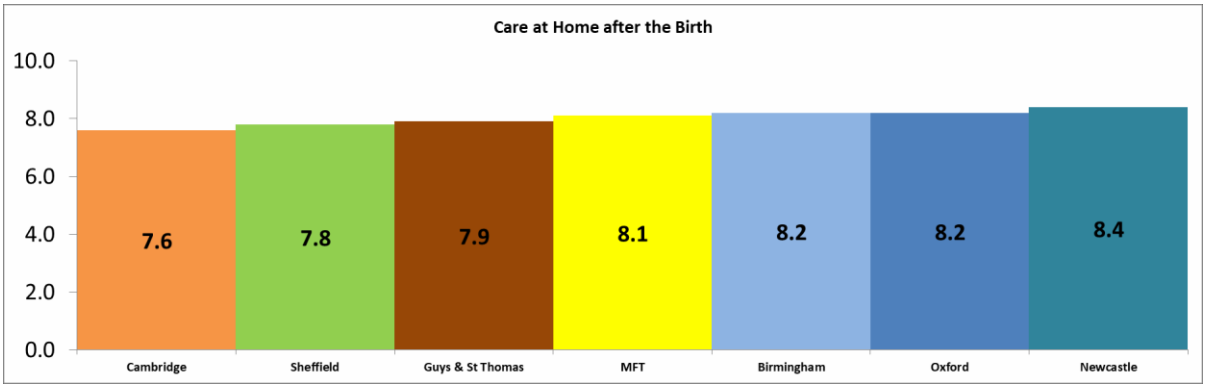


Chart H: Overall Scores for 'Care at Home after the Birth'



Appendix 2: Hospital Site Results MRI and Wythenshawe Hospital compared to MFT Score and National highest and lowest scores

Question	The Accident & Emergency Department (answered by emergency patients only)	Nat High Score	Nat Low Score	MFT Score	MRI Score	MRI Responses	Wythen Score	Wythen Responses
Q3	While you were in the A&E Department, how much information about your condition or treatment was given to you?	9.0	7.4	7.8	7.95	78	7.65	129
Q4	Were you given enough privacy when being examined or treated in the A&E Department?	9.5	7.7	9.0	8.78	84	9.07	134
	Waiting list or planned admissions (answered by those referred to hospital)							
Q6	How do you feel about the length of time you were on the waiting list?	9.7	6.1	8.3	7.90	88	8.71	120
Q7	Was your admission date changed by the hospital?	9.9	8.3	9.2	8.97	90	9.32	121
Q8	Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?	9.6	7.9	9.2	9.17	90	9.23	122
	Waiting to get to a bed on a ward							
Q9	From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	9.5	5.9	7.1	6.49	185	7.43	271
	The hospital and ward							
Q11	Did you ever share a sleeping area with patients of the opposite sex?	9.7	7.5	8.8	8.26	187	9.34	272

Q13	Did the hospital staff explain the reasons for being moved in a way you could understand?	8.8	4.7	6.1	5.58	51	6.14	37
Q14	Were you ever bothered by noise at night from other patients?	8.5	4.6	6.1	5.81	184	6.38	270
Q15	Were you ever bothered by noise at night from hospital staff?	9.3	6.9	8.0	7.78	185	8.11	272
Q16	In your opinion, how clean was the hospital room or ward that you were in?	9.7	8.0	8.5	8.17	188	8.78	274
Q17	Did you get enough help from staff to wash or keep yourself clean?	9.2	6.8	7.9	7.36	114	8.13	162
Q18	If you brought your own medication with you to hospital, were you able to take it when you needed to?	8.8	6.0	7.3	6.39	95	7.74	161
Q19	How would you rate the hospital food?	7.9	4.4	4.7	4.53	181	4.70	252
Q20	Were you offered a choice of food?	9.5	7.7	8.2	8.52	185	7.90	264
Q21	Did you get enough help from staff to eat your meals?	8.8	4.6	7.5	7.00	48	8.01	52
Q22	During your time in hospital, did you get enough to drink?	9.9	8.6	9.0	8.89	175	9.04	261
Q72	Did you feel well looked after by the non-clinical hospital staff?	9.7	7.9	8.9	8.73	168	9.07	252
	Doctors							
Q23	When you had important questions to ask a doctor, did you get answers that you could understand	9.4	7.5	8.3	7.90	176	8.54	243

Q24	Did you have confidence and trust in the doctors treating you?	9.7	8.4	9.0	8.54	185	9.18	271
Q25	Did doctors talk in front of you as if you weren't there?	9.4	7.7	8.5	8.06	185	8.70	270
	Nurses							
Q26	When you had important questions to ask a nurse, did you get answers that you could understand?	9.4	6.9	8.3	7.94	173	8.58	246
Q27	Did you have confidence and trust in the nurses treating you?	9.6	7.7	8.6	8.29	187	8.87	271
Q28	Did nurses talk in front of you as if you weren't there?	9.6	7.8	9.0	8.42	186	9.24	270
Q29	In your opinion, were there enough nurses on duty to care for you in hospital?	9.1	6.1	7.3	6.72	185	7.62	270
Q30	Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)	8.4	5.3	6.9	6.50	184	7.20	269
	Your care and treatment							
Q31	Did you have confidence and trust in any other clinical staff treating you?	9.4	7.7	8.8	8.41	114	9.08	172
Q32	In your opinion, did the members of staff caring for you work well together?	9.6	7.7	8.5	8.14	175	8.84	265
Q33	Did a member of staff say one thing and another say something different?	9.3	6.9	8.1	7.32	187	8.48	272
Q34	Were you involved as much as you wanted to be in decisions about your care and treatment?	8.8	6.2	7.1	6.53	187	7.26	268

Q35	Did you have confidence in the decisions made about your condition or treatment?	9.4	7.4	8.3	7.83	187	8.51	273
Q36	How much information about your condition or treatment was given to you?	9.7	8.1	8.7	8.44	180	8.86	264
Q37	Did you find someone on the hospital staff to talk to about your worries and fears?	8.0	4.1	5.3	4.15	126	5.83	159
Q38	Do you feel you got enough emotional support from hospital staff during your stay?	8.9	5.8	6.6	5.68	122	7.22	170
Q39	Were you given enough privacy when discussing your condition or treatment?	9.5	7.7	8.3	7.92	187	8.43	271
Q40	Were you given enough privacy when being examined or treated?	9.9	9.1	9.6	9.59	188	9.57	268
Q42	Do you think the hospital staff did everything they could to help control your pain?	9.3	7.0	8.1	7.76	119	8.33	161
Q43	If you needed attention, were you able to get a member of staff to help you within a reasonable time?	9.2	6.2	7.5	7.19	171	7.83	245
	Operations & procedures							
Q45	Did a member of staff answer your questions about the operation or procedure in a way you could understand?	9.6	8.3	8.7	8.40	123	8.76	178
Q46	Were you told how you could expect to feel after you had the operation or procedure?	8.7	6.7	7.5	7.77	123	7.39	188

Q47	Afterwards, did a member of staff explain how the operation or procedure had gone in a way you could understand?	9.2	7.3	8.1	7.93	125	8.16	187
	Leaving hospital							
Q48	Did you feel you were involved in decisions about your discharge from Hospital?	8.4	5.9	6.6	5.71	178	7.09	264
Q49	Were you given enough notice about when you were going to be discharged?	8.4	6.3	7.2	6.40	187	7.67	272
Q51	Discharge delayed due to wait for medicines/to see doctor/for ambulance.	8.2	5.0	6.0	4.92	176	6.56	258
Q52	How long was the delay?	9.1	6.3	7.3	6.24	175	7.87	258
Q54	Did you get enough support from health or social care professionals to help you recover and manage your condition?	7.9	4.8	7.1	6.99	112	7.04	144
Q55	When you left hospital, did you know what would happen next with your care?	8.4	5.8	7.0	6.47	156	7.28	236
Q56	Were you given any written or printed information about what you should or should not do after leaving hospital?	8.8	5.3	5.8	5.31	181	5.99	260
Q57	Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	9.4	7.6	8.1	7.17	135	8.51	192
Q58	Did a member of staff tell you about medication side effects to watch for when you went home?	7.4	3.4	4.3	3.59	120	4.67	155
Q59	Were you given clear written or printed information about your medicines?	8.9	6.6	7.5	7.67	127	7.41	173
Q60	Did a member of staff tell you about any danger signals you should watch for after you went home?	8.0	4.0	5.0	4.36	143	5.34	191

Q61	Did hospital staff take your family or home situation into account when planning your discharge?	8.7	5.7	7.1	6.60	125	7.40	170
Q62	Did the doctors or nurses give your family, friends or carers all the information they needed to help care for you?	8.1	4.2	5.9	5.19	129	6.27	166
Q63	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	9.7	6.4	7.8	7.53	165	7.80	240
Q64	Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?	9.5	6.1	7.5	6.53	56	8.02	67
Q65	Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	9.5	6.4	8.1	7.82	104	8.15	129
Q66	Was the care and support you expected available when you needed it?	9.3	7.2	8.2	7.32	117	8.58	173
	Overall views of care and services							
Q67	Overall, did you feel you were treated with respect and dignity while you were in the hospital?	9.8	8.2	9.1	8.68	186	9.36	268
Q69	During this hospital stay, did anyone discuss with you whether you would like to take part in a research study?	4.8	0.6	1.7	1.62	161	1.81	229
Q70	During your hospital stay, were you ever asked to give your views on the quality of your care?	3.7	0.5	2.0	1.63	148	2.34	235
Q71	Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	4.6	1.1	2.2	1.66	144	2.48	210
Q68	Overall…	9.1	7.3	8.0	7.57	180	8.19	258

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Peter Blythin, Group Executive Director of Workforce & Corporate Business
Paper prepared by:	Alwyn Hughes, Trust Board Secretary
Date of paper:	September 2019
Subject:	**Board Assurance Framework (September 2019)**
Purpose of Report:	Indicate which by ✓ • Information to note • Support • Accept ✓ • Resolution • Approval • Ratify
Consideration of Risk against Key Priorities:	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 Audit Committee is asked to receive the new BAF (September 2019) aligned to the MFT Strategic Aims.
Contact:	Name: Alwyn Hughes, Trust Board Secretary Tel: 0161 276 4841

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

THE BOARD ASSURANCE FRAMEWORK (September 2019)

1. Background

Performance against the Board Assurance Framework (BAF) is reviewed at every formal Board of Directors via the Intelligent Board metrics. Significant risks to achieving the Trust's key priorities are reviewed and reported on at the Group Risk Management Committee (GRMC) and across other corporate Executive committees, where necessary, appropriate committees dependent on the risk rating.

The Trust Scrutiny Committees, on behalf of the Board of Directors, utilise the BAF to inform and guide their key areas of scrutiny and especially targeted 'deep dives' into areas requiring further assurance.

The full BAF (see **APPENDIX A**) is received and noted at least twice a year by the full Board of Directors and Trust Audit Committee.

2. MFT Strategic Aims

Key Priorities & Risks associated with the following Strategic Aims will be regularly reviewed at MFT Board Scrutiny Committees and the Group Audit Committee:

- *To complete the creation of a Single Hospital Service for Manchester/ MFT with minimal disruption whilst ensuring that the planned benefits are realised in a timely manner*
- *To improve patient safety, clinical quality and outcomes*
- *To improve the experience of patients, carers and their families*
- *To achieve financial sustainability*
- *To develop single services that build on the best from across all our hospitals*
- *To develop our research portfolio and deliver cutting edge care to patients*
- *To develop our workforce enabling each member of staff to reach their full potential.*

3. Development of the Board Assurance Framework

The 2019/20 BAF continues to be developed and refined following a developmental review of Leadership & Governance arrangements using the 'Well Led' framework during the Summer 2018, an Internal Audit review of the BAF in October 2018 followed by key recommendations from a Task & Finish Group (consisting of Group Non-Executive Directors and Group Corporate Directors) during Q3 and early Q4 2018/19.

The next phase in the development of the BAF will include enhanced training and awareness for key contributors with a particular focus on 'Risk Scoring Consistency' & 'Quality Control'.

4. Recommendation

The Audit Committee is asked to receive the new BAF (September 2019) aligned to the MFT Strategic Aims.

APPENDIX A

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

THE BOARD ASSURANCE FRAMEWORK

(September 2019)

Introduction

The Board Assurance Framework is one of the tools that the Trust uses to track progress against the organisation's Strategic Aims. As part of the development of the Board Assurance Framework each financial year, the Key Priorities for the year are identified and the potential risks to achieving these assessed for inclusion on the framework. As such, all risks on the Board Assurance Framework are set out under the Strategic Aims.

The Board Assurance Framework is based on several key elements:

- **An inherent risk rating (Impact / Likelihood)** - Without Controls
- **Clearly defined Strategic Aims for 2019/20** - -
- **Clearly defined principal risks to the Strategic Aims** - What is the cause of the risk?
- **Risk Consequences** - What might happen if the risk materialises?
- **Key existing controls** - What controls/systems are currently in place to mitigate the risk?
- **Gaps in controls** - What Controls should be in place to manage the risk but are not?
- **Assurance that risks are being reasonably managed** - What evidence can be used to show that controls are effectively in place to mitigate the risk?
- **Gaps in assurance** - What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?
- **Current risk rating (Impact / Likelihood)** - With Controls
- **Actions required** - Additional actions required to bridge gaps in 'Controls' & 'Assurance'
- **Progress** - -
- **Target risk rating (Impact / Likelihood)** - Based on successful impact of Controls to mitigate the risk

Risk Matrix

The table below demonstrates the Trust's risk matrix that is used within the framework:

Severity ↓	Likelihood →				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
1: Low	1 Very Low	2 Very Low	3 Very Low	4 Very Low	5 Very Low
2: Slight	2 Very Low	4 Very Low	6 low	8 low	10 Medium
3: Moderate	3 Very Low	6 Low	9 Medium	12 Medium	15 High
4: Major	4 Very Low	8 Low	12 Medium	16 High	20 High
5: Catastrophic	5 Very Low	10 Medium	15 High	20 High	25 High

1	**Strategic Aim: To complete the creation of a Single Hospital Service for Manchester with minimal disruption whilst ensuring that planned benefits are realised in a timely manner**

PRINCIPAL RISK (What is the cause of the risk?):
There is a risk that MFT may not be able to access sufficient resources to address the finance, clinical, estates and IM&T issues identified at NMGH through the finance counterfactual and due diligence processes.

Enabling Strategy:
SINGLE HOSPITAL SERVICE

Group Executive Lead:
EXECUTIVE DIRECTOR OF WORKFORCE AND CORPORATE BUSINESS

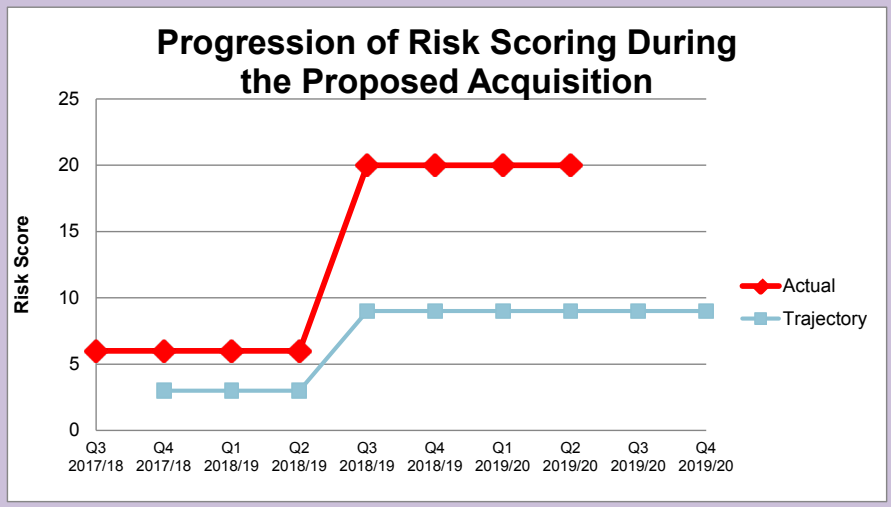
RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Negative and potentially destabilising impact on MFT.**
2. **Inability to deliver services at NMGH to the standard MFT would expect..**
3. **If funding is not secured other options would need to be considered by NHSI /E and Commissioners for delivering care at NMGH.**
4. **Existing difficulties with staff recruitment and retention compounding due to uncertainty about the transaction prompting further de-stabilisation of NMGH.**
5. **If service delivery at NMGH is compromised by uncertainty about the transaction, unplanned shifts in clinical activity to MFT might occur.**
6. **Support contingent on demonstrating multi-agency commitment and delivery of a wider set of objectives.**

Associated Committees:
MFT TRANSACTION MANAGEMENT GROUP
GROUP MANAGEMENT BOARD
GROUP BOARD OF DIRECTORS

Operational Lead:
DIRECTOR, SHS PROGRAMME

Material Additional Supporting Commentary (as required):



Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*		ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
25 (5x5)	A.1 Senior level discussions with NHSE/ I and local commissioners on access to financial support. A.2 Further Due Diligence work underway on IM&T to understand the extent of the IM&T risk and identify future options. A.3 Further Due Diligence work being commissioned on Estates and Facilities to add to MFT's understanding of the risks associated with the NMGH site. A.4 Further Due Diligence work to be commissioned to develop understanding of PAHT's revenue position. A.5 Inclusion of caveats to Strategic Case on submission to NHS I to protect the interests of MFT. A.6 Regular briefings at NMGH and MFT staff engagement sessions. A.7 Complying with NHS I review of Strategic Case. A.8 Active discussions around alternative future options. A.9 Close joint working with a wide stakeholder group to maximise potential benefits of NMGH investment.	B.1 The process for accessing resources is unclear in light of the merger of NHSE and NHSI and the associated consequences of such a significant national reorganisation. B.2 It is unknown whether MFT's requirements, notably capital, will be prioritised ahead of other NHS Trusts requiring significant investment. B.3 Funding to enable the transfer of NMGH to MFT may take time to secure and therefore could impact negatively on the proposed transaction completion date of April 2020. B.4 Information provided by the Pennine Data Room on finances, IM&T and clinical services may not be accurate or complete which will impact of the Due Diligence and disaggregation processes. B.5 Existing governance processes within GMH&SCP do not facilitate timely decision making processes.	C.1 NHSE/I agrees an acceptable financial plan within the necessary timeframe. C.2 The IM&T acquirer Due Diligence enables MFT to prioritise the process for stabilising NMGH IM&T services and integrating NMGH within existing MFT systems. C.3 The acquirer estates Due Diligence enables MFT to prioritise work to develop a safer site at NMGH as soon as possible. C.4 The acquirer Finance Due Diligence enables MFT to complete an LTFM which takes account of the NMGH financial position. C5. Development of a comprehensive Post-Acquisition Plan.	D.1 The financial plan is either unacceptable or not offered within the appropriate time frame. D.2 The information provided by the Pennine Data Room to support the IM&T Due Diligence is incomplete/inaccurate leading to a sub-optimal Due Diligence reports by the potential acquirers. D.3 The financial information provided by the Pennine Date Room is incomplete/inaccurate affecting MFT's ability to produce a robust LTFM.	20 (5x4)	A.1 Continue discussions with NHSE/NHSI and local Commissioners about a financial plan to enable the safe transfer of NMGH to MFT. B.4 Continue to work with the Pennine Data Room to ensure that data provided is quality assured by PAHT. A.6 Continue to keep MFT staff briefed on current position with the transaction. A.7 Agreement and comply fully with the NHS I review processes.	CEO, Chief Finance Officer, Executive Director of HR and Corporate Business	April 2020	MFT Board of Directors	Discussions with NHSE/NHSI underway. Weekly calls with Pennine Data Room on quality and completeness of data. Co-operating with GM oversight arrangement. MFT Transaction Management Group in place. Due Diligence progressing as planned. NHSI review of Strategic case almost complete..	**9 (3x3)**

1	**Strategic Aim:** To complete the creation of a Single Hospital Service for Manchester with minimal disruption whilst ensuring that planned benefits are realised in a timely manner

PRINCIPAL RISK (What is the cause of the risk?):

There is a risk that the acquisition of North Manchester General Hospital (NMGH) could have a negative impact on the rest of MFT's services.

Enabling Strategy:

SINGLE HOSPITAL SERVICE

Group Executive Lead:

EXECUTIVE DIRECTOR OF WORKFORCE AND CORPORATE BUSINESS

RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Demands on senior leaders to deliver the transfer of NMGH to MFT could mean a reduced focus on MFT including PTIP delivery.**

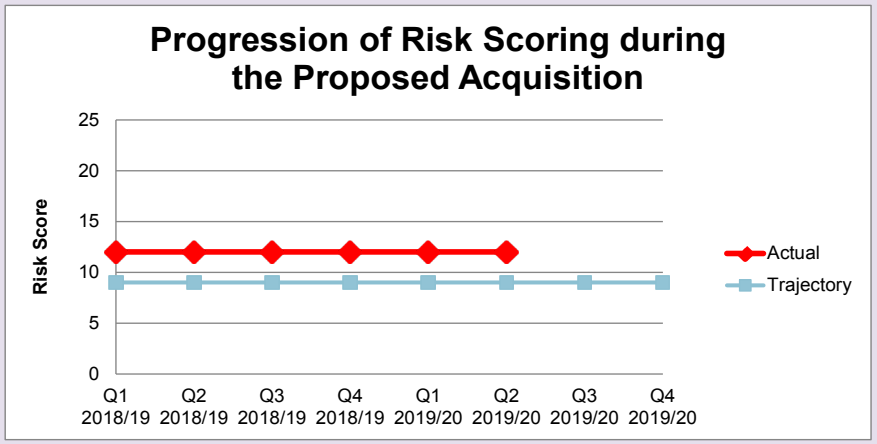
Associated Committee:

GROUP BOARD OF DIRECTORS

Operational Lead

DIRECTOR, SHS PROGRAMME

Material Additional Supporting Commentary (as required):



Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
12 (4x3)	A.1 Project funding secured through the Greater Manchester Transformation Fund (GMTF) to minimise demand on existing MFT resources during transaction. A.2 Experienced team of managers appointed to SHS Team to project manage the transaction and provide targeted support to core MFT teams. A.3 Regular dialogue maintained between senior MFT and Northern Care Alliance Executive Directors/Senior Managers to discuss key issues relating to NMGH. A.4 Clearly defined clinical and corporate disaggregation processes being implemented to enable senior MFT staff to understand the services being acquired. A.5 Post Transaction Operational Group (PTOG) established jointly with SRFT to ensure MFT COO is aware of current and forthcoming operational changes at NMGH site. A.6 Strategic Case contains an outline plan for managing NMGH. A.7 Integration Steering Group provides oversight for integration activity. A.8 MFT Transaction Management Group oversees delivery of the Programme.	B.1 It is not known whether it will be possible to establish an appropriate financial plan to enable the transfer of NMGH to MFT.	C.1 Reaching a settled financial position through agreement with NHSE/I and Commissioners. C.2 Secure GM Transformation Funding to enable the infrastructure required to deliver the transaction. C.3. MFT internal governance arrangements working effectively including the sustained input of the SHS Team to support core leadership teams.	D.1 An agreed financial plan is currently not in place.	**12 (4x3)**	A.8 Work of the MFT Transaction Management Group to continue alongside focussed discussion at EDT. A.1 Deliver metrics linked to the Manchester Investment.	Executive Director of HR and Corporate Business	April 2020	MFT Board of Directors	Programme of staff engagement events at NMGH Programme of meetings with MFT Corporate Directors and Senior Clinicians underway. Monthly meetings with NMGH Senior Leadership Team. North Manchester Strategy Board in place.	**9 (3x3)**

2	Strategic Aim: To improve patient safety, clinical quality and outcomes

PRINCIPAL RISK (What is the cause of the risk?): If the Quality and Safety Strategy is not delivered then harm may occur to patients

Enabling Strategy: **QUALITY AND SAFETY STRATEGY**

Group Executive Lead: **JOINT GROUP MEDICAL DIRECTOR**

RISK CONSEQUENCES (What might happen if the risk materialises?):

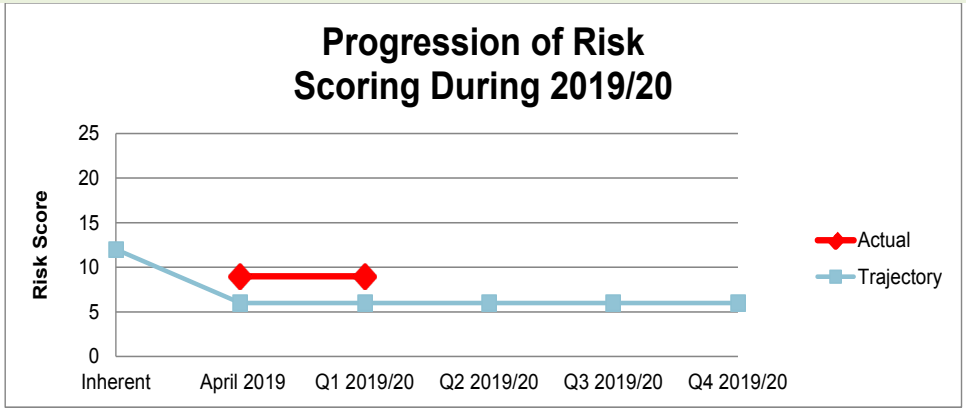
1. **Increase in serious harm to patients**
2. **Poor safety culture (including leadership) undermines Trust performance**
3. **Failure to eradicate 'Never Events'**
4. **Reputational damage because of safety concerns**
5. **Poor staff experience**
6. **Regulatory consequence**

Associated Committee: **QUALITY AND SAFETY COMMITTEE**

Operational Lead: **DIRECTOR OF CLINICAL GOVERNANCE**

Material Additional Supporting Commentary (as required):

The patient safety commentary detailed here covers all aspects of patient safety including but not limited to, clinical outcomes, infection control, clinical incidents (including never events), mortality review and harm free care.



Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
12 (3x4)	A.1 Freedom to Speak Up (F2SU) programme and personnel A.2 Quality and Safety Strategy and related policies A.3 Trust Governance structure – including Quality and Performance Scrutiny Committee, Infection Control Committee and other specialist groups A.4 AOF monitoring A.5 Patient Safety Training Programme – e.g. Infection Control, Human Factors and clinical mandatory training A.6 Root Cause Analysis (RCA) Training Programme A.7 Trust alert circulation process A.8 Trust incident investigation process – to include focussed investigations such as IPC and Falls	B.1 Policy controls weak B.2 F2SU not fully embedded B.3 Governance structure still in development B.4 PST Training not mandatory for all staff B.5 No capacity to deliver this to all staff B.6 No current evaluation of impact of PST or RCA training B.7 General Patient Safety training not included in mandatory training packages – including induction B.8 Lack of links with University and Training Schools on PST B.9 Lack of patient involvement in investigation and feedback to staff B.10 Mechanistic circulation and response to alerts without follow up and audit programme B.11 Lack of Trust wide visible Patient Safety Champions B.12 Patient safety commitment not fully embedded into recruitment practice B. 13 Variation in compliance with clinical policies and guidelines	C.1 Trust incident reporting system data (incident information including harm level, frequency, type of incident and duty of candour information) C.2 Trust clinical and internal audit systems C.3 Staff survey C.4 Regulatory inspection processes C.5 Internal quality assurance processes (Ward accreditation, Quality Review) C.6 AOF and leading and lagging patient safety metrics reporting – including harm free care, infection control and never events	D.1 Incident reporting system may not capture all harm – can be a cumbersome process D.2 Staff survey indicates lack of feedback from incident reporting and investigation – may impact on reporting levels D.3 Staff survey does not adequately capture full understanding of patient safety culture D.4 Patient safety metrics not yet fully developed or reported on D.5 Actions following harm not always evaluated or reviewed D.6 Lack of full understanding of finance and performance cost of harm in relation to claims, lost bed days etc	**9 (3x3)**	B.3 Share the new National Patient Safety Strategy and align with MFT Q&S Strategy B.6 Define processes for on-going evaluation of safety culture C.5 Develop patient information leaflet on 'When things go wrong' B.4 Obtain accreditation for PST D.4 Develop an in-house Patient Safety Champion qualification – PST / RCA + Patient Safety Project D.5 Implement revised process following 'Never Event' to include a panel review similar to the Emergency Bleep Meeting concept – consider NED lead for this process D.3 Undertake Trust wide patient safety training needs analysis B.7 Build the requirements of this analysis into the mandatory training framework B.13 Include statement on commitment to patient safety in all Trust contracts D.2 Develop post-investigation feedback questionnaire for staff and patients D.4 Set clear aims in relation to reduction of harm aligned with NHS Patient Safety Strategy – Deterioration, Sepsis, NEWS, medication safety, IPC, maternity, falls pressure ulcers, nutrition and mental health C.1 Appoint Trust Compliance Officer to oversee alert circulation, response, review and follow-up B.3 Define CSG/CAC/CGC roles in standardisation of clinical practice	Medical Director's / Chief Nurse / Director SHS and Group Director of Workforce and Corporate Business	March 2020	Quality and Performance Scrutiny Committee	1. Trust Compliance Officer appointed 2. Development workshops completed with GMB on NHS Patient Safety Strategy and safety culture 3. MFT Quality & Safety Strategy reviewed to ensure it is fully aligned with ne National Patient Safety Strategy (awaiting further guidance on Serious Incident Framework before completion)	**6 (3x2)**

2	Strategic Aim: To improve patient safety, clinical quality and outcomes

PRINCIPAL RISK (What is the cause of the risk?): Underachievement of National Standards for planned care could impact on clinical outcomes and patient experience.

Enabling Strategy:
QUALITY & SAFETY STRATEGY
TRANSFORMING CARE FOR THE FUTURE STRATEGY

Group Executive Lead:
GROUP CHIEF OPERATING OFFICER

RISK CONSEQUENCES (What might happen if the risk materialises?):

1. Increase risk of serious harm to patients
2. Poor patient experience
3. Risk to Hospital capacity, income plans
4. Reputational damage to Trust
5. Poor staff experience
6. Low system confidence

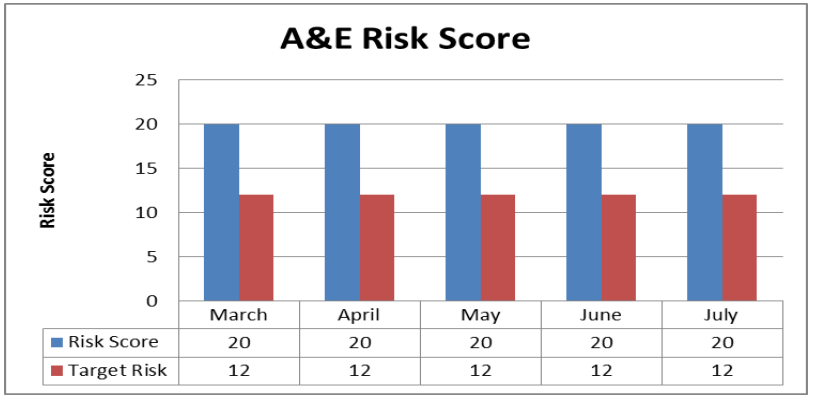
Associated Committee:
QUALITY & SAFETY COMMITTEE
OPERATIONS & TRANSFORMATION GROUP

Operational Lead:
HOSPITAL / MCS CHIEF EXECUTIVES

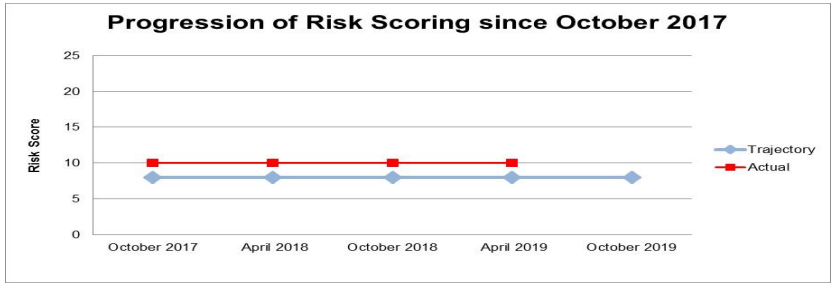
Material Additional Supporting Commentary (as required):

Indicator	Target Risk	Actual Score March 19	Actual Score April 19	Actual Score May 19	Actual Score June 19	Actual Score July 19
Cancer 62 day	12	16	16	16	16	16
18 weeks RTT	16	20	20	20	20	20
Diagnostic 6 week wait	12	16	16	16	16	16

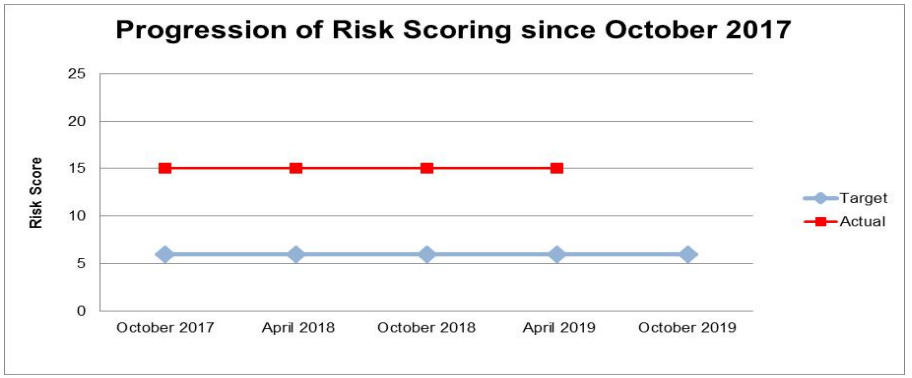
Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
20 (5x4)	A.1 The Accountability Oversight Framework (AOF). A.2 Board Assurance Report. A.3 Reporting to Trust Committees A.4 Annual contracting round. A.5 Annual Capacity and Demand planning round. A.6 GM and Trust Access Policy. A.7 Trust Transformation Programme A.8 Hospital replication of AOF process, and supporting operational management and oversight structures A.9 Operational reporting readily available through the HIVE A.10 Escalation processes in place i.e.cancelled operations A.11 MFT Transformation programme which feeds into Hospital Transformation and Efficiency forums, with reporting of progress to OTOG and Quarterly updates to the Board of Directors. A.12 Opportunity packs to support annual planning process identifying efficiencies against benchmarked peers for theatres, LoS, Outpatients.	B.1 Best practice pathways across multiple sites. B.2 Limited standardisation of processes across MFT to support the patient access policy. B.3 Capacity shortfalls requiring reliance on private sector. B.4 Fit for purpose PAS B.5 Live validation and Data Quality Cleansing. B.6 NHSI Competency Based training for Administration and Clerical Staff. B.7 Interruption of diagnostic/ elective pathways during peak holiday periods. B.8 Critical care constraints impacting on activity. B.9 National Campaigns for cancer driving demand. B.9 Primary care demand management. B.10 Workforce availability, vacancies to deliver activity B.11 Ability to routinely measure adherence to and progress towards fully embedding SAFER, elective and outpatient standards as data is not automated. B.12 Different reporting systems and processes limit the ability to effectively utilise up to date benchmarking data and to identify consistent opportunities	C.1 Reporting to the Executive Board and Committees C.2 Monthly AOF outputs. C.3 Minutes/Papers from meetings underpinning the access standards i.e. Cancer Committee. C.4 Trust Capacity Board/ Hospital Activity plans. C.5 Internal/external audit of data quality. C.6 Risk register C.7 Monthly forecasting and planning for diagnostics. C.8 Quarterly transformational reports. C.9 Quarterly updates on progress against Hospital / MCS capacity plans. C.10 Getting It Right First Time Programme to focus on removing unwarranted variations in clinical practice C11. Clinical Standards Groups focus on ensuring patients receive high quality experience and outcomes, standardised across MFT locations	D.1 Trust ERS performance oversight, and training. D.2 GM Capacity and demand for risk specialities. D.3 NHSI best practice review of Cancer and RTT.	16 (4x4)	B2 - 5, 7, 9RTT Taskforce to remain in place throughout 2019/20 D.1 Optimisation of ERS in line with transparent capacity management. D.1, D2 Appoint Trust role responsible for corporate oversight of ERS performance, training, compliance. B.6 Introduce electronic competency training for A&C Staff booking, validating and managing waiting lists. B1, B9 Appoint dedicated project management to review and embed national cancer pathways. D.2 GM ongoing review of high risk/ high demand specialities. D.3 NHSI support to Cancer and RTT pathways	Julia Bridgewater	March 2020	Quality & Performance Scrutiny Committee	B2 - 5, 7, 9 – Zero +52 week waits since April. Weekly Task and Finish Group oversight of introduction of new IT solution, training, RTT performance. Working with MHCC focusing on outpatient transformation. B.6 - Trust wide training in progress, awaiting agreed electronic competency in line with appraisal process. B1,B9 – Additional resource secured, post secured, recruitment in progress. D.2 GM Four Eyes review completed to Provider Federation Board. GM establishing a planned care Board. D.3 NHSI team met with Trust representatives plans agreed. A.1 Hospitals and CSS reported delivery of **0.89% diagnostics against 1%** standard for July. Risk score reassessed when sustainable performance assured.	**12 (3x4)**

2	**Strategic Aim: To improve patient safety, clinical quality and outcomes**	
PRINCIPAL RISK (What is the cause of the risk?): **Underachievement of National Standards for A&E 4 hour waiting standard could impact on clinical outcomes and patient experience.**	Enabling Strategy: **QUALITY & SAFETY STRATEGY** **TRANSFORMING CARE FOR THE FUTURE STRATEGY** Group Executive Lead: **GROUP CHIEF OPERATING OFFICER**	
RISK CONSEQUENCES (What might happen if the risk materialises?): **1. Increase risk of serious harm to patients** **2. Poor patient experience** **3. Risk to Hospital capacity, income plans** **4. Reputational damage to Trust** **5. Poor staff experience** **6. Low system confidence**	Associated Committee: **QUALITY & SAFETY COMMITTEE** **OPERATIONS & TRANSFORMATION GROUP** Operational Lead: **HOSPITAL / MCS CHIEF EXECUTIVES** Material Additional Supporting Commentary (as required):	

Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
20 (5x4)	A.1 The Accountability Oversight Framework (AOF). A.2 Board Assurance Report. A.3 Reporting to Trust Committees A.4 Annual contracting round A.5 Annual Capacity and Demand planning round. A.6 Manchester Urgent Care and Transformation Board, supported by Operational Delivery Group. A.7 Daily SITREP Reporting A.8 Daily Executive Reporting – EDT. A.9 Patient Flow Boards at MRI, Wythenshawe. A.10 Stranded patient monitoring and escalation calls to the LCO A.11 Twice Weekly Urgent Care meeting with COO/ Hospital Directors. A.12 GM Tableau system reporting – Escalation Status. A.13 Operational reporting readily available through the HIVE A.14 MFT Transformation programme which feeds into Hospital patient flow boards, with reporting of progress to OTOG and Quarterly updates to the Board of Directors. Tracking key metrics through the AOF process and Wave.	B.1 Workforce to match demand. B.2 Estate restrictions. B.3 Reliance on partners to mobilise capacity releasing schemes. B.4 Market forces limiting care home capacity. B.5 Out of Area assessments by Local Authority. B.6 Changes to external partners models of care delivery. B7 DTOC in Mental Health bed capacity	C.1 Outputs from MRI / Wythenshawe improvement programmes and Patient Flow Boards. C.2 External support from ECIST to Wythenshawe (LOS & Discharge) and MRI (Patient Flow and Discharge) C.3 Weekly LLOS meetings with MLCO to manage stranded patients to agreed targets. C.4 Reporting to the Executive Board and Committees and AOF outputs. C.5 Minutes/Papers from meetings underpinning the urgent standards i.e. Urgent Care Board, Operational Delivery Group C.6 Weekly ED assurance meeting papers and actions. C.7 MRI/ PED estate plans managed through Estates and Facilities C.8 Ambulance Turnaround time C.9 Individual action plans and trajectories in place to support recovery of standards. C.10 Plans to support bank holiday periods. C.11 Quarterly transformational reports. C.12 Quarterly updates on progress against Hospital / MCS capacity plans. C13. Getting It Right First Time Programme to focus on removing unwarranted variations in clinical practice C.14. Clinical Standards Groups focus on ensuring patients receive high quality experience and outcomes, standardised across MFT location C.15 North East Sector review commissioned by GM	D.1 Dedicated Major Trauma ward to expedite polytrauma patients out of A&E. D.2 Local Authority assessment. D.3 External surge demand management	20 (5x4)	**D**.1 Major Trauma ward with dedicated consultant rota. D.2 GM system wide policy agreement for internal social workers to assess out of area patients. B.1 Job planning and mutual aid between sites. C.5 Sustainable steaming pilots at RMCH/ Wythenshawe with long term models agreed. D.3 Manchester Urgent Care Board action plan, aligned to the GM plan. D.3 MRI/Wythenshawe supporting GM deep Dive work in relation to identifying system opportunity for Same Day Emergency Care D.4 Shared learning from GM Peer Review B.7 Joint working with the MLCO to support reduction in long length of stay patients and DToCs – plan with MRI and WTWA in place A.1 Due to challenged performance in Q1/Q2 2019 additional governance / escalation arrangements remain in place, with further actions being taken by hospitals aligned to national priorities of: Streaming, Same Day Emergency Care, Discharge and Flow.	Julia Bridgewater	March 2020	Quality & Performance Scrutiny Committee	D.1 Business Case in progress, case mix agreed. Ward to open in Q3 at MRI. D.2 MFT Representatives contributed to workshops to develop system policy. B.1 Annual job planning round, focused work being undertaken at Wythenshawe. C.5 Evaluation included in Manchester workshop for winter planning. D.3 MFT representatives support the Board with cascading of relevant actions through MFT operational structures. A.14 Annual transformation plan developed for Board sign off in May. D.4 MFT System Peer Review planned for 04.09.19 C.15 Awaiting outcome of North East Commissioning Sector GM Review B.7 progress made against plan, although needs to impact on performance A.1 Some improvement in performance seen in August, although reducing variation and strengthening resilience required.	**12 (3x4)**

2	Strategic Aim: To improve patient safety, clinical quality and outcomes	
PRINCIPAL RISK (What is the cause of the risk?): If appropriate safeguarding systems and processes are not in place then Children and Adults at risk of abuse or neglect may not be safeguarded from harm	Enabling Strategy: **QUALITY & SAFETY STRATEGY** Group Executive Lead: **GROUP CHIEF NURSE**	
RISK CONSEQUENCES (What might happen if the risk materialises?): **1. Adults and children at risk of abuse or neglect may come to harm** **2. Failure to comply with statutory and regulatory safeguarding standards**	Associated Committee: **SAFEGUARDING COMMITTEE** Operational Lead: **DEPUTY CHIEF NURSE** Material Additional Supporting Commentary (as required):	

Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
15 (5x3)	A1. Safeguarding Governance Structures in place. A2. Safeguarding policies and procedures. A3. Trust Safeguarding Teams actively support staff. A4.Directors of Nursing/Midwifery/Healthcare Professionals accountable for safeguarding within each hospital/MCS/ MLCO. A5. Named Doctors and Named Nurses provide professional support and advice to staff. A6. Senior representation at MSCB and MSAB and underpinning Leadership/Executive Groups to support statutory duty to cooperate. A7. Safeguarding adults and children's training programme in place as per Intercollegiate guidance underpinned by learning from SCRs/SARs/ DHRs. A8. Safeguarding Supervision process A9. Learning Disability flag in place to alert Matron review. A10 Reports provided to statutory meetings if Trust staff are unable to attend. A11. Child Protection Information Sharing System (CP-IS) in place in all relevant areas except SMH maternity services. A12 AOF monitoring (MLCO)	B1. Mental Capacity Act (MCA) assessments and Deprivation of Liberty Safeguards (DoLS) are of inconsistent quality B2. DoLS applications are often not authorised by Local Authority due to lack of capacity B3. Level 2 and 3 Safeguarding training compliance is below the required threshold of 90% B4. The Trust is not compliant with the recent changes to Statutory Intercollegiate Guidance, which requires increased numbers of staff to receive level 3 adult safeguarding training B5. LD Specialist Nurse Capacity is limited B6. LD and/or Autism Strategy not finalised	C1. Annual Safeguarding Report to Board of Directors. C2. Hospital/Managed Clinical Service/MLCO annual Safeguarding Work Programme, monitored by Safeguarding. C3. Hospital/MCS/ MLCO annual safeguarding assurance processes to assess compliance with CQC requirements. C4. Completion of SCR actions - reported to the Safeguarding Committee. C5. Local Safeguarding Children's Board Section 11 audit - reported to the Safeguarding Committee. C6.Submission of MSAB Annual Assurance statement and supporting evidence. C7. Trust incident reporting system data C8. Regulatory inspection process C9. Training compliance data C10. Annual safeguarding audit programme C11. Safeguarding supervision data	D1. Prevent training compliance below threshold D2. No central system to record all invitations to strategy meetings and case conferences	**10 (5x2)**	B1. Deliver MCA and DoLS training to relevant staff B1. Audit the quality of MCA assessments and DoLS applications B2. Submit DoLS applications in accordance with statutory requirements B3. Deliver targeted safeguarding training to meet Intercollegiate requirements B4. Increase level 3 training capacity. B5. Review LD Specialist Nurse capacity and develop Business Case to increase capacity to meet patient needs B6. Finalise and launch a System-wide LD and/or autism Strategy B6. Deliver the Trust's LD work plan D1. Target Prevent training to non-complaint areas D2. Work with the Local Authority to agree a process for invitations to strategy meetings and case conferences to be recorded centrally	Assistant Chief Nurse (Safeguarding)	March 2020	Safeguarding Committee	B1. Increased provision of DoLS training. B1. DoLS audits undertaken and actions delivered to improve quality and compliance with DoLS criteria. B1. On-going audit of MCA/DoLS continues during 2019/20. B2. DoLS applications across MFT increased by 56% in Q1 of 2019/20 compared to same period in 2018/19. Low levels of assessment by Local Authority continues. B3. Competencies matched to roles in accordance with revised Intercollegiate Guidance and staff groups prioritised to receive training. Improvement plans developed by Directors of Nursing to improve compliance. Training compliance remains below Trust target of 90% but improved across all training levels compared to Q4 in 2018/19. B3.On-going programme of safeguarding training delivered. B4. Increased level 3 adult safeguarding training capacity continues to be provided with further increase planned for September 2019. B5. Assessment of LD Specialist Nurse requirements completed and case developed. B6 MLCO Chief Nurse leading development of system-wide LD Strategy B6. The revised LD governance structure that was presented to Safeguarding Committee in April 2019 is now in place. B6. Self-assessment against NHS I learning disability improvement standards for NHS trusts refreshed and LD work programme updated. Safeguarding Committee update report scheduled for October 2019.	**8 (4x2)**

2	Strategic Aim: To improve patient safety, clinical quality and outcomes	
PRINCIPAL RISK (What is the cause of the risk?): **If we do not comply with appropriate building regulations or maintenance requirements there is a risk to the critical infrastructure of the hospitals that could result in harm to staff, patients or the public**	Enabling Strategy: **QUALITY & SAFETY STRATEGY** **ESTATES STRATEGY** Group Executive Lead: **CHIEF OPERATING OFFICER**	
RISK CONSEQUENCES (What might happen if the risk materialises?): **1. Inability to use public, staff or clinical areas as intended, leading to inability to provide treatment as planned** **2. Potential impact for harm to staff, patient of public**	Associated Committee: **CEO FORUM** Operational Lead: **GROUP DIRECTOR OF ESTATES AND FACILITIES** Material Additional Supporting Commentary (as required):	

Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
15 (3x5)	A.1 Detailed business continuity plans to mitigate the impact of any failure A.2 Multiple redundancy and layered systems to prevent the escalation of an issue (eg fire alarms; fire doors and sprinkler system; HV backup generation). A.3 Agreed maintenance regimes to ensure the infrastructure is maintained to the required level A.4 Internal & external reviews of systems and processes to highlight gaps and required actions	B.1 Not all maintenance regimes have been adhered B.2 Not all infrastructure schematics accurately represent the 'as built' estate B.3 Given above points redundancy systems may not operate as planned B.4 Sodexo on the ORC have migrated to a new Computer Aided Facilities Management (CAFM) system for Hard FM that will take a period to bed in. B.5 Some controls are reactionary, based on minimising impact should an issue occur	C.1 Ongoing certification (internal or external as required) of actions completed by the team undertaking the remedial actions reducing the number of outstanding defects. C.2 Schematics are being updated on a periodic basis to reflect the as built environment C.3 The old ORC CAFM system will remain in operation for circa 12 months to ensure continuity. C.4 External audit carried out of CAFM and hard FM policies and procedures. Highlighted areas requiring further work & those that were compliant	D.1 Survey and remedial works take a significant period to complete & until complete full assurance cannot be gained. D.2 Some schematics remain outdated in the review period and the update process will take several years to complete D.3 The new CAFM system will need to run for 12 months to give full assurance as some tasks are yearly D.4 The external audits highlighted areas of further work which is being carried out but full assurance cannot be gained until works are complete	15 (3x5)	D.1 Complete surveys and agree programme of remedial works by site and infrastructure system D.2 Infrastructure schematics updated in line with the survey and remedial work D.4 External audit agreed for June (covering May data) to identify any remaining gaps. Periodic focus thereafter in relation to comparison between old & new CAFM outputs D.4 External audit agreed for June (covering May data) to identify any remaining gaps in FM policy and procedure	Chief Operating Officer	July 2019 for key assurance tasks. Remedial actions will run for a prolonged period (circa 24 months)	CEO Forum	Survey and remediation work on track Schematics being updated on an as needed basis External audits agreed and arranged for August Fire compliance risk to be detailed at a Hospital level following GRMC in June 2019 Electrical infrastructure risk stepped down following completion of all key actions	**6 (3x2)**

2	Strategic Aim: To improve patient safety, clinical quality and outcomes

PRINCIPAL RISK (What is the cause of the risk?): Inability to access the patient health record at the point of care, or poorly maintained health records may cause patient harm and poor patient experience.

Enabling Strategy:
MFT GROUP INFORMATICS STRATEGY

Group Executive Lead:
GROUP CHIEF FINANCE OFFICER

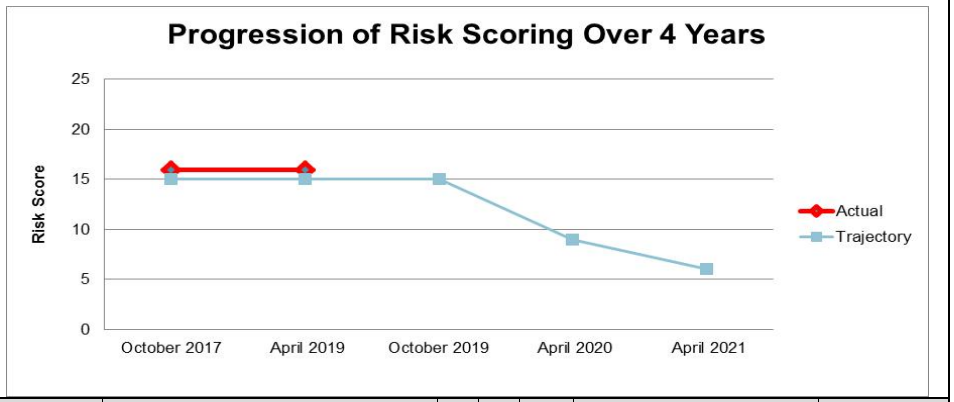
RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Increase in serious harm to patients**
2. **Poor patient experience**
3. **Poor safety culture (including leadership) undermines Trust performance**
4. **Reputational damage because of safety concerns**
5. **Lower staff morale**
6. **Regulatory and Information Governance consequences**
7. **Financial penalty and damage**

Associated Committee:
GROUP INFORMATION GOVERNANCE BOARD

Operational Lead:
GROUP CHIEF INFORMATICS OFFICER

Material Additional Supporting Commentary (as required):



Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGRESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
16 (4x4)	A.1 Oxford Road Campus (ORC): Best Practice Standards for Records Management in place & achievement of the standard monitored through a suite of KPIs which improve availability at point of need. A.2 Improve visibility of electronically captured patient information by providing access through one system. A.3 Creation of Case Notes reduced to 5 areas and the PAS district number has replaced the manually allocated case note number for ORC, to become the unique identifier in the system. A.4 Clinic preparation for ORC has moved to ORC Health Records Hub 3rd Floor RMCH. A.5 New sets of case notes now labelled with barcodes to facilitate tracking. A.6 Obstetric notes will be retained in the Health Records Hub (3rd Floor RMCH) from Sep 2018. A.7 Commencement of Terminal Digit Filing within the Gorton Library. A.8 Performance Indicators now being presented to the Group Information Governance Board.	B.1 Best practice Records Management standards are not followed. B.2 Fulll KPI suite not yet embedded into operational practice. B.3 Full EPR not in place.	C.1 Trust incident reporting system data (incident information including harm level, frequency, type of incident and duty of candour information). C.2 Internal quality assurance processes (Health Records KPI suite).	D.1 Accurate tracking of the location of the case note, particularly once delivered to Hospitals.	16 (4x4)	**B**.1 Best Practice Standards for Records Management implemented through Health Records Improvement Programme. Best Practice Standards for Records Management implemented through Health Records Improvement Programme . D.1 To support the Hospitals in ensuring that case note is in the appropriate location to support patient care. B.3 Tactical EPR Roadmap identified to support journey to full EPR implementation.	Director of Digital Delivery	December 2019	Group Informatics Strategy Board (Performance Metrics are reported to Group Informatics Strategy Board	• Significant progress made on a range of Actions completed 2018/19. • Continued tactical development of EPR in place to for 2018 -2020 and procurement and full implementation of new EPR solution. • Ongoing implementation of best practice standards for records management implemented through Health Records Improvement Programme. Further Business Case approved to facilitate the turning of the whole library to Terminal Digit Filing. • Patient Records campaign on what is a patient record and promoting the use of the electronic systems has concluded. • Deployment of scanners to improve tracking of case notes completed. • Concluded review of the impact to patient experience when the case note is missing and evidence of harm. • Assurance report has been presented to Quality & Performance Scrutiny Committee and was accepted as assurance was proven. • Good progress made with MREH who are piloting the hospital engagement programme of work, seen in the movement of records within hospital to appropriate setting. • Lessons learned from this pilot will be rolled out across other hospitals on Oxford Road Campus.	**6 (3x2)**

2	**Strategic Aim: To improve patient safety, clinical quality and outcomes**

PRINCIPAL RISK (What is the cause of the risk?):
If the Trust fails to recruit and retain a nursing and midwifery workforce to support evidence based nursing and midwifery establishments due to national Nursing and Midwifery workforce supply deficit, the quality and safety of care may be compromised

RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Compromised patient care**
2. **Adverse patient experience**
3. **Increased complaints**
4. **Failure to comply with NHSI regulatory standards**
5. **Inability to recruit well trained nursing and midwifery staff further compounding the staffing issue**
6. **Inability to offer a quality training experience to students**

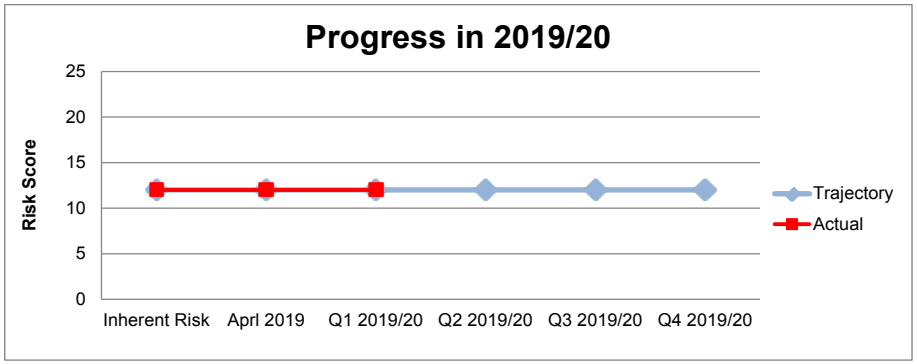
Enabling Strategy:
QUALITY AND SAFETY STRATEGY;
NURSING, MIDWIFERY & AHP STRATEGY

Group Executive Lead:
CHIEF NURSE

Associated Committee:
NMAHP PROFESSIONAL BOARD
HR SCRUTINY COMMITTEE

Operational Lead:
CORPORATE DIRECTOR OF NURSING

Material Additional Supporting Commentary (as required):



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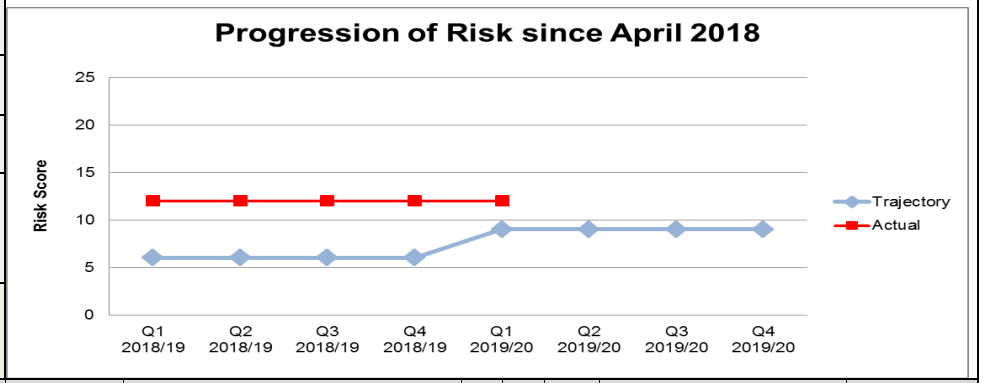
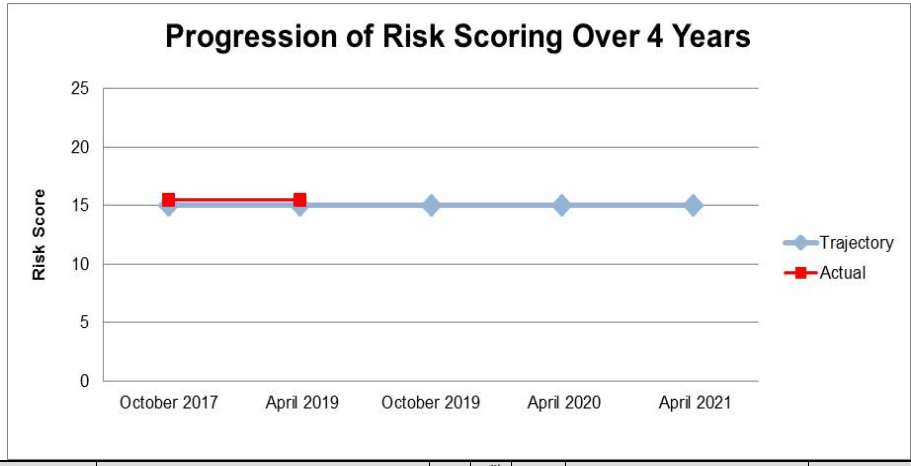
12 **4x3**	A1. Reports on controls to- Nursing, Midwifery and AHP Professional Board, Clinical Risk Management Committee and HR Scrutiny Committee A2. Domestic and International recruitment campaigns A4. Hospital workforce dashboards including recruitment pipeline A6.Hospital Nursing and Midwifery retention strategies A7. Monthly ESR reports established to monitor turnover and new starter activity/ e roster KPIs and dashboard A8. Daily safe staffing huddles and staff deployment based on acuity and dependency A10. Temporary staffing reporting processes aligned with finance and workforce planning data A11 Triangulation of workforce establishment data with clinical quality metrics A12 Developing and embedding new roles within the Nursing workforce. A13 Establishments reviews undertaken utilising SNCT	B3 Current recruitment process provides limited assessment for values and behaviours B9 Embedding use of E roster and safe care in real time within all clinical areas. B4 National shortage of nurses for the pipeline with no increase in trainees graduating until 2021	C2. Programme of domestic and international recruitment events C9. NHSI safe staffing report C6. Reduced turnover and improved retention rate C9 E Rostering C10. Programme of work to reduce nursing and midwifery absence rates and improve retention of staff C11. Embed Nursing Associates within the established workforce. C12. Bi annual Safer Staffing reports to Board of Directors Group Management Board, HR Scrutiny Committee, NMAHP Professional Board, Risk Management Committee. C13 Nursing and Midwifery vacancies and turnover reported against Hospital/MCS AOF KPI's C11Safer Nursing Care Tool (SNCT) introduced to support quarterly inpatient establishment reviews.	D1. MFT have been selected to undertake NHSI Retention Direct Support Programme Cohort 5 due to the retention issues within Nursing and Midwifery. D10.Variation in staffing within the hospitals MCS/ MLCO.	**12** **4x3**	D2. Recruitment campaigns resulting in substantive appointments of both nurses and midwives D9. NHSI safe staffing report taken from Health Roster to ensure accuracy of planned and actual staffing data D3. Regular reports from recruitment management system to identify delays in process and enable actions to be taken D10.Reduced turnover and improved retention rate in band 5 roles. D7 Time to fill reporting by recruitment phase to support continuous improvement cycle D1 Reduced overall qualified vacancy levels and vacancy levels of staff nurse (band 5 roles) D5 Continue with the International recruitment programme D9 Roster review meetings implemented in all areas to ensure effective rostering of staff and appropriate use of temporary staff D6. Programme of work in partnership with HR to reduce nursing and midwifery absence rates and improve retention of staff D12. Embed the Nursing Associates within the workforce establishments	Chief Nurse's Team	March 2020	NMAHP Professional Board	D2 Programme of recruitment events planned for the next 12 months D2 Recruitment and retention schemes have resulted in reduction in vacancy rate for band 5 roles D6 Predicted vacancy rates will reduce in Q3 and Q4 following graduation of newly qualified nurses D1 MFT has been accepted onto the NHSI Retention Support Programme due to commence in September 2019. The programme will support the Trust in developing sustainable retention schemes based on best practice. D7 Over the last 12 months the annual Trust turnover rate for nursing and midwifery has improved D12 The first group of Nursing Associates graduated between February and May 2019 and all have secured a substantive position in the Trust. There are 170 trainee Nursing Associates in training at MFT the Trust plan to continue to recruit Trainee Nursing Associates. D5 MFT continues to recruit International nurses D11 Hospital/MCS/MLCO sickness/absence reduction trajectories are established D8 The Safer Nursing Care Tool has been introduced across all inpatient ward areas to support safe staffing establishment reviews.	**6** **3x2**

2	Strategic Aim: To improve patient safety, clinical quality and outcomes	
PRINCIPAL RISK (What is the cause of the risk?): Failure to deliver medical workforce workstreams (consolidated risk)	Enabling Strategy: WORKFORCE STRATEGY Group Executive Lead: JOINT GROUP MEDICAL DIRECTORS	
RISK CONSEQUENCES (What might happen if the risk materialises?): **1. Patient safety & quality of care risk if unable to fill medical shifts/vacancies** **2. Inequity of care delivered at weekends v weekday** **3. Loss of control on medical agency & internal bank spend**	Associated Committee: WORKFORCE & EDUCATION COMMITTEE Operational Lead: CHIEF OF STAFF / GROUP ASSOCIATE DIRERCTOR OF WORKFORCE Material Additional Supporting Commentary (as required):	

Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
12 (4X3)	A1. Group Executive Sponsors of Medical Workforce Workstreams A2. Hospital/MCS Executive teams A3. HR Scrutiny Committee oversight A4. Finance scrutiny committee oversight A5. Hospital Review meetings A6. Accountability Oversight Framework (AOF) A7. Medical Directors' Workforce Board A8. Workforce Systems Programme board A9. LNC Liaison A10.Job Planning & Medical Leave Policy A11.Medical Workforce Electronic systems (job planning, rotas etc) A12.Internal Turnaround governance programme including WAVE A13.Management of Direct Engagement supplier A14. 7DS Joint Assurance Group	B1. Consistency in approach of Hospitals/MCS to management of temporary medical staffing B2. Consistency in approach to use of Medical Agency suppliers across group B3. Key medical workforce processes (job planning, leave etc)require alignment across Group) B4. Medical Workforce systems not fully rolled out across Group B5. Medical workforce dashboards not fully in place and information not shared between systems B6. No electronic means of recording the 7DS standards. B7. 7DS Joint Assurance Group needs review to ensure meeting needs of new MDT Structure B8. Guardian of Safe Working (GOSW) post vacant	C1. NHSI weekly agency report C2. NHSE Monitoring reports C3. Percentage of consultant job plans on electronic system C4. Reducing agency/locum spend C5. Reduction in medical vacancies/unfilled shifts C6. Medical Workforce AOF Metrics C7. Audits of 7DS standards by Hospital/MCS C8. GOSW reports C9. Hospital/MCS Review meetings – risk/mitigation plans	D1. Medical Workforce dashboards need refinement and to be aligned to Hospital/ MCS and KPIS D2. GOSW reports do not cover non training posts	**12 (3X4)**	B1. Develop and expand MFT Medical Bank B1. Further develop and expand Internal recruitment programme B2. Introduce single Group wide Medical Agency Tier and Cascade process B3. Roll out new MFT job plan policy and leave policy B4. Develop job plan training guide for clinical leaders B4. Provide regular reports on job plan status to Hospitals/MCS B4. Complete the roll out of the Allocate Medical Workforce systems (job planning, e-rota) and embed into culture B4. Submit application to NHSI as part of their Capital Technology Bids process to accelerate MFT workforce systems strategy B5. (and D1) Develop and roll out new dashboards for Medical temporary staffing B6. Review potential to include 7DS standards 2 and 8 in existing MFT IT systems in advance of full EPR deployment B7. Review the Terms of the 7DS Joint Assurance Board B8. Recruit new GOSW and ensure improved engagement with all stakeholders D2. Develop GOSW reports to include non training grade vacancies	Group Medical Directors Team & Group HR Directors' team	March 2020	Human Resources Scrutiny Committee	B1. Temporary staffing manager appointed. Formal options appraisal/procurement initiated for medical bank which will be concluded in March 2020. MFT Tier 5 GMC sponsorship approved which will improve international recruitment B2. Complete. B3. Impact assessment of planned changes to job plan policy to be completed July 2019. Leave policy will be reviewed following finalisation of job plan policy. B4. Job plan training guide will be finalised once policy agreed. Monthly reports sent to hospitals/MCS on job plan status Project team now in place for roll out of Allocate Medical Workforce systems NHSI bid being finalised and will be submitted on time B5. Complete B6. 7DS standard included in Patientrack scoped and testing will commence in MRI B8. Complete B9. New GOSW appointed and engagement plan initiated	**9 (3X3)**

2	Strategic Aim: To improve patient safety, clinical quality and outcomes	
PRINCIPAL RISK (What is the cause of the risk?): If there are malicious attacks to IT system(s), vulnerabilities could compromise or disable access to systems and or data.	Enabling Strategy: **MFT GROUP INFORMATICS STRATEGY** Group Executive Lead: **GROUP CHIEF FINANCE OFFICER**	
RISK CONSEQUENCES (What might happen if the risk materialises?): 1. **Delivery of patient care could be affected by loss of access to systems and/or data leading to patient harm.** 2. **Patient experience could be adversely impacted (e.g. wait times increased) by loss of access to systems and/or data.** 3. **Financial damage.** 4. **Reputational damage.** 5. **Staff morale.**	Associated Committee: **GROUP INFORMATICS STRATEGY BOARD** Operational Lead: **GROUP CHIEF INFORMATICS OFFICER** Material Additional Supporting Commentary (as required): Please note there is a national mandate that Cyber risk scoring remains at 15, despite work being undertaken to reduce severity.	

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15 (5x3)	A.1 Appropriate Controls are in place to manage the threat of Cyber attack and other IT vulnerabilities and security threats.	B.1 Regular reviews are undertaken to manage any gaps in control & mitigate any emergent risk.	C.1 Independent assurance scheduled at regular intervals to ensure best practice in addressing cyber threat and other IT security vulnerabilities	D.1 Emerging Cyber Risk may mean gap in assurance through non-availability of specialist knowledge at point of risk.	15 (5x3)	A.1 Implementation of the Group Informatics Cyber Security Action Plan, which will track and monitor all ongoing Actions at a detailed level. This will ensure continuous monitoring in line with ongoing and emerging risks at a national and global level.	Group Chief Informatics Officer	Ongoing	Group Informatics Strategy Board	• Continual service improvement in key IT infrastructure and raising organisation understanding through appropriate guidance, to reduce the incidence and impact of cyber risk. Additional improvements have been carried out and Cyber Essentials Plus Action Plan updates submitted to NHS Digital for ratification.	**6 (3x2)**

3	Strategic Aim: To improve the experience of patients, carers and their families

PRINCIPAL RISK (What is the cause of the risk?): If the care provided to patients is not responsive to their individual needs and the environment is unsuitable, this could impact negatively on patient experience, outcomes and reputation

Enabling Strategy:
QUALITY AND SAFETY STRATEGY;
NURSING, MIDWIFERY & AHP STRATEGY

Group Executive Lead:
GROUP CHIEF NURSE

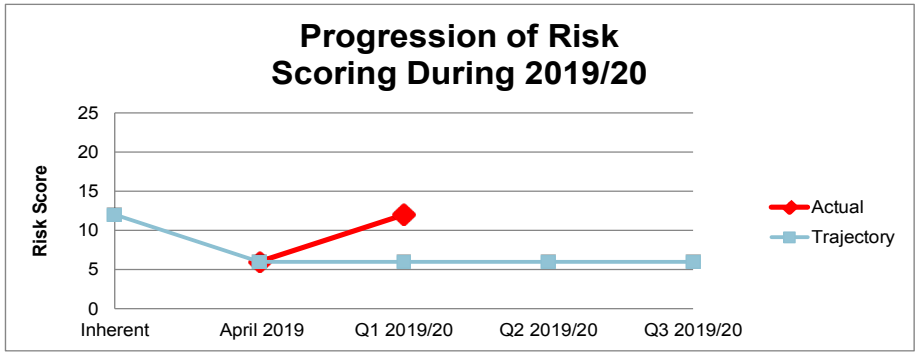
RISK CONSEQUENCES (What might happen if the risk materialises?):

1. Adverse patient experience
2. Increased complaints
3. Failure to comply with regulatory standards
4. Damage to Trust reputation

Associated Committee:
QUALITY AND SAFETY COMMITTEE; PROFESSIONAL BOARD

Operational Lead:
CORPORATE DIRECTOR OF NURSING

Material Additional Supporting Commentary (as required):



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12 **4x3**	A1. Corporate and hospital/MCS/ MLCO Quality governance and delivery structures. A2. Patient Environment of Care Group oversees delivery of work programme and monitors impact. A3. Contract monitoring focused on patient experience outcomes. A4. Monitoring and reporting systems in place for complaints, concerns and compliments. A5. MFT Compliments, Complaints and Concerns Policy A6. Complaints management guidance provided to Hospitals/Managed Clinical Services. A7. Accountability Oversight Framework (AOF) monitoring. A8. Improving Quality Programme (IQP). A9. What Matters to Me (WMTM) Patient Experience programme A10. Clinical accreditation programme. A11. Nutrition and Hydration Strategy A12. Quality and Patient Experience Forum A13 PLACE inspections A14 EHO inspections	B1. WMTM patient experience programme not fully embedded in all areas. B2. IQP not fully embedded in all areas. B3. Nutrition and Hydration Strategy not fully embedded B4. Lack of Patient Experience Involvement Strategy B5 Lack of food handling training to comply with the EHO recommendation 's	C1. Internal quality assurance processes (Accreditation programme, Quality Reviews) with annual Accreditation report to BoD C2. AOF metrics reporting C3. Quarterly and annual complaints reports C4. Quality of Care Round data C5. WMTM patient experience survey data C6. National patient survey data/reports C7. Regulatory inspection processes C8. Friends and Family Test data C9. Joint compliance audits with Sodexo C10. PLACE inspections C11. Reports to Professional Board	D1. Below average scores in national patient surveys for quality of food, discharge, experience, knowing how to complain and being ask about the quality of care D2. Variation in AOF scores across the Trust D3 Training for all staff involved in food handling processes with level 32 training for certain categories of staff	**12** **4X3**	B1. Matron to support areas where WMTM is not yet embedded B2. Matron to support areas where IQP is not yet embedded B3. WTWA, MRI and RMCH to establish local nutrition groups B3. SMH, MREH and CSS to establish nutrition as a standing agenda item within quality and safety meetings B3. Hospitals/MCS/MLCO to develop and deliver nutrition and hydration implementation plans B3. Establish escalation processes where patients' nutrition and hydration needs are not being adequately met B5 Develop and implement the appropriate food handling training programmes to satisfy the regulatory requirements of the EHO B4. Development of Patient Experience Involvement Strategy D1. Deliver Environment of Care work programme D2. Develop and deliver Hospital/MCS/MLCO action plans to drive improvement supported corporate services as required.	Chief Nurse's Team	March 2020	Quality and Performance Scrutiny Committee	B1. Matron in post and working with Hospital/MCS teams to embed WMTM and IQP B1. Programme Manager to introduce Always Events® as part of the WMTM Programme B3. Hospital/ MCS/ MLCO/ E&F updates to be tabled at Patient Environment of Care and Quality and Patient Experience Forum B.4 Patient Experience Involvement Strategy – Engagement Event with stakeholders arranged for August 2019 D1 Environment of Care work programme progressingD2 Hospital/MCS/MLCO action plans monitored at the AOF meetings B5 Food task and finish group with E&F and nursing to comply with the regulatory requirements set by the EHO	**6** **3x2**

4	Strategic Aim: To Achieve Financial Sustainability

PRINCIPAL RISK (What is the cause of the risk?):
Going into 2019/20, the underlying operating deficit position at Hospital level, when combined with the new year's efficiency challenge, has resulted in an overall delivery challenge of £62m of productivity and efficiency improvements required within 2019/20 financial year.

Enabling Strategy:
MFT CONSTITUTION & LICENCSING REQUIREMENTS

Group Executive Lead:
CHIEF FINANCE OFFICER

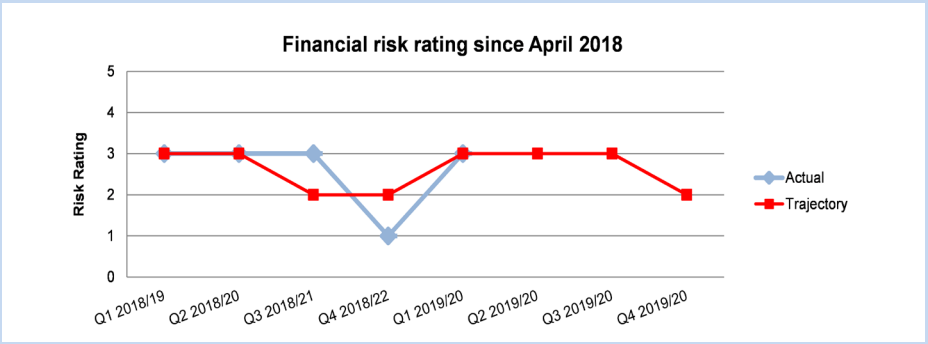
RISK CONSEQUENCES (What might happen if the risk materialises?):

Breach of Control Total leading to loss of Sustainability Funding would significantly jeopardise the ability to invest in and sustain improvements for patients.

Associated Committee:
FINANCE SCRUTINY COMMITTEE

Operational Leads:
HOSPITAL FINANCE DIRECTORS

Material Additional Supporting Commentary (as required):



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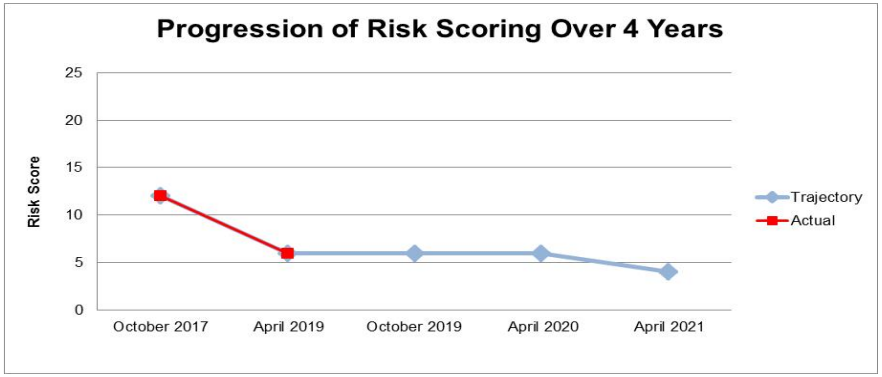
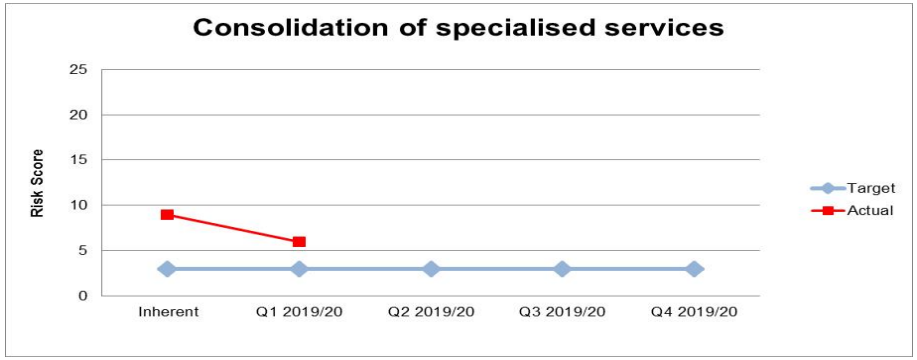
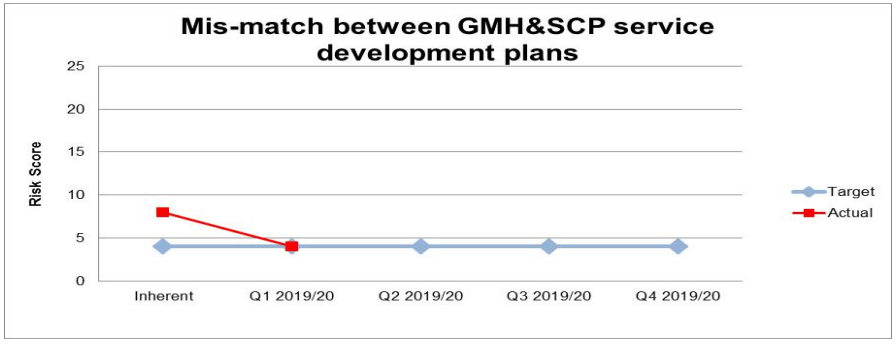
20 (5x4)	A1 2019/20 Control totals at hospital/MCS level have been agreed at Finance Scrutiny Committee (FSC) A.2 Specific additional recovery and delivery actions were agreed with each Hospital/MCS leadership team during the second week of June, to secure stronger, more A.3 Follow up discussions will continue to be held fortnightly between the Group CFO, Group COO and Hospital CEOs and leadership teams to ensure that progress is maximised and any delay factors are systematically tackled and removed A.4 Hospitals' performance against their agreed 2019/20 control totals will continue to be reported on a monthly basis at Hospital Management Boards and reviewed in the Group Executive Team, with formal reporting bi-monthly to Group Management Board and the Board of Directors A.5 The Board Finance Scrutiny Committee will review the evidence of effectiveness of Hospitals' stabilisation of the month-on-month run rate in September A.6 All delivery plans continue to benefit from structured Quality Impact Assessments by the Hospital/MCS, which are further QA'd at Group level	None	C.1 An extensive framework of review, challenge and escalation is fully embedded within the organisation C.2 Each month the Hospitals/MCS are assigned an AOF rating against the finance domain based on their performance, which determines the level of progress recognised, intervention and support required	None	20 (5x4)	None	Group Chief Finance Officer / Hospital/MCS FDs	Ongoing	Finance Scrutiny Committee		**12 (3x4)**

4	Strategic Aim: To Achieve Financial Sustainability	
PRINCIPAL RISK (What is the cause of the risk?): The Trust remains at a lower level of digital maturity than its ambition.	Enabling Strategy: **MFT GROUP INFORMATICS STRATEGY** Group Executive Lead: **GROUP CHIEF INFORMATICS OFFICER**	
RISK CONSEQUENCES (What might happen if the risk materialises?): 1. **Inability to deliver against Trust strategies.** 2. **Inability to deliver benefits associated with transformational programmes of work.** 3. **Poor patient care and or experience.** 4. **Reputational damage.** 5. **Financial loss.** 6. **Low staff morale.**	Associated Committee: **GROUP INFORMATICS STRATEGY BOARD** Operational Lead: **Group CIO, Corporate Directors, and Hospital CEOs.** Material Additional Supporting Commentary (as required):	

Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGRESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
12 (4x3)	A.1 Monitoring of: • Delivery of Informatics Plan. • Benefits Realisation - Qualitative and Quantitative. • Digital Maturity Index for Trust. • Integration Steering Group monitoring of Informatics PTIP Plan. • Strategic and Outline EPR Business Case approved. • Procurement is drawing to a close for strategic EPR solution. • Trust Board EPR Task & Finish Committee has been established for Milestone Approvals.	B.1 Changes in the external landscape.	C.1 Introduction of SHS Informatics Governance in 2018/19 C.2 Group Management Board approval made in January 2018 to go to Open Procurement for the strategic EPR solution. C.3 Monitoring against HIMSS digital maturity Index. C.4 Regular updates to Hospitals and Group C.5 Informatics Membership on Boards. C.6 Informatics PTIP Reporting C.7 EPR Task & Finish Committee, Aug 2018 approval for EPR OBC; commencement of OJEU Competitive Dialogue; and Procurement Gateways C.8 EPR Task & Finish Committee, Apr 2019 approval to commence EPR Procurement dialogue phase, and approval of the EPR Benefits Approach C.8 Review of Informatics governance framework completed and revised structure and associated processes implemented. C.9 Governance for the management and implementation of EPR approved.	D.1 The significant workload to understand the landscape of the MFT organisation and the planned programmes of work.	**6 (3x2)**	C.2 Procure and implement strategic EPR solution for MFT organisation C.2 Cross section of staff to participate in Innovation Council. A.1 Appropriate engagement with Workforce Committee and wider Trust,, to ensure staff are skilled to meet the needs of our digital organisation. A.1 Operational readiness work programme is in progress to support the cultural change. A.1 Continued monitoring of the delivery roadmap for the EPR tactical work until the strategic solution is implemented.	Group Chief Informatics Officer	Ongoing	Group Informatics Strategy Board	• Robust Monthly Monitoring against plans. • Good development work with both EPR Tactical Business cases going through the approval process. • EPR Innovation Council implemented. • HCCIOs appointed. • New MFT Informatics Strategy Approved by GISB. • Concluded the Group Informatics Management of Change process.	4 (2x2)

5	**Strategic Aim:** To develop single services that build on the best from across all our hospitals	
PRINCIPAL RISK (What is the cause of the risk?): **There is a risk that commissioners will further consolidate specialised services at a national level (e.g. ACHD), where MFT is not made the designated provider.**	Enabling Strategy: **GROUP SERVICE STRATEGY / CLINICAL SERVICES STRATEGIES (in development), GROUP QUALITY STRATEGY, GROUP WORKFORCE STRATEGIES** Group Executive Lead: **GROUP DIRECTOR OF STRATEGY**	
RISK CONSEQUENCES (What might happen if the risk materialises?): **1. Loss of Service** **2. Reduction in a range of services (offered within GM)** **3. Damage to reputation** **4. Loss of staff** **5. Reduction in research opportunities**	Associated Committee: **GROUP SERVICE STRATEGY COMMITTEE** Operational Lead: **DIRECTORS OF STRATEGY** Material Additional Supporting Commentary (as required):	

Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING OMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
9 (3X3)	A.1 Involvement in the GM Partnership forums to provide a united voice on maintaining GM-based services. A.2 Involvement in strategic clinical networks A.3 Regular discussions with NHS England Medical Director Representation through the Shelford group A.4 Active involvement in Operational Delivery Networks A.5 Regular meetings with NHSE North established	B.1 Management capacity within corporate hospital and MCS teams to identify ongoing risks and issues against each of our specialised services (as flagged through quality surveillance reviews and other national and local reviews) B.2 Lack of Group wide review of compliance against service specifications	Award of: C.1 National tender for Auditory Brainstem Implantation - one of only two providers in the country. C.2 CAR-T designation for adults and children C.3 Northern Paediatric MS service (MFT lead with Alder Hey and Newcastle), Genomics Lab Hub C.4 Outcome of 18/19 quality surveillance reviews. C.5 Outcome of Peer Reviews	D.1 No Gaps in Assurance	**6 (3X2)**	B.2 Completed the annual surveillance reviews across ORC and Wythenshawe sites and have made overall assessment of areas of compliance across the Group. Planned outcome – Have a Trust wide view of compliance across all specialist services. Report to next GSSC (September) 0	Group Governance Team	July 2019	GSSC	Underway	**3 (3x1)**
						B.2 Work through areas of non-compliance with hospitals and MCSs as part of annual planning. Planned outcome – All hospital and MCS annual plans for 20/21 will include plans for addressing compliance issues in specialised services.	Hospitals / MCS	March 2020	GSSC	To commence	
						B.2 National specialised services under review by NHSE to be analysed and individually risk rated by the strategy team as part of the corporate team's regular risk management process. This will identify specialised services viewed as being most vulnerable to consolidation away from MFT. Planned outcome – Risk rated list of specialised services under NHSE review for prioritisation and further action.	Group Strategy Team	Q3 19/20	GSSC	Ongoing	
						A.5 Maintenance of control - maintain regular dialogue with NHSE contacts regarding portfolio of national clinical service reviews. Planned outcome – Strategy team to remain informed regarding NHSE clinical service review priorities and timescales. Monthly meetings with NHSE specialised services arranged as part of structured intelligence gathering.	Group Strategy Team	Ongoing 19/20	GSSC	Ongoing	

5	**Strategic Aim:** **To develop single services that build on the best from across all our hospitals**	
PRINCIPAL RISK (What is the cause of the risk?): There is a mismatch between MFT and Greater Manchester Health & Social Care Partnership plans for the development of services	Enabling Strategy: **GROUP SERVICE STRATEGY / CLINICAL SERVICES STRATEGIES (in development)**	
	Group Executive Lead: **GROUP DIRECTOR OF STRATEGY**	
RISK CONSEQUENCES (What might happen if the risk materialises?): **1. Loss of united voice for GM**	Associated Committee: **GROUP SERVICE STRATEGY COMMITTEE**	
	Operational Lead: **DIRECTORS OF STRATEGY**	
	Material Additional Supporting Commentary (as required):	

Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
8 (4X2)	A.1 MFT representatives on GM boards inc Health and Care Board, Partnership Executive Board, Provider Federation Board, Chairs' group, HR, Directors of Finance, Directors of Strategy, Directors of Ops, JCB Executive Group etc. A.2 MFT representatives on Improving Specialist Care (ISC) Board, ISC Executive, ISC Clinical Reference Group A.3 Strengthened role of PFB enables providers to engage as a group within GM A.4 Process in place for GM decision making which involves and recognises the Trust's decision making requirements A.5 Development of MFT group and individual clinical service strategy, takes GM decisions into account to form coherent strategies for the Trust that align with GM decisions. A.6 Involvement of key GM stakeholders in development of Group and Clinical Service Strategies	B.1 Complete MFT Group and Clinical Service Strategies	C.1 MFT designated lead provider for specialist emergency care and emergency general surgery (Healthier Together) C.2 MFT (Wythenshawe) designated lead provider for urology cancer surgery (ISC) C.3 MFT designated lead provider for Haematological Malignancy Diagnostics Services across GM C.4 GM PACS procurement in alignment with MFT aims C.5 Positive response to outcome of MFT Group service strategy and wave 1 clinical service strategies from key GM stakeholders	D.1 Outcome of GM decisions re ISC in scope services D.2 Response from GM stakeholders to MFT clinical service strategy for waves 2 and 3 and the Managed Clinical Services	4 (4X1)	A.1 Maintenance of control - Ensure regular MFT representation at all GM meetings	MFT Strategy team	On-going	GSSC	Mapping of all meetings and MFT coverage underway	4 (4X1)
						B.1 Finalise MFT group clinical service strategy	MFT Strategy team	Q1	GSSC	Completed. Group Clinical Service Strategy approved by BoD (July 2019)	
						D.2 Complete underpinning clinical service level strategies engaging with GM stakeholders in development.	MFT Strategy team	Q1	GSSC	Completed. Clinical services strategies completed and approved by BoD. GM stakeholders engaged and communications plan developed.	

7	**Strategic Aim:** To develop our workforce enabling each member of staff to reach their full potential.

PRINCIPAL RISK: (What is the cause of the risk?): Failure to deliver high quality safe care due to the inability to recruit, retain and engage the current and future workforce of MFT.

Group Executive Lead:
GROUP EXECUTIVE DIRECTOR OF WORKFORCE AND CORPORATE BUSINESS

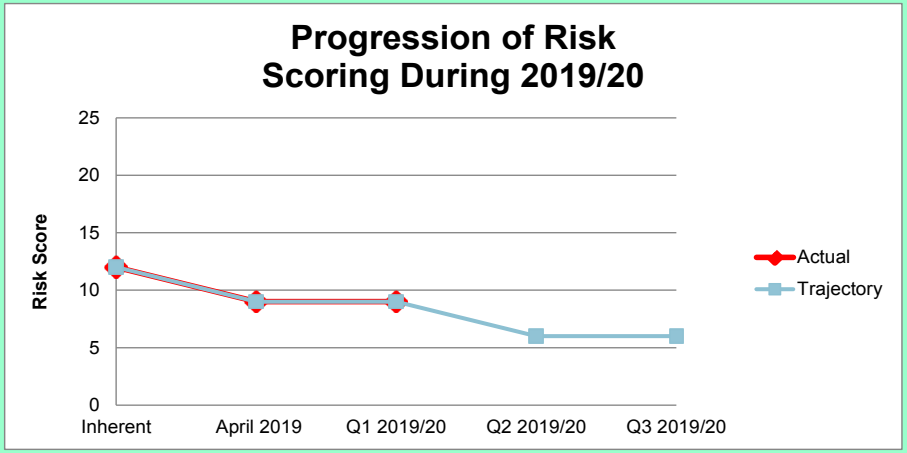
Associated Committee:
WORKFORCE & EDUCATION COMMITTEE

Operational Leads:
Group Director of Organisation Design and Development
Associate Director of Workforce Quality and Governance
Associate Director of Inclusion, Community & EHWB

Material Additional Supporting Commentary (as required):

RISK CONSEQUENCES

1. **Inability to attract, source and recruit staff**
2. **High temporary staff costs**
3. **Low morale, engagement and wellbeing**
4. **Higher number of employee relation cases**
5. **Poor patient experience**
6. **Regulatory consequences**
7. **Damage to MFT reputation**
8. **Failure to deliver services**



Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
12 (3x4)	A.1 Emergent People and related policies A.2 Trust Governance structure – including Human Resources Scrutiny Committee A.3 AOF monitoring A.4 Mandatory Training programme A.5 Workforce Plans A.6 MFT Operational Plan A.7 Equality, Diversity and Human Rights Strategy A.8 Workforce Technology Framework A.9 Leadership and Culture Strategy	B.1 Some policies still under development B.2 People Strategy to be approved B.3 Mandatory Training Programme still needs embedding B.4 Workforce systems programme in its infancy B.5 Inadequate funding in training and development to match current and forecast demand B.6 Apprenticeship policy still to be embedded B.7 Limited intelligence informing workforce plans relating to global influences B 8 Ensuring the basics are delivered	C.1 Realignment of Workforce related strategies providing one strategy aligned to Trust service clinical strategy C.2 Trust Workforce systems and reporting eg eWIP C.3 Trust external and internal audit systems C.4 Staff survey and pulse checks C.5 Regulatory and statutory inspection processes and standards C.6 Internal quality assurance processes (Ward accreditation, Quality Review) C.7 AOF C.8 External accreditations C.9 Hospital/MCS reviews C.10 ISG Board reviews PTIP progress C.11 Agreed objectives for the Executive Director of Workforce and Corporate Business C.12 Review of HR Scrutiny committee arrangements completed and revised assurance process agreed C.13 Increased Executive presence at various key committees eg: TJNCC, HRD group, Workforce technology/Informatics Board C.14 Employee Health and Wellbeing Service framework to be approved	D.1 Limited interoperability of Workforce systems D.2 Competing priorities impacting on engagement in workforce agenda D.3 Workforce metrics not yet fully developed or reported on D.4 Resource and funding pressures in workforce teams D 5 Currently no formal outputs from Shelford HRD Forum D.6 Partial and time limited investment which may impact on delivery of Workforce Strategy D.7 Capacity to deliver competing large scale strategic change	**9 (3x3)**	B.2 Implement People Strategy and enabling framework plans D.1 Implementation of Workforce Technology Framework D.2 Clear terms of Reference and membership to ensure attendance and commitment at relevant committees ensuring engagement D.3 Develop full range of workforce metrics as part of balanced scorecard D.4 Resourcing plan for corporate Workforce Team B.1 Complete policy reviews B.8 Scope and research global partnerships/organisations with exemplary workforce initiatives for shared learning and insights C.13 Refresh of the Workforce, Education Committee	Workforce Team	March 2020	Human Resources Scrutiny Committee	***B.2 Draft People Strategy out for comments. Paper presented to WEC on plans for further development and ratification. External partner to be commissioned to lead completion of implementation plan.*** ***D.1 Delivery of key programme activities ongoing aligned to project delivery plans. Absence Manager programme launched.*** ***D.2 All current committees Terms of Reference have been review. WEC to be completed in September.*** ***D.3.Workforce metrics reviewed and agreed for AOF and the BAF + report in place. Further development in line with People Strategy.*** ***D.4 Vacancies in Workforce Corporate HRBP team filled. Continue to review and finalise establishment with Finance to determine resource plan.*** ***B.1 Policies reviewed in line with implementation plan.*** ***B.8 Research completed and informed draft People Strategy*** ***C.13 Review of WEC completed in August and Terms of Conditions will be approved in September.***	**6 (3x2)**

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING
(MEETING IN PUBLIC)

TO BE HELD ON MONDAY, 9th SEPTEMBER 2019
AT 2.00pm IN THE MAIN BOARDROOM

A G E N D A

1.	Apologies for Absence	
2.	Declarations of Interest	
3.	Patient Stories	*(DVD)*
4.	To Approve the Minutes of the Board of Directors' (Public) meeting held on 8th July 2018	*(Enclosed)*
5.	**Matters Arising**	
6.	**Chairman's Report**	*(Verbal Report of the Group Chairman)*
7.	**Chief Executive's Report**	*(Verbal Report of the Group Chief Executive)*
8.	**Operational Performance**	
	8.1 To Consider the Board Assurance Report	*(Summary Enclosed)*
	8.2 To Receive the Group Chief Finance Officer's Report	*(Report of the Group Chief Finance Officer Enclosed)*
	8.3 To Receive the EU EXIT Preparation Report	*(Report of the Group Chief Operating Officer Enclosed)*
9.	**Strategic Review**	
	9.1 To Receive an Update on Strategic Developments	*(Report of the Group Executive Director of Strategy Enclosed)*
	9.2 To Receive an Update Report on the Manchester Local Care Organisation	*(Report of the Chief Executive MLCO Enclosed)*
10.	**Governance**	
	10.1 To Receive an Update Report on the Regulatory Assessment Process (2019/2020)	*(Report of the Group Chief Nurse Enclosed)*
	10.2 To Receive the Nursing & Midwifery Safer Staffing Report	*(Report of the Group Chief Nurse Enclosed)*
	10.3 To Receive the Q1 (2019/20) Complaints Report	*(Report of the Group Chief Nurse Enclosed)*
	10.4 To Receive the 'Freedom to Speak Up' Annual Report	*(Report of the Group Deputy Chief Executive Enclosed)*

10.5 To Receive the Annual Medical Workforce Revalidation Report (2018/2019) *(Report of the Joint Group Medical Director Enclosed)*

10.6 To Accept and Ratify a Report on the Equality, Diversity and Inclusion Strategy *(Report of the Group Executive Director of Workforce & Corporate Business Enclosed)*

10.7 To Receive the Annual Patient Experience Report *(Report of the Group Chief Nurse Enclosed)*

10.8 To Accept the Board Assurance Framework (September 2019) *(Report of the Group Executive Director of Workforce & Corporate Business Enclosed)*

10.9 To note the following Committees held meetings:

- 10.9.1 Group Risk Management Committee held on 1st July 2019
- 10.9.2 Charitable Funds Committee held on 8th July 2019
- 10.9.3 MLCO Scrutiny Committee held on 10th July 2019
- 10.9.4 Finance Scrutiny Committee on 11th July 2019
- 10.9.5 HR Scrutiny Committee held on 6th August 2019
- 10.9.6 Quality & Performance Scrutiny Committee on 6th August 2019

11. Date and Time of Next Meeting

The next meeting will be held on **Monday, 11th November** at **2pm** in the **Main Boardroom**

12. Any Other Business