NHS
Manchester University
NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS' MEETING

Meeting Date: 13th January 2020

(Held in Public)

12/20 Apologies for Absence

Apologies were received from Professor Luke Georghiou and Mrs Gill Heaton.

13/20 Declarations of Interest

There were no declarations of interest received for this meeting.

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

14/20 Patient Story

The Group Chief Nurse introduced a DVD Story in the form of a DVD clip.

The Board did not debate or discuss the clip, preferring to use the story and the imaging 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

15/20 Minutes of the Board of Directors Meeting held on 11th November 2020

The minutes of the meeting held on the 11th November 2020 were agreed as a correct record.

16/20 Matters Arising

The Board reviewed the actions from the Board of Directors meeting 11th November 2019 and noted progress.

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

17/20 Group Chairman's Report

(i) The Chairman was pleased to report that Michelle Proudman, the MLCO's Lead Nurse for North Manchester community healthcare services had been awarded an MBE for services to community nursing in the 2020 New Year's Honours List. She explained that Michelle had been a nurse in Manchester for almost 40 years and had started as a community staff nurse in North Manchester in 1980.

(ii) The Chairman and Group Chief Nurse reminded the Board that 2020 was the 200th Anniversary of the birth of Florence Nightingale and to mark this event, The World Health Organisation had designated 2020 as the first ever *'International Year of the Nurse and Midwife'* (YNM2020). The Group Chief Nurse provided examples of how MFT would be celebrating YNM2020 over the next 12 months; culminating in a special event in the Manchester Cathedral on 2nd December 2020 (more details to follow nearer the time).

(iii) The Board noted that the world premiere of a new film featuring internationally renowned performance poet Tony Walsh and co-starring patients, parents and 'angels of the ward' was launched the previous week in the Royal Manchester Children's Hospital.

(iv) The Chairman was pleased to report that she had recently visited the new Helipad site on the Oxford Road campus with Mr Stephen Lowe from the Stoller Charitable Trust and Mr Robert Bertram from HELP Appeal. She explained that alongside clinical colleagues from the MRI, RMCH and Saint Mary's, she was delighted to see how the project was progressing and discussed with colleagues the enormous benefits the Helipad would bring for patients at the Trust.

(v) The Chairman reported that at the end of November (2019), she opened an event at Wythenshawe Hospital to launch the Trust's Equality, Diversity and Inclusion Strategy 2019-2023. The Board was advised that around 70 colleagues from across Wythenshawe, Trafford, Withington & Altrincham had gathered to hear keynote speakers and an interesting panel discussion where members offered their personal insights.

(vi) The Board noted that the Emergency Multidisciplinary Unit at Trafford General Hospital had won a national award in the NHS Elect Awards. It was confirmed that they had won the 'Excellent Teamwork' category for a pilot scheme that was implemented on the Acute Medical Unit to improve patient experience, frailty standards and workflow.

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

18/20 Group Chief Executive's Report

(i) The Group Chief Executive acknowledged the heightened demand and operational pressures evident within the system; both locally and across Greater Manchester. He particularly wished to express his gratitude to all staff for their continued efforts, energy and commitment in maintaining patient safety and experience during these challenging times.

(ii) The Group Chief Executive highlighted the continued work around the NMGH Management Contract with a North Manchester Implementation Plan (Day One) being developed for 1st April 2020 which would outline the proposed governance and leadership arrangements for NMGH as well as plans for the delivery of services under a management contract.

(iii) The Joint Group Medical Director reported that the MRI's new dedicated Major Trauma Ward had successfully opened in December (2019) to patients and would be a significant asset to the Hospital when the Helipad was fully functioning. She explained that the Ward would help to underpin the MRI's position as a Major Trauma Centre for Greater Manchester and the surrounding areas.

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

19/20 Operational Performance

Board Assurance Report

The Joint Group Medical Director provided an update under several key areas under the main heading of 'Safety'. It was noted there had been notification of two new 'Never Events' (NEs) in December 2019 under the theme of electronic checklist and areas of improvement and best practice. The Board was also advised that whilst the Trust continued to report higher level of patient safety incidents, 99% of those reported were of a lower level.

The Joint Group Medical Director also reported that two recent Mortality Reviews had indicated that 'death could have been avoided' and both cases (which had occurred in October 2019) was in the MRI and the common theme was 'Sepsis' and associated 'antibiotic prescribing'. It was noted that the Mortality Reviews for both cases had occurred in November 2019 with a focus on avoidable factors and key 'lessons learnt'. It was confirmed that once completed, an Action Plan(s) was formulated and shared with the immediate clinical teams involved, and, to the wider Group of Hospitals/MCS in MFT via the Joint Group Medical Director. In response to an observation from the Chairman, It was also confirmed that both Action Plans would also be presented to the Board's Quality & Performance Scrutiny Committee.

The Board also received an update on the Mortality Indices (SHMI & HSMR) and whilst MFT's position continued to be exceptionally good and below expected levels (below = good), it was confirmed that the Trust regularly benchmarked performance against other *Shelford Hospitals* (with comparable data). It was noted that when benchmarked against other Providers in the North West (inc. Merseyside), MFT had the lowest SHMI and overall Crude Mortality and Non-elective (low = good). The Joint Group Medical Director also confirmed that improvements to co-morbidity coding were underway and would serve to further improve the Trust's overall position going forward.

The Group Chief Nurse reported that Complaints Management performance was progressing well with continued improvement in the Trust's >41 days response rate and overall management of complaints within the MRI. She also highlighted that the Trust's overarching Nursing & Midwifery vacancy factor was 7% (9% AFC Band 5 Staff Nurses) with only one ward in MFT now reporting an overall vacancy factor of 25%. In response to observations from the Chairman, it was also noted that there were 580 vacancies (compared to c.1,000 12 month previously) and this was largely due to the success of the International Nurse Recruitment Campaign.

The Group Chief Nurse also explained that the current Infection prevention and control indicator (*All attributable bacteraemia*) presented within the Board Assurance Report would be reviewed and refined prior to the next annual reporting period in order to provide the Board with further assurance. In response to questions and observations by Mr Barry Clare & Dr Ivan Bennett, the Group Chief Nurse described the data currently presented and the proposed data going forward. It was agreed that the refined indicators would be presented to the Quality & Performance Scrutiny Committee prior to inclusion in a future Board Assurance Report. The Joint Group Medical Director also agreed to provide further details, produced for the Acute Care Board, in relation to the performance of the Acute Care Teams in 'Sepsis' from each Hospital/MCS.

The Group Chief Operating Officer wished to first reiterate her appreciation to all staff throughout the Group for their heightened efforts, energy and commitment in response to the increased demand and very high volumes of patients witnessed during the weeks leading up to, and, over the Christmas & New Year period. She went on to provided several headline messages under the main Board Assurance Report category of 'Operational Performance'.

Particular attention was drawn to urgent and emergency care activity presented and it was reported that following a further detailed analysis of activity throughout Q3 (2019/20), the Trust's final performance against the National A&E Target was 80.2% which was a 4% deterioration from the Trust's performance in Q3 (2018/19). The Board was advised that nationally (and throughout GM), overall, there had been a 6% deterioration in performance over a 12 month period. The Group Chief Operating Officer emphasised the continued focus, in all areas, on ensuring that the Trust provided a safe service for patients despite the heightened demand. The Board noted the continued resilience which exists within the MFT Group of Hospitals with examples cited of close collaboration and support between the Oxford Road Campus, Wythenshawe, MLCO and NWAS.

The Chairman joined the Group Chief Operating Officer in commending the MFT workforce for their incredible multi-professional Team Work and relentless focus on placing the 'Patient' and 'Patient Safety' at the centre of all activities throughout the Trust.

In response to questions and observations from Dr Ivan Bennett, the Group Chief Operating Officer described the plans in place to accommodate elective and non-elective patients (inc. Cancer patients), particularly those requiring operative procedures, during heightened periods of demand and challenge within the system.

The Group Executive Director of Workforce & Corporate Business described 'Attendance' performance during Q3 (2019/20) and the various support networks in place for staff. He also explained that whilst performance against the core Mandatory Training indicator was meeting the threshold, there was a requirement for added focus on Levels 2 & 3. This had activated a 'deep dive' (diagnostic) into these areas and a report on the outcome and key recommendations would be presented to the next meeting of the HR Scrutiny Committee (HRSC) in February 2020.

In response to a question and observation from Mr Trevor Rees, the Group Executive Director of Workforce & Corporate Business confirmed that long-term absence did influence the attendance performance data and further breakdown could be presented to the HRSC. In response to comments and observations from Mr John Amaechi (as Chair of the HRSC) regarding the key HR performance indicators (inc. attendance and retention) which are regularly reviewed at the HRSC, the Group Executive Director of Workforce & Corporate Business reported that key timescales for expected improvement would be discussed at the next meeting.

The Board Assurance Report was noted.

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

Group Chief Finance Officer's Report

The Group Chief Finance Officer reported that the financial performance to the end of November 2019 was a bottom line deficit on a control total basis (excluding Provider Sustainability Fund) of £9.5m (0.8**%** of operating income). He explained that the operating financial performance deteriorated again in month 8, and had now reached £18.1m worse than the approved Hospital/MCS Control Totals. The Board noted that current progress with delivery was still inconsistent with the financial plans put into place across Hospitals.

The Group Chief Finance Officer emphasised that successful delivery of both the overall 2019/20 plan, and the demonstration of financial sustainability moving into 2020/21, demanded further significant improvements to be embedded and sustained over the months ahead. He confirmed that specific additional recovery and delivery actions were agreed with each Hospital/MCS leadership team during the second quarter to secure stronger, more consistent delivery of the required operating financial performance through the immediate upcoming months. It was also reported that follow up discussions would continue to be held regularly between the Group Chief Finance Officer, the Group Chief Operating Officer and Hospital Chief Executives and leadership teams to ensure that progress was maximised and any delay factors were systematically tackled and removed.

The Group Chief Finance Officer confirmed that a revised capital spending forecast of £81.2m had been agreed and the position now reported reflected the internal profiling of plan and that expenditure would be within this ceiling at year-end.

The Chairman expressed her disappointment at the Q3 (2019/20) financial position and it was agreed that further detailed scrutiny and challenge would be undertaken at the next Finance Scrutiny Committee on 4th February 2020.

The Month 8 (2019/120) Report was noted.

Decision:	Month 8 (2019/120) Report Noted	**Action by:** n/a	**Date:** n/a

20/20 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.

The Board noted that following the result of the General Election in December 2019, it was anticipated that the 'Queen's Speech' would give a clearer outline of what the Government's plans would be for healthcare and the NHS in the immediate future.

The Group Executive Director of Strategy also reported that there was growing national interest in the role of hospitals as anchor organisations in their regional economies and their role in supporting improvements in population health for their local communities. With this in mind, it was confirmed that the Shelford Group was launching a programme to support member organisations in planning their role as anchors (details noted). It was also reported that NHS E / I was reviewing the future direction for specialised services and the focus was on integration and working with sustainability and transformation partnerships (STPs) and integrated care systems (ICSs).

Within Greater Manchester, it was noted that the Improving Specialist Care (ISC) Programme was currently defining how "single services" for GM would operate. It was also noted this would be developed further as part of the work to produce the pre-consultation business cases (PCBCs). The various waves of PCBCs were duly noted in the report presented.

The Group Executive Director of Strategy also described activities with the GM Cancer Network along with the development of Rapid Diagnostics Centres (RDC). It was noted that there were currently RDC pilots in place at Wythenshawe and Royal Oldham Hospital.

At a local level, it was noted that development of the MFT strategies for clinical support services has commenced and covered Laboratory Medicine, Imaging, Therapies, Pharmacy and Anaesthetics (with end March 2020 identified as the expected completion date).

In conclusion, the Board noted the updates in relation to the national, GM and local MFT issues.

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

Update Report on the Proposed NMGH Acquisition

The Group Executive Director of Workforce & Corporate Business provided summary overview of the proposed acquisition of North Manchester General Hospital (NMGH) and the associated development of the NMGH site.

The Board noted progress with the implementation planning work underway as the Trust prepared to assume management responsibility for NMGH on 1st April 2020. The Group Executive Director of Workforce & Corporate Business also confirmed the current position on due diligence, the on-going disaggregation work and explained the effort underway to plan for the redevelopment of NMGH site. It was also noted that a communications an engagement plan had been developed with a set of key messages agreed by MFT, SRFT and GMHSCP to support the development of briefings and internal updates.

The Board was advised that a North Manchester Implementation Plan was being developed that would outline the systems and processes that needed to be instigated to ensure the safe transition of services on day one of the management contract and it was confirmed that Ms Dena Marshall had been appointed as Interim Chief Executive of NMGH and would commence in a shadow role from on 22nd January 2020. It was also confirmed that the NMGH *Post Transaction Implementation Plan* (PTIP) would be presented to the Board at the development session scheduled for February 2020.

The Group Executive Director of Workforce & Corporate Business also confirmed that the North Manchester Implementation Plan would be presented to the newly convened *MFT North Manchester Scrutiny Committee* ahead of discussion with the MFT Board of Directors in February. The Board also noted that whilst the process and timescales for capital investment remained under discussion with NHS E / I regional and national teams, the Trust and its partners would continue to develop detailed proposals to ensure that the current planning momentum was maintained whilst capital funding allocations were confirmed. It was also confirmed that plans for the regeneration of hospital site and the surrounding area would continue to be finessed as part of the formal planning processes required to deliver a scheme such as the rebuilding of NMGH.

In response to questions and observations from Mrs Chris McLoughlin, the Group Executive Director of Workforce & Corporate Business explained that the Trust was working closely with other key Partners and Stakeholders (e.g. Local Commissioners, MCC) in developing a comprehensive communications strategy for both the NMGH workforce, patients and the local communities in North Manchester.

In conclusion, the Board noted the progress being made with the transaction process and supported the strategic direction of the programme.

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

Update Report on the Local Care Organisation (LCO)

The Chief Executive of the MLCO presented an update on the progress the MLCO had made in delivering against its agreed winter planning priorities and five point programme. He drew attention to the work that had been, and continued to be undertaken in conjunction with the three MFT hospital sites in Manchester (MRI, Wythenshawe, and NMGH), to support the recovery of the Manchester delayed transfer of care (DTOC) position, and an alleviation of other hospital based pressures.

The Board also noted the key work streams to stabilise the care market in the short term in Manchester. It was recognised that in a broader context, the residential and nursing market in Manchester was amongst the most challenged in the country, and from a quality perspective the most challenged in Greater Manchester. The Chief Executive of the LCO described some of the key actions and option appraisals which were being pursued in response to this challenge.

The Board received an update on the future procurement of the MLCO which would be achieved through the production of a comprehensive joint business case. Key workstreams to develop this was noted as presented in the report under the headings of 'Core operational delivery and stability'; 'Core operational delivery (planned services)'; and, 'Service Transformation'.

The Board was also reminded that the overarching vision for the MLCO was focussed upon proactive, integrated care in neighbourhoods. The Chief Executive of the LCO explained this would deliver improved health, financial balance and system resilience for Manchester. It was therefore important to broaden out the scope of MLCO again in order to rebalance the Manchester health and care system in line with the Locality Plan vision. He also explained that through the Partnership Board, it had been agreed that the scale up of MLCO services (phase 2) was likely to commence from October 2020.

The Chief Executive of the MLCO provided an update on the Trafford LCO transaction and it was noted that in order to minimise disruption, the MLCO had sought to minimise the amount of changes that would be made. He reminded the Board that the MLCO had focussed on ensuring that the gaps in governance that would emerge as result of Pennine Care Foundation divesting themselves of their interest in the services were identified and alternate arrangements had been put in place. The Board was also reminded that the clinical governance, including risk management arrangements for Trafford LCO, would replicate the arrangements that were in place for MLCO, with MLCO continuing to offer assurance through the relevant subcommittees of the Board.

The Chief Executive of the MLCO confirmed that the MLCO had earmarked an early review of governance arrangements which would now conclude in early February 2020 with work also focused on finalising a Post Transaction Implementation Plan, and to develop the required programme of transformation. The Board was also reminded that both commissioners and MLCO were in clear agreement that there would be a significant programme of transformation required in Trafford to address legacy financial and performance challenges.

In response to questions and observations from Mr Trevor Rees and Dr Ivan Benett, discussion also centred on both the effectiveness of the *'111'* service in meeting heightened demand and supporting 'patient pathways/gateways' along with continued challenges within the Social Care system.

In conclusion, the Board noted the contents of the update report.

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

21/20 Governance

2019/20 MFT Emergency Preparedness Resilience & Response Care Standards Self-assessment

The Board received and noted MFT's self-assessment against the NHS England Core Standards for Emergency Preparedness Resilience and Response (EPRR) and how the Trust's Emergency Planning team were working collaboratively to provide mutual support and expertise to progress the associated action plan which would be overseen through the MFT EPRR Group.

It was also noted that in addition, required actions would be cascaded through local Site EPRR Forums with external oversight provided through the Local Health Resilience Partnership and Health Economy Resilience Groups.

The Group Chief Operating Officer confirmed that MFT had declared a compliance level of **substantial**, which was the same level of compliance as in 2018/19. The full statements of compliance were noted by the Board in the accompanying appendices.

In response to observations and questions from Mr Nic Gower and Mr Barry Clare, the Group Chief Operating Officer agreed to present to an identified Board Scrutiny Committee further details on the agreed action plans which were focused on areas of the EPRR standards which were deemed to be only *'partially compliant'.*

The Board of Directors noted the content of the update report.

Decision:	Update Report Noted EPRR Action Plans to be presented to the *Quality & Performance Scrutiny Committee* for further review and scrutiny	**Action by:** Group Chief Operating Officer	**Date:** April 2020

Committee meetings which had taken place:

- Group Risk Management Committee held on 4th November 2019
- Audit Committee held on 6th November 2019
- Finance Scrutiny Committee held on 20th November 2019
- Quality & Performance Scrutiny Committee held on 3rd December 2019
- Charitable Funds Committee held on 11th November 2019
- MLCO Scrutiny Committee held on 13th November 2019
- EPR Task & Finish Committee held on 9th December 2019
- HR Scrutiny Committee held on 17th December 2019

22/20 Date and Time of Next Meeting

The next meeting of the Board of Directors held in public will be on **Monday 9th March 2020** at **2pm** in the **Main Boardroom**

23/20 Any Other Business

There was no other business.

Present:	Mr J Amaechi	-	Group Non-Executive Director
	Professor Dame S Bailey	-	Group Non-Executive Director
	Mr D Banks	-	Group Director of Strategy
	Dr I Benett	-	Group Non-Executive Director
	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
	Mr N Gower	-	Group Non-Executive Director
	Professor C Lenney	-	Group Chief Nurse
	Mrs C McLoughlin	-	Group Non-Executive Director
	Miss T Onon	-	Joint Group Medical Director
	Mr T Rees	-	Group Non-Executive Director
	Mr A Roberts	-	Group Chief Finance Officer
In attendance:	Mr 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 L Georghiou	-	Group Non-Executive Director
	Mrs G Heaton	-	Group Deputy CEO

ACTION TRACKER

Board Meeting Date: 13th January 2020			
Action	Responsibility	Timescale	Comments
EPRR Action Plans to be presented to the *Quality & Performance Scrutiny Committee* for further review and scrutiny	Group Chief Operating Officer	April 2020	Scheduled

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Directors
Paper prepared by:	Gareth Summerfield, Head of Information, Information Management, MFT
Date of paper:	February 2020
Subject:	Board Assurance Report – January 2020
Purpose of Report:	Indicate which by ✓ • Information to Note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	The Board Assurance Report is produced on a monthly basis to inform the Board of compliance against key local and national indicators as well as commenting on key issues within the Trust.
Recommendations:	The Board of Directors is asked to note the content of the report.
Contact:	Name: Gareth Summerfield, Head of Information Tel: 0161 276 4768

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS

BOARD ASSURANCE REPORT

(January 2020)

1. Introduction

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

2. Overview

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

3. Key Priority Areas

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

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

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

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

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

> Board Assurance Narrative Report – Guidance Notes

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

Summary Bar (Example –Safety Domain)

Safety
R.Pearson\T.Onon

Core Priorities	✓	◇	×	No Threshold
	3	1	1	0

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

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

Headline Narrative

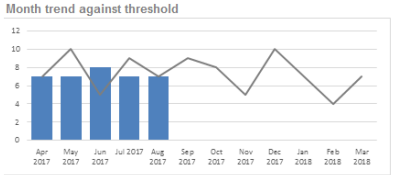
Headline narratives give context to the domain, stating current issues, good news stories, future challenges and risks, and commenting on the latest developments around performance of the indicators. Narrative is provided by the person(s) accountable for the individual domain

Section - Core Priorities

Hospital Incidents level 4-5
MFT

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

Month trend against threshold



12 month trend (Sep 2016 to Aug 2017)

Hospital level compliance

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

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

Key Issues
Serious harm (level 4 & 5 actual harm incidents). The organisation continues to report high numbers of patient safety incidents per 1000 bed days, 57.69 in the last NRLS data report. This indicates a willingness to report and learn (an assumption supported by the staff survey results). Over 99% of these incidents are low level harm or no harm incidents. The CQC described a culture of reporting and learning from incidents.

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

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

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

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

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

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

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

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

NHS
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> Board Assurance

January 2020

Safety

J.Eddleston\T.Onon

Core Priorities	✓	◇	✕	No Threshold
	3	0	3	0

Headline Narrative

There are three core priorities which are not currently being met.

The Group has had 9 Never Events reported over the last 12 months with 8 of these reported since April 2019.

A number of actions are underway and local assessment is being undertaken of further work required in those Hospitals / MCS with more than one reported event in the last 2 years (RMCH, WTWA and CSS). The Quality and Safety Committee will be overseeing this work and the aim continues to be to eradicate these events.

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

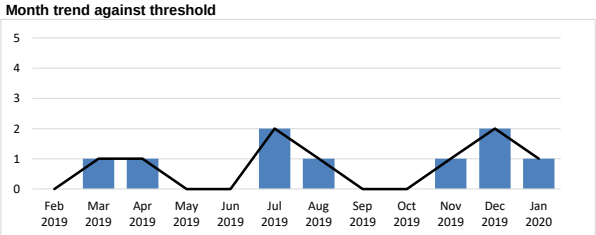
There have been two **avoidable deaths** reported and these have been investigated and action implemented to avoid further harm.

Safety - Core Priorities

Never Events

Actual	8	YTD (Apr 19 to Jan 20)	**Accountability**	J.Eddleston\T.Onon
Threshold	0	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✕	✓	✕	✓	✕	✓	✕
1	0	2	0	2	0	3

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 9 Never Events: 1 misplaced NG Tube, 4 wrong site surgery/wrong site block, 2 retained items, 1 connection to air instead of oxygen and 1 insulin event . 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.

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 checklist and item counts, with a focused pilot in MRI now completed. This work will be reported to the Quality & Safety Committee.

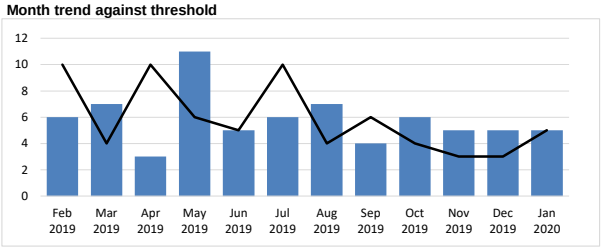
> Board Assurance

January 2020

Hospital Incidents level 4-5

Actual	57	YTD (Apr 19 to Jan 20)	**Accountability**	J.Eddleston\T.Onon
Threshold	56	(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
✗	✗	✓	✓	✗	✗	✓
5	18	4	5	2	1	22

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, 54.10 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

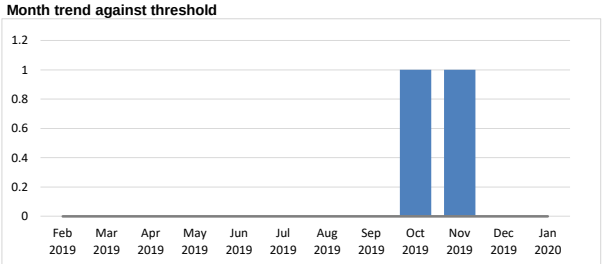
Communication of test results remains a focus across the Group and work is underway to further develop the clinical risk plan in respect of communication and response to clinical tests.

Thematic reports are reviewed at a number of forums and will inform the 2019/20 work plans.

Mortality Reviews - Grade 3+ (Review Date)

Actual	2	YTD (Apr 19 to Jan 20)	**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
✗	✓	✓	✓	✓	✓	✓
2	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. The Chief Medical Examiner and a supporting team have now been appointed.

Actions

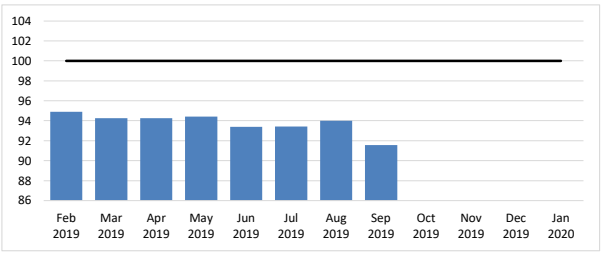
The creation of MFT has provided an opportunity to re-evaluate the approaches to learning from deaths in both organisations, and to implement a new policy based on national guidance and best practice in both organisations. Going forward, the focus will be on learning from deaths, and dissemination of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

> Board Assurance

January 2020

SHMI (Rolling 12m)

Actual	91.6	R12m (Oct 18 to Sep 19)	**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	97.7	157.1	154.5	NA	NA	85.2

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.

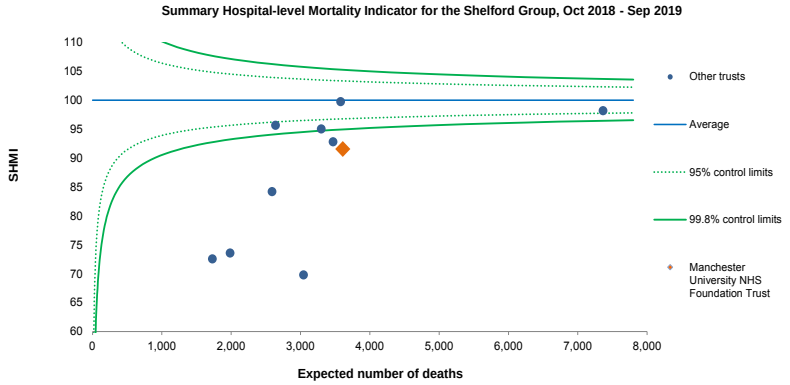
Progress

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.

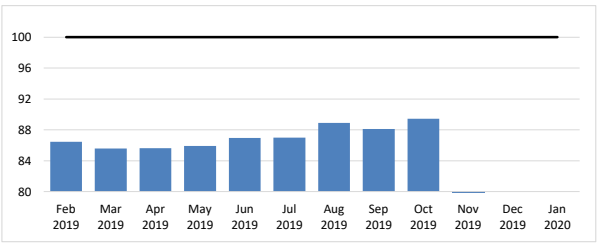
All child deaths and adults with a Learning Disability undergo a detailed mortality review.

Performance is well within the expected range.



HSMR (Rolling 12m)

Actual	89.5	R12m (Nov 18 to Oct 19)	**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	82.9	NA	NA	NA	NA	89.8

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.

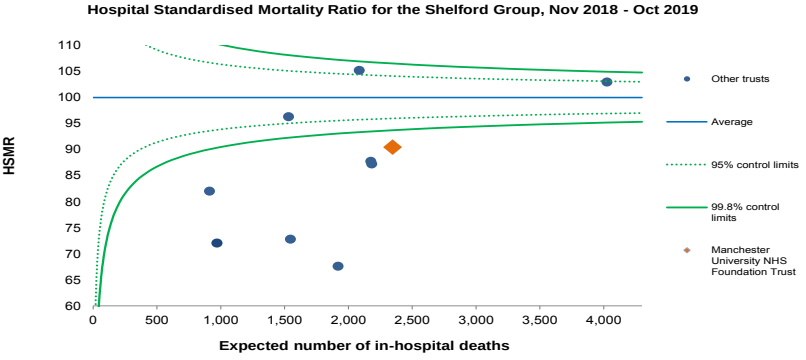
HSMR is a metric designed for adult practice.

HSMR is a weighted metric for all adult acute settings (RMCH, REH and UDHM are excluded)

Performance is well within the expected range.

Progress

The Group HSMR is within expected levels.



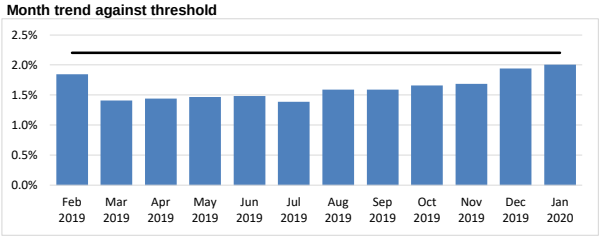
> Board Assurance

January 2020

Crude Mortality

Actual	1.62%	YTD (Apr 19 to Jan 20)	**Accountability**	J.Eddleston\T.Onon
Threshold	2.20%	(Lower value represents better performance)	**Committee**	Audit Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
NA	✓	✓	✓	✓	✓	◇
NA	2.0%	0.2%	0.3%	0.0%	0.0%	2.5%

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

Key Issues

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

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

Patient Experience

C.Lenney

Core Priorities	✓	◇	✕	No Threshold
	4	2	1	2

Headline Narrative

There was an increase in the number of complaints received in January 2020 and a slight decrease in the overall year to date performance for responses within timescale. The number of new formal complaints received across the Trust during January 2020 was 142, which is an increase compared to 112 in December 2019.

Performance is monitored and managed through the Accountability Oversight Framework (AOF). The number of over 41 day complaint cases at the end January 2020 (39) increased in number by 2 compared to December 2019 (37). The closure of complaints resolved within the agreed timescales across MFT in January 2020 was 84.8%.

The Friends and Family Test (FFT) score of 'Extremely Likely' or 'Likely' to recommend the service they received to their Friends and Family in January 2020 was 94.6%, a slight increase when compared to 93.7% achieved in December 2019.

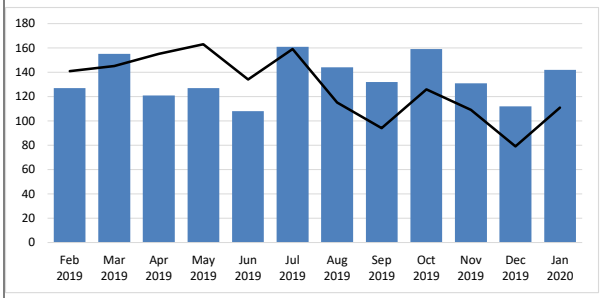
Infection prevention and control remains a priority for the Trust. Trust performance for the current financial year (until the end of January 2020) is below trajectory for CDI but above trajectory for MRSA due to seven trust-attributable cases having been reported since April 2019 (against a threshold of zero).

Complaint Volumes

✕

Actual	1337	YTD (Apr 19 to Jan 20)	**Accountability**	C.Lenney
Threshold	1245	(Lower value represents better performance)	**Committee**	Quality & Safety 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
✕	✓	✕	✕	✓	✓	✕
83	363	155	169	48	31	409

The KPI shows total number of complaints received. Complaint volumes 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 January 2020 was 142, which is an increase compared to 112 in December 2019.
MRI and WTWA received the highest number of formal complaints in January 2020; each receiving 41 complaints (28.87% of the Trust total). This is an increase by 12 complaints for MRI and 12 for WTWA compared to the previous month. Of the 41 complaints received for MRI the specific themes were 'attitude of staff' and 'treatment/procedure. No specific areas were identifed in the complaints relating to these specific themes.
Of the 41 complaints received for WTWA the specific themes were 'treatment & procedure', 'attitude of staff', 'communication' and 'clinical assessment'. In the complaints relating to 'treatment/procedure', Orthopaedics was identified as a specific area.

At the end of January 2020 the total number of over 41 days old complaint cases increased by 2 from the previous month at 39. The Hospital/MCS with the highest number of cases over 41 days at the end of January 2020 was WTWA with 11 (28.20%) of total cases at 41 days old. This number is lower than the number of WTWA cases over 41 days old at the end of December 2019 (13) and higher than the number at the end of November 2019 (6).

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.

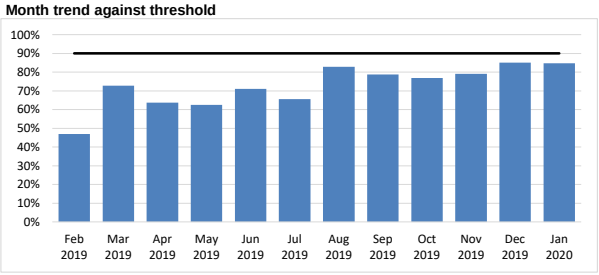
> Board Assurance

January 2020

Percentage of complaints resolved within the agreed timeframe

Actual	75.3%	YTD (Apr 19 to Jan 20)	**Accountability**	C.Lenney
Threshold	90.0%	(Higher value represents better performance)	**Committee**	Quality & Safety 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
◇	✗	✗	✓	✓	◇	✓
89.2%	60.9%	50.0%	92.6%	90.2%	82.1%	91.4%

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.

There was a slight decrease in the number of complaints resolved within the agreed timeframe with 84.8% in January 2020 compared with 85% in December 2019.

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.

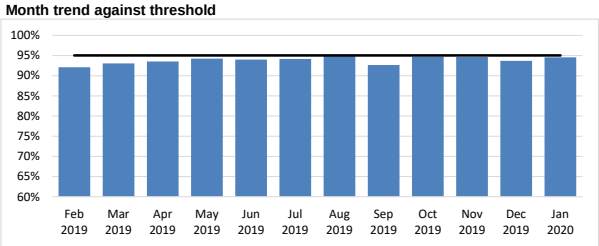
Actions

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

FFT: All Areas: % Extremely Likely and Likely

Actual	94.2%	YTD (Apr 19 to Jan 20)	**Accountability**	C.Lenney
Threshold	95.0%	(Higher value represents better performance)	**Committee**	Quality & Safety Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	◇	✗	✓	◇	✓	◇
97.1%	92.5%	90.2%	97.6%	94.8%	97.4%	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.

Progress

The response rate for Inpatients in January 2020 was 23.2%, this is an increase when compared to 21.5% in December 2019.

The Emergency Departments' response rate in January 2020 was 7.7%, a decrease when compared to 9.62% in December 2019.

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.

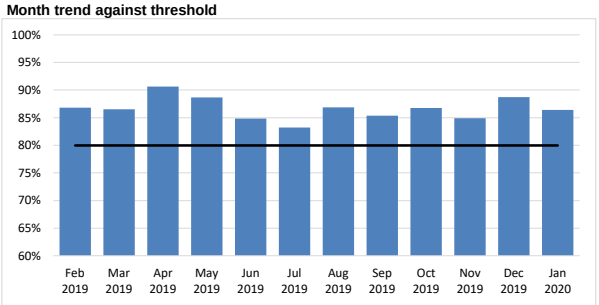
> Board Assurance

January 2020

Nursing Workforce – Plan v Actual Compliance for RN

Actual	86.4%	(January 2020)	**Accountability**	C.Lenney
Threshold	80.0%	(Higher value represents better performance)	**Committee**	Quality & Safety 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	82.4%	84.7%	91.5%	83.2%	NA	88.8%

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 January 2020 there were 6 (6.25%) 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 86.4% in January 2019.

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

Actions

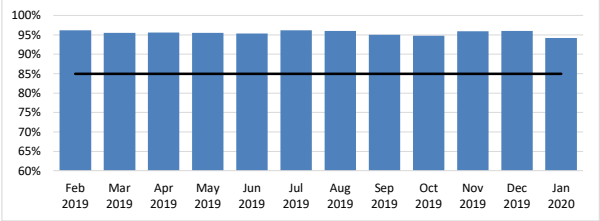
Where shortfalls in nurse staffing levels occur and this cannot be resolved, staff are redeployed from other areas following a risk assessment and professional judgement based on the acuity and dependency of patients in each area. Nursing assistant levels are increased in some areas to support such a 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) is used to support establishment reviews. The hospitals have completed 3 census collection periods in 2019 to determine the acuity and dependancy of patients on their wards. Inpatient areas have collected SNCT quarterly in 2019 in order to provide sufficient data to support upcoming establishment reviews. The tool is now well embedded across the Trust to ensure wards are staffed safely based on patients' needs.

Food and Nutrition

Actual	95.5%	YTD (Apr 19 to Jan 20)	**Accountability**	C.Lenney
Threshold	85.0%	(Higher value represents better performance)	**Committee**	Quality & Safety Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✓	✓	✓	✓	✓
97.4%	95.6%	91.0%	96.8%	98.3%	85.0%	96.1%

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 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.

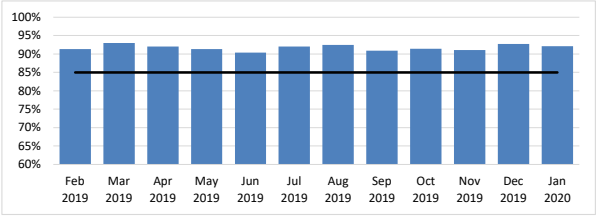
The Hospital/ MCS progress related to delivering the commitments withing the Nutrition and Hydration Strategy is monitored through the Trust Patient Experience and Quality Forum.

In recognition of the need to further improve the quality of food, a designated work programme, established in collaboration between Nursing, Estates and Facilities, was initiated in December of 2019 with the intention of identifying a number of high impact changes. A key work stream is the concept of a 'Model Ward'.The aim of the 'Model Ward' is to develop an exemplar ward with regard to the catering provision and the dining experience for patients, which will identify the changes that deliver the highest impact and which can be replicated across the wider Trust.

Pain Management

Actual	91.6%	YTD (Apr 19 to Jan 20)	**Accountability**	C.Lenney
Threshold	85.0%	(Higher value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham
✓	✓	✓	✓	✓	✓	✓
97.0%	86.9%	87.7%	94.9%	97.3%	97.3%	92.1%

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

Progress

Work continues across the Trust to drive improvements in pain assessment and management.

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

> Board Assurance

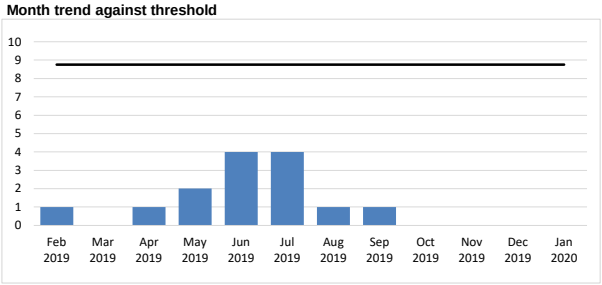
January 2020

Clostridium Difficile – Lapse of Care

✓

Actual	13	YTD (Apr 19 to Jan 20)	**Accountability**	C.Lenney
Threshold	88	(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
✓	✓	✓	✓	✓	✓	✓
1	4	0	0	0	0	8

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 means 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

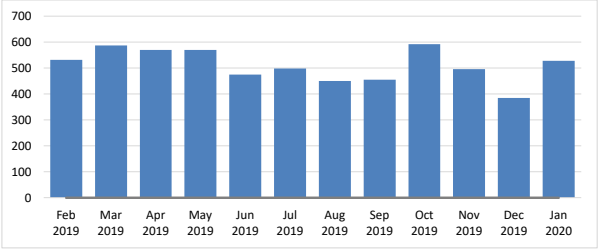
There have been a total of 167 cases of Clostridium difficile infection reported since April 2019: 123 (74%) of which were trust-attributable against a trajectory of 149. Following CCG review, there have been 13 lapses in care identified: four lapses in care identified at MRI and nine lapses in care identified at Wythenshawe Hospital, with 70 cases pending final review (awaiting ribotyping results, details of further investigations and direction from the CCG regards the new apportioning algorithm).

PALS – Concerns

-

Actual	5017	YTD (Apr 19 to Jan 20)	**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
-	-	-	-	-	-	-
286	1262	538	447	311	194	1656

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

Key Issues

A total of 527 PALS concerns were received by MFT during Jauary 2020 compared to 384 PALS concerns in December 2019.

WTWA received the highest number of PALS concerns in January 2020; receiving 162 (30.74 %) of the total. This is an increase of 39 compared to the previous month (123). The specific themes related to 'appointment/delay/cancellation', 'attitude of staff', 'communication', 'discharge/transfer', 'treatment/procedure' and 'security'. Specific areas identified in the PALS concerns included 'appointment/delay/cancellation' and 'attitude of staff' for Cardiology, Surgery Directorate 'communication, Ward F4 for 'security' and for the Emergency Department, Surgery Directorate, Orthopaedics 'treatment & procedure'.

MRI received the second highest number of PALS concerns in January 2020 with 135 (25.61%). This is a increase of 43 in number from the previous month (92).

Actions

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

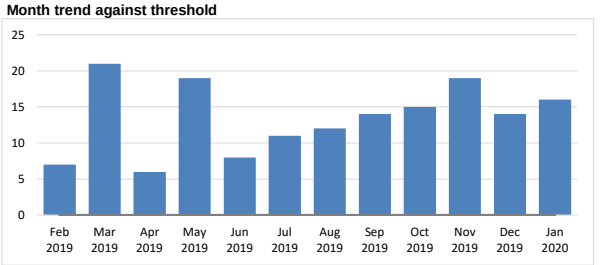
Work continues to reduce the time taken to resolve PALS enquiries with formal performance management of cases over 5 days in place.

All Attributable Bacteraemia

-

Actual	134	YTD (Apr 19 to Jan 20)	**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
-	-	-	-	-	-	-
11	71	9	9	0	0	34

MRSA and E.coli. There is a zero tolerance approach to MRSA bacteraemia. For healthcare associated Gram-negative blood stream infections (GNBSI), 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 127 incidents of MFT-attributable E. coli bacteraemia reported since April 2019 against a trajectory of 83. Exceedances have recently been seen across the country in both acute and community settings. A number of reduction strategies are in place at MFT, working in collaboration with colleagues from the CCG, MLCO and neighbouring trusts on Antimicrobial Stewardships, CAUTI reduction and hydration improvement strategies.

There have been seven trust-attributable MRSA bacteraemia cases reported since April 2019: two from AICU, one from the Burns Unit and one from Ward A7 (all at Wythenshawe Hospital), and one case from each of Ward 36, Manchester Vascular Centre and HDU (Oxford Road Campus). Full RCAs have been completed, action plans devised and implemented locally. There have also been six non trust-attributable MRSA bacteraemia cases reported for this period. A thematic review of the first six MRSA cases reported this year was conducted and concluded that most cases were unavoidable with no common themes: the most recent cases (HDU, January 2020) is under review.

Operational Excellence

J.Bridgewater

Core Priorities	✓	◇	✕	No Threshold
	3	2	6	0

Headline Narrative

Diagnostic standard - achieved between July - November, there has been a marginal increase in performance during December due to demand pressures and capacity constraints in Paediatric MRI.

No 52 week waits occurred in December.

MFT waiting list size has consistently been better than its trajectory in 2019/20. However, December has been challenged reflecting capacity pressures across the system.

RTT performance remains below the standard, as expected due to an upgrade of the Patient Administration to support management of RTT pathways. In recognition of the risk to the elective programme throughout the winter, additional funding has been provided by Commissioners and NHSI to support outsourcing of activity in Q4 to reduce the longest waits.

Two Cancer Standards achieved, 5 standards are not being achieved, in part due to continued significant increases in demand (12%), in addition, timely access to diagnostics is a key factor affecting cancer pathways. Across the 5 standards challenged sites are: Urology, Lung, Lower and Upper GI, and Gynaecology. Breast has underperformed due to aid provided by MFT to the Stockport service, although 2ww performance against both standards has significantly improved as expected in line with the action plan, and provisional data for Nov / Dec demonstrates this has continued to improve. October 62 Day performance has reduced, mainly due to LGI at the MRI site and Lung at WTWA, although there is expected to be improvement in November. Effective governance and a programme of work are in place to support improvements against the standard, with external assurance of Trust plans from the NHSI team.

MFT 4 hour performance was ranked 2nd in GM both for December and Q3. Demand out with the national profile of 4% is a key factor affecting delivery ,and MFT attendances in December were 5% higher (circa 2000) compared to the same period last year. Wythenshawe Hospital has experienced the largest increase 9%, which continues to be driven by patients self presenting. In addition, paediatric demand at EDs and bed capacity has been a key issue across GM. The update provided to the Board of Directors in January for the Christmas period also identified higher acuity and complexity of patients as a key issue. Despite lower performance, more patients in December were seen within 4 hours compared to December 18. Safety is the key priority, with no 12 hour trolley waits, strong performance against the ambulance turnaround standards, and limited corridor care. In addition, flexible use of staffing and diverting of activity between sites to provide respite occurs to maintain safety and reduce waiting times for patients. Urgent care delivery is impacting on other operational standards and is a risk to the elective programme, with the potential for 52 week waits to occur. MFT joint working with Commissioners and the Manchester Local Care Organisation is focused on improving long length of stay performance, and reducing Delayed Transfers of Care. Additional investment has supported the development of an integrated discharge team at MRI, and secured additional social care / care home capacity.

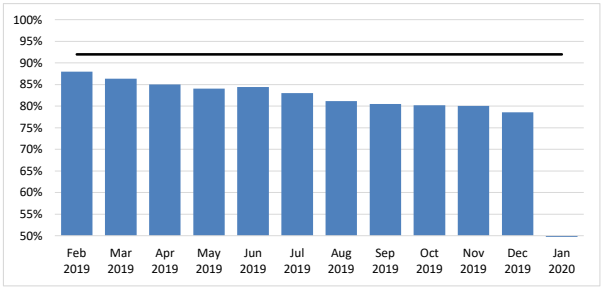
Cancelled Operations >28 days - Cancelled operations increased in December compared to the previous month. Clinical triage and rescheduling of these patients is in progress.

RTT - 18 Weeks (Incomplete Pathways)

✕

Actual	78.6%	(December 2019)	**Accountability**	J.Bridgewater
Threshold	92.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



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 a small increase in referrals across in 19/20 YTD Vs 18/19.
- Capacity and workforce pressures.
- Urgent Care pressures a risk to the elective programme.
- Work to upgrade the PAS across the ORC and implementation of Clinicom 4.4 impact on waiting list size.

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.
- Elective care education programme, in conjunction with NHS Improvement, has been rolled out.
- Working with Commissioners in relation to demand management, particularly for specialist hospitals, to support stability of the waiting list.
- 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.
- Establishment of a joint planned care board between MFT and MHCC and Trafford Commissioners to focus on transformation opportunities, in particular related to outpatients.
- Pilot programme of advice and guidance due to commence in January 2020 with support from the transformation team
- Additional funding secured from MHCC and NHSI to undertake independant sector activity in Q4 to reduce the number of longest waits, and maintain the waiting list size trajectory given the risk of winter pressures.

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
◇	✕	✕	✕	✕	✕	✕
88.0%	77.6%	75.6%	77.5%	83.2%	79.2%	79.1%

Progress

- Trust's RTT waiting list size has been delivered below trajectory for the past 8 months. However, December has seen some increase in volume reflective of system pressures and urgent care demand.
- The Trust has had no 52 week breaches to date in 19/20
- Circa 500 staff have participated in face to face RTT and elective care training workshops
- A new RTT e-learning package has been deployed to the learning hub
- The Trust Access policy and associated supporting documents including a new Elective care Training policy are in the process of being refreshed and ratified
- The NHSI training course delivered in partnership with MFT has been completed by 34 senior operational managers
- Additional monies to support expanded use of the IS throughout Q4 have been confirmed at ~£2.4M.

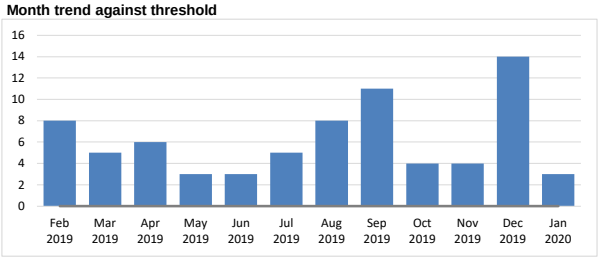
> Board Assurance

January 2020

Cancelled operations - rescheduled <= 28 days

Actual	61	YTD (Apr 19 to Jan 20)	**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
✗	✗	✓	✓	✓	✓	✗
10	26	0	0	0	0	25

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 long length of stay patients and Delayed Transfers of Care.
- 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

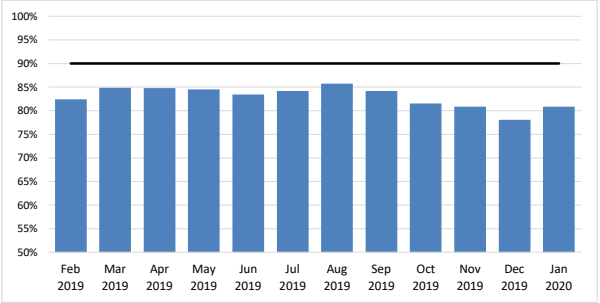
In December, the Trust reported an increase in 28 day breaches compared to the previous month. There was a total of 14 breaches, 8 at MRI and 6 at Wythenshawe. The rise in cancelled operations reflecting the increased demand for Urgent Care bed capacity. All patients have been clinically reviewed for TCI dates.

Operational Excellence - Core Priorities

A&E - 4 Hours Arrival to Departure

Actual	80.84%	Q4 19/20 (Jan to Jan 20)	**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	74.2%	90.4%	99.0%	100.0%	99.5%	79.0%

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

Increased demand continues to be a key pressure, with exceptional peaks experienced across EDs, and paediatric demand a significant pressure across GM.
Flu and increased presentation of respiratory conditions impacting on ED and flexible use of the bed base.
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.
Community capacity as alternative to A&E, Primary care capacity to facilitate increased streaming.
Reduction/changes in community/care home capacity across GM.
Age profile of presentations to Wythenshawe weighted with older, frail patients.

Actions

Internal oversight arrangements are in place with twice 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 programmes

Hospital plans focus on key areas aligned to national priorities including:
- Development of new models and urgent care treatment centres.
- Maximising streaming, and increasing Same Day Emergency Care Pathways
- Focus on improving flow, timely discharge, reducing long length of stay and Delayed Transfers of Care

In addition, the Trust is working with GM Mental Health, to improve ambulatory pathways and assessment times.
Working with the MLCO to implement new models of care, with agreed additional funding to support the implementation of an Integrated Discharge Team (IDT) at MRI, and some additional physical capacity. Recruitment to the IDT is in progress, with full establishment expected to complete in full by January.
Longer term capital upgrade is planned for MRI, and PED.
Working with system partners and NHSI ECIST team to seek external expertise and assurance.
Additional interim actions have been taken over Q3 / Q4 to maintain safety and resilience, although the positive impact of these has in part been offset by demand pressures. Furthermore, action to reduce elective programmes has been overseen by Hospital Chief Executives and MFT COO, based on safety considerations.
MFT winter plan in place to support resilience, with bank holiday plans in place for the Christmas and New Year period.

Progress

MFT GM ranking for 4 hour performance was 2nd in December and Q3 .
December demand is 5% higher across the Group compared to December 18 with (c2000) more patients.
Safety remains a keys indicator for the Trust, reporting no 12 hour breaches, and no corrdor care as defined by the GM Policy.
MRI has continued to perform better than the standard for ambulance handover in December. WTWA performance has reduced slightly falling outside the standard in month. A joint working group with partners in place to share learning and WTWA is part of a national programme to support delivery.
The NHSI Intensive Support Team continues to work alongside MRI / WTWA operational teams to support discharge processes and reducing long length of stay.
Pressures overnight remain a challenge at MRI and Wythenshawe, full 24/7 site management in place to maintain and assess patient safety.

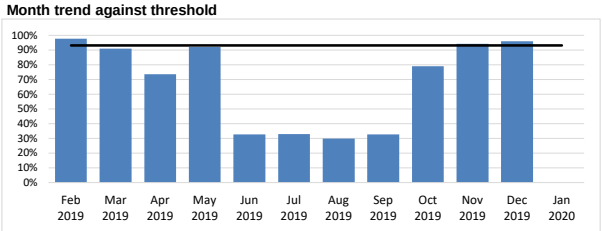
> Board Assurance

January 2020

Cancer 2 Week Wait - Breast

Actual	89.1%	Q3 19/20 (Oct to Dec 19)	**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	89.1%

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 delivery. Support to Stockport has placed considerable pressure on service delivery.

Actions

Actions to support recovery of the service are outlined as per the 2ww standard, which also incorporates Breast activity.

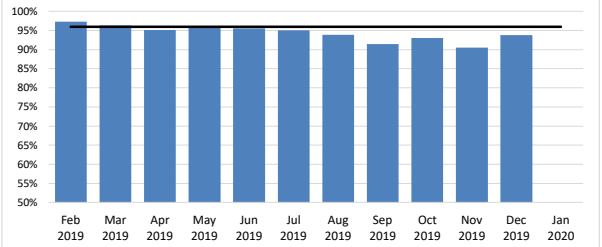
Progress

November performance has significantly improved from 78.9% in October to 94.3% in November, and 97.2% in December (unvalidated).

Cancer 31 Days First Treatment

Actual	92.4%	Q3 19/20 (Oct to Dec 19)	**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	88.9%	100.0%	88.7%	NA	NA	93.5%

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

Key Issues

- Cancer Demand
- 3 key challenged pathways: Lung, Urology and Gynaecology
- HDU/ICU capacity pressures
- Capacity pressures within Lung due to other Cardiac demand and transplant

Actions

- Cancer Excellence Programme will support resilience across all cancer pathways.
- Gynaecology capacity increase in December/January due to return from extended absence of two consultants
- Renal surgery moved to WTWA in January - this should allow greater flexibility and capacity.
- Lung estates and staffing issues are the main factors.

Progress

- In November, 7 out of 11 tumour groups are achieving the standard.
- Typically the Trust performs well against this standard. However, MRI Urology and Wythenshawe Lung pressures have contributed to lower performance.

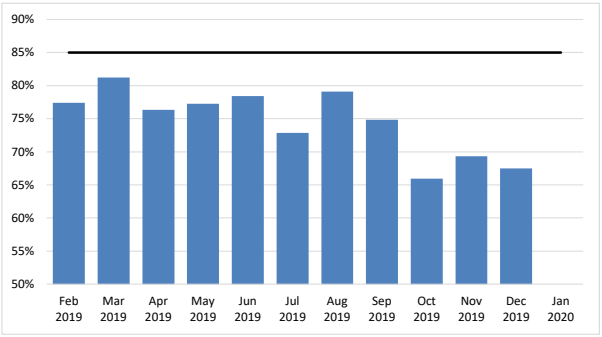
> Board Assurance

January 2020

Cancer 62 Days RTT

Actual	67.5%	Q3 19/20 (Oct to Dec 19)	**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	65.5%	100.0%	55.8%	NA	NA	69.2%

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.
- Capacity pressures within high demand services.
- Capacity pressures within radiology, as a result of increased cancer demand and diagnostic demand for other patient groups i.e. inpatients.
- Urgent care, high bed occupancy and inpatient demand impacts on diagnostic and lab capacity.
- Physical resource constraints within labs and radiology.
- LGI, Gynae and lung were the worst performing specialties.

Actions

Governance processes are in place through the MFT Cancer Committee and Hospital Cancer Boards.
Assurance and challenge through MFT Accountability Oversight Framework
Cancer Excellence Programme in place - 6 Key Elements based on NHSI and Best Practice including:

1. Patient pathways and innovation
2. Capacity and demand planning
3. Training and best practice
4. Operational delivery
5. Professional development & resilience
6. Data

In addition, working with NHSI to access external expertise and assurance of the programme of work, focused on utilisation of demand and capacity tools, strengthening training for teams.
There are a number of tumour specific developments incorporated within the programme which are jointly supported by the corporate performance team and the Hospital / MCS teams.
GM Cancer has formed a new Performance board and have five main themes to tackle immediately across GM to improve 62 day performance including a backlog clearance plan, scoping using third party diagnostic providers to deliver diagnostics, improve time to first seen and OPA post inter provider referral, Single queue for specialist diagnostics and system level reporting.

Progress

- The Trust is underperforming against the 62 day standard. November saw an improving position moving from 65.9% in October to 69.3% in November.
- WTWA continues to experience reduced performance due to challenge in Lung. Lung breaches account for 15 of the total 31 , and performance of 68.4% for November.
- SMH continue to experience significant pressure in Gynaecology reporting 5 breaches in November, and 52.4% performance. The pressures in Gynaecology are reflective of GM demands on this service.
- Two consultants returning from Maternity and sick leave in December will increase capacity and current December predictions show only 1.5 breaches.
- MRI performance improved to 73.6% however only 3 out of 8 tumour groups exceeded the threshold.

Progress against the cancer excellence programme:
The total number of actions in phase one is 22, of which:
12: Completed/Implemented
7: Anticipated Completion January 2020
1: Anticipated Completion March
1: On Track - Runs into phase 2
1: On Hold – Due to other initiative

Rapid Access to detect GI Cancer - Wythenshawe have implemented the pathway in December and 53 patients have gone STT colonoscopy without the need for a consultant OPA first. Trafford go live with the process on the 27th January and MRI continue to offer STT although the criteria for inclusion will be expanded in March.
CT Colon reorganisation - has allowed for patients with failed colonoscopy to be rapidly scanned without the need for further bowel prep. This has also led to 31% of patients having their scan within 7 days, an increase form 4%.
National Optimal Prostate pathway - Wythenshawe and MRI have implemented the STT MRI pathway with Trafford due to implement following recruitment of the navigator post.
Rapid Diagnostic Centre - group plans to be submitted to GM Cancer by 28th January to allow for National submission. Funding already agreed for January to March 2020.
MRI submitted bids to GM Cancer to address backlog clearance in Q4 - outcome awaited.
Single Queue Diagnostics work to commence across GM to create a single booking pathway for 3 specialist diagnostic tests.

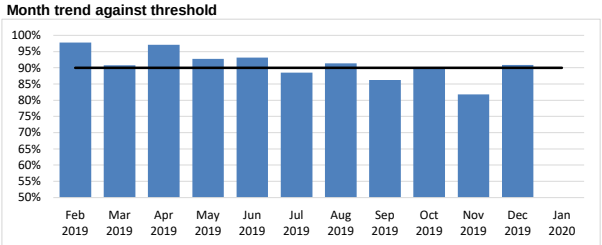
> Board Assurance

January 2020

Cancer 62 Days Screening

Actual 87.7% Q3 19/20 (Oct to Dec 19) **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	✓
NA	12.5%	NA	0.0%	NA	NA	91.3%

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 is currently below target at 86.0% for the Quarter.
There is a current nationally known risk in the bowel screening programme due to the national implementation of a less invasive and more sensitive screening test being introduced. This has led to an increase in demand over and above national predictions.

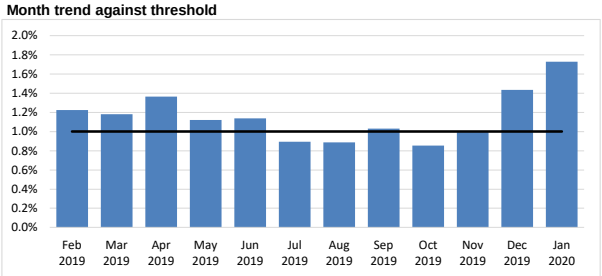
Actions

Performance below the standard due to 8.5 breaches in breast , 1 breach in Gynaecology and 2.5 in bowel screening.
Recovery includes: an agreement to defer the bowel scope programme due to the implementation of the new FIT test, with plans to recommence and cover any backlog once the bowel screening programme is recovered.

Diagnostic Performance

Actual 1.7% (January 2020) **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	✓
1.4%	1.7%	31.3%	0.0%	NA	NA	0.2%

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.
- Physical capacity constraints of paediatric scanners.
- Ability to secure ad hoc sessions and workforce to increase capacity.
- Prioritisation of cancer scanning/reporting, which is also increasing, is a risk to routine capacity.
- Capacity and progress hampered by not being able to outsource follow up patients because measurements from clinical scans would not be clinically comparable on different systems.

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.
- Outsourcing of routine capacity - utilising MES and the University to support the reduction of breaches.

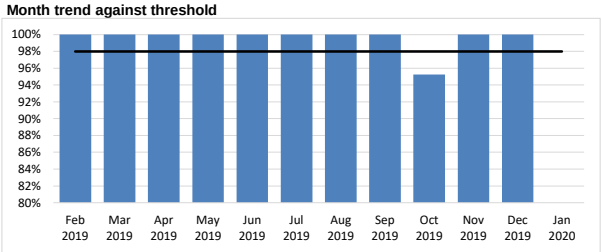
Progress

The Trust has maintained the 1% target for five consecutive months reporting better than the national standard.
Increased and pressures in Paediatric MR anaesthetic capacity has created challenge in December.
DEXA scan capacity has been a pressure due to staff sickness although this is improving, and better permance in December.
- The % performance for SMH and RMCH is high due to a very small waiting list. SMH has reported 4 breaches in December. RMCH have noted some increase in Endoscopy breaches due to reduced private sector capacity in month.

Cancer 31 Days Sub Chemo Treatment

Actual 98.3% Q3 19/20 (Oct to Dec 19) **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	97.5%

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

Trust performance is slightly below the standard. This is due to 1 breach in Lung, with performance likley to recover for the quarter.

Actions

Cancer Excellence Programme will support resilience across all cancer standards.

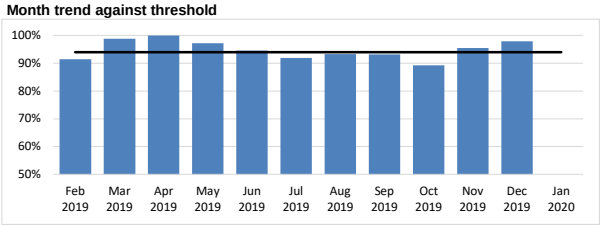
> Board Assurance

January 2020

Cancer 31 Days Sub Surgical Treatment

Actual	94.1%	Q3 19/20 (Oct to Dec 19)	**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	100.0%	NA	63.2%	NA	NA	97.0%

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

Key Issues

- Cancer Demand
- Smaller volume of treatments on this pathway

Actions

Group is narrowley under the threshold for this standard for Q3 currently.
Underperforming areas are again Lung and Gynaecology - gynaecology are due to increase capacity following return from leave of clinicians in December but the same estate and staffing issues remain in lung

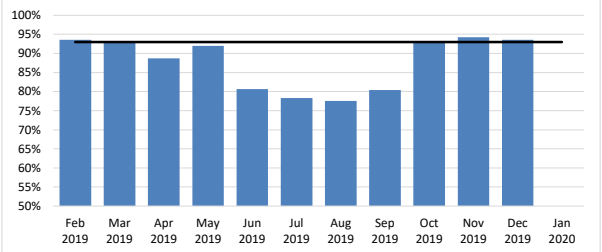
Progress

- The Trust is currently 1.4% below the threshold for Q3
- In November 8 out of 11 tumour groups are achieving the standard in Q3. MRI are currently performing at 100%
- Improving performance in Lung and Gynaecology saw breaches reduce from 6 in October, to 3 in November.

Cancer Urgent 2 Week Wait Referrals

Actual	93.6%	Q3 19/20 (Oct to Dec 19)	**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	90.6%	100.0%	90.8%	NA	NA	95.3%

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.
- Aid to the Stockport Breast service had exceeded capacity and had significant impact on performance.
- Wythenshawe have submitted and implemented a recovery plan for Breast, improving performance to 97.8% in November.

Actions

The MFT Cancer Excellence Programme incorporates actions to support 2ww delivery including: increasing the number of patients seen within 7 days, implementation of best practice pathways, straight to test models, currently considering options for expansion of Rapid Diagnostic Centre pathways.
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

Breast - November performance recovered.
MRI improving performance with failure only in GI services.
Trafford are due to commence STT endoscopy in LGI late January.
Gynaecology performance on the Oxford road site has been challenged through Q1 and Q2, however November performance improved to 91.3%.
NHSI are currently helping undertake a capacity and demand exercise across group with results expected to be fed back mid February to allow input into the capacity planning rounds.

Workforce and Leadership

P. Blythin

Core Priorities	✓	◇	✕	No Threshold
	4	1	6	3

Headline Narrative

The new employer brand 'All Here For You' was launched in January.

Following an extensive procurement process the King's Fund have been selected to deliver the Group Clinical Leadership programmes.

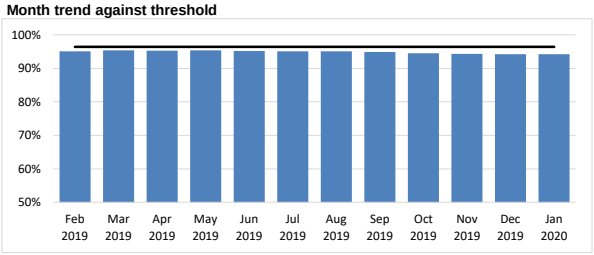
Workforce and Leadership - Core Priorities

Attendance

Actual 94.2% (January 2020) **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
✕	✕	✕	✕	✕	✕	✕
94.8%	93.6%	95.6%	93.9%	92.7%	94.9%	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 attendance rate for January was 94.2% which is the same as the previous month's figure (94.2%). The attendance rate was slightly higher at the same point last year (January 2019) at 94.7%. Meanwhile the latest figures released by NHS Digital show that for June 2019 the monthly NHS staff sickness absence for the whole of the North West HEE region was 4.8% (these figures include all provider organisations and commissioners). MFT's performance for the same period was 4.8%.

Actions

The Employee Health & Wellbeing Framework Oversight Committee was agreed by Corporate Directors in November 2019 and has been established to start in March 2020. A manager's guide to providing psychological support for staff has been launched to enable all managers to access advice this includes a new approach to supporting staff. Training has had a positive response with strong uptake from managers.

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) / LCO also features prominently in the actions to improve performance. Corporate performance is addressed though the Corporate Directors' Group.

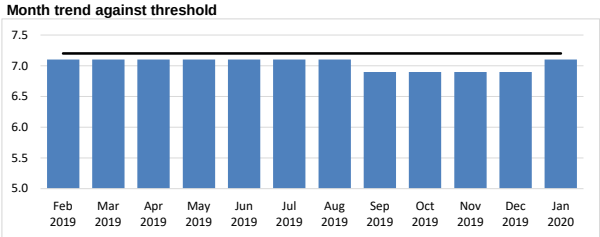
A programme to implement Absence Manager across all sites and manged services was launched last year and is sponsored by Group Deputy Chief Executive to oversee implementation. Cohort 1 which included Corporate Services, Trafford and Altrincham Hospitals launched the system in September 2019. Cohort 2 (SMH) was launched in October and cohort 3 (CSS) was launched in December. Cohort 4 (REH & UDH) has just gone 'live' in January, with RMCH planned for March, the MRI in April and the LCO in May.

Engagement Score (quarterly)

Actual 7.10 Q4 19/20 **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
✕	✕	✓	✕	✕	✓	✕
7.0	7.0	7.2	6.9	7.1	7.6	7.1

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 Q3 staff engagement score for the MFT Group taken from the 2019 NHS Staff Survey is 7.1. This is unchanged from 2018. The Hospital / Managed Clinical Service (MCS) / LCO staff engagement scores from the survey are now available, subject to final ratification prior to the embargo on the results being lifted on 18th February. The results have been shared with EDT and Hospital / MCS / LCO senior leaders via the HRDs.

The 2019-20 Quarter 4 Pulse Survey was replaced with a Leadership Behaviours Survey, which was conducted as part of the Culture Diagnostic work, due to conclude in March 2020. Recommendations for the use of Pulse Surveys in 2020-21 will be considered initially by the Group Executive team by March in Q4.

The Friends and Family Test (SFFT) will be conducted in Q4, with the exception of the MLCO, which will again carry out a full Pulse Survey.

Actions

The first stage of the MFT culture diagnostic, which included board interviews, focus groups and marketplace events, as well as the Leadership Behaviours Survey, has now concluded, with analysis of the results now taking place. A report published in March 2020 and presented to the Group Board in April, along with an action plan

Staff Survey plans and improvement trajectories are in place across all Hospitals / MCS / LCO, in response to the 2019 results, and have been presented to HR Scrutiny Committee. These will be updated for the 2019 results and presented to the Group Board and to the HR Scrutiny Committee.

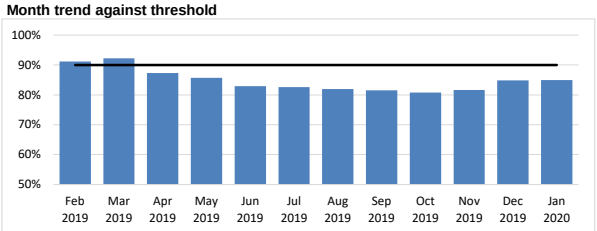
> Board Assurance

January 2020

Appraisal- medical

Actual 84.9% (January 2020) **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
◇	✗	◇	✓	✗	✗	✗
86.0%	81.1%	85.7%	91.1%	83.1%	82.2%	84.8%

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

Key Issues
Compliance increased by 0.1% in January to 84.9%.

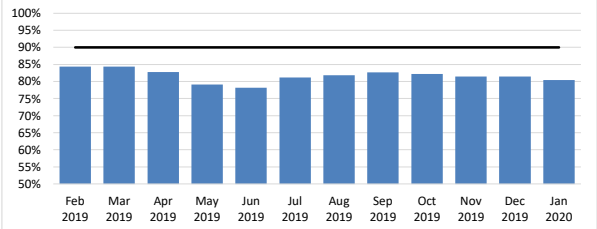
Actions
The medical appraisal rate has remained constant over the last month; however, the majority of doctors that are non-compliant are now those who have exceeded the 12 month reporting period rather than new starters. This includes a large number of consultants. As an end of year return (1 April 2019 – 31 March 2020) needs to be returned to NHS England detailing the appraisal compliance of all connected doctors over the past 12 months, it is vital that appraisals are completed prior to this deadline.

HR Scrutiny Committee to receive a detailed assurance report in April 2020.

Appraisal- non-medical

Actual 80.5% (January 2020) **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
✗	✗	✗	✗	✗	✓	◇
80.6%	80.0%	82.8%	81.0%	80.6%	90.8%	86.0%

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 January decreased by 1.1% to 80.5%. The Dental Hospital is achieving target compliance. There were increases in compliance in month for WTWA and one Corporate Directorate. However, compliance for all other Hospitals and Corporate Directorates position declined. This decrease may be linked to the fact that historically high numbers of appraisals are completed within the last quarter of the financial year - this time last year (2018-19) compliance had also decreased across the Group but by 4.2%.

Actions
Current plans will be reviewed and refocussed to ensure demonstrable improvements in compliance. Hospitals / MCS / LCO and Corporate teams will be held to account through the AOF and Corporate Director's Group.

As part of the Mandatory Training review, workforce information processes are being strengthened to improve accurate reporting and monitoring.

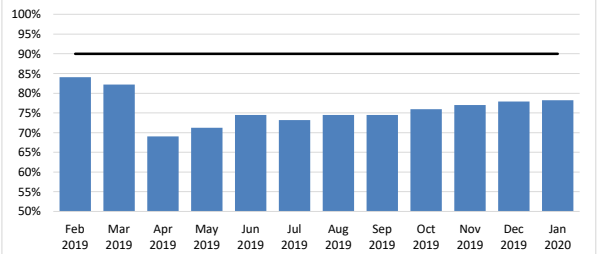
Weekly compliance reports are made available for all Hospitals / MCS / LCO to support the management of compliance.

HR Scrutiny Committee to receive detailed assurance report in April 2020.

Level 2 & 3 CSTF Mandatory Training

Actual 78.2% (January 2020) **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
✗	✗	✗	✗	✗	✗	✗
79.2%	73.6%	73.9%	84.3%	80.7%	78.2%	79.8%

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 all Hospitals / MCS / LCO ensure 90% compliance by October 2019 and the trend has been reset to April 2020. Plans are now in place and improvements are monitored through the AOF. The aggregate compliance for January increased by 0.3% to 78.2%.

Actions
The Mandatory Training Steering Committee, chaired by the Group Executive Director of Workforce and Corporate Business, was established in January and meets every 2 weeks. 5 key Mandatory Training work streams, chaired at CEO / Director level, have also been established and have developed detailed action plans. Progress against these action plans is reported at each Steering Group meeting.

HR Scrutiny Committee to receive detailed assurance report in May 2020.

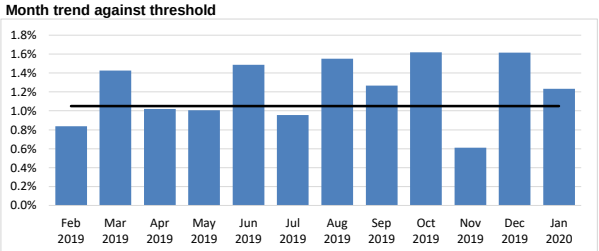
> Board Assurance

January 2020

B5 Nursing and Midwifery Turnover (in month)

Actual	1.23%	(January 2020)	**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	✗
1.50%	1.38%	0.88%	1.23%	1.01%	NA	1.24%

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 January 2020 is 1.2% against a monthly target of 1.05%. This is a decrease from December 2019 at which the turnover was 1.6%.

Actions

Retention of Nurses and Midwives remains a key focus for the Trust with each site and manged service establishing a retention strategy that includes:-

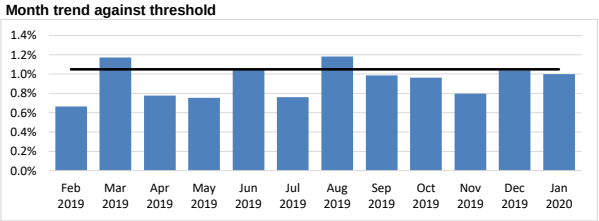
- Internal transfer process pilot in February 2020 for band 5 Staff Nurses and Nursing Associates
- Development of an apprenticeship strategy to support nursing careers
- Opportunities for Nurses and Midwives to retire and return flexible
- Expansion of rotational programmes
- Staff engagement events
- Pastoral support for new starters

Participation as part of NHSI retention programme has commenced to oversee the actions to improve retention.

Turnover (in month)

Actual	1.00%	(January 2020)	**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
✓	✓	◇	✓	✓	◇	✗
0.90%	0.92%	1.02%	0.75%	0.65%	1.01%	1.09%

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 1.00% compared to 1.04% for the previous month.

The turnover rate was slightly lower at the same point last year (January 2019) at 0.86%.

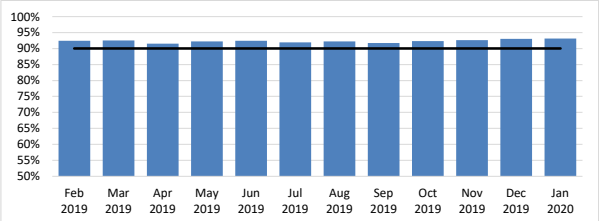
Actions

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

Level 1 CSTF Mandatory Training

Actual	93.2%	(January 2020)	**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
✓	✓	✓	✓	✓	✓	✓
92.6%	92.0%	91.6%	97.1%	94.3%	95.7%	91.8%

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 December the aggregate compliance increased by 0.3% to 93.3%.

Actions

The Mandatory Training Steering Committee, chaired by the Group Executive Director of Workforce and Corporate Business, was established in January and meets every 2 weeks. 5 key Mandatory Training work streams, chaired at CEO / Director level, have also been established and have developed detailed action plans. Progress against these action plans is reported at each Steering Group meeting.

HR Scrutiny Committee to receive detailed assurance report in May 2020.

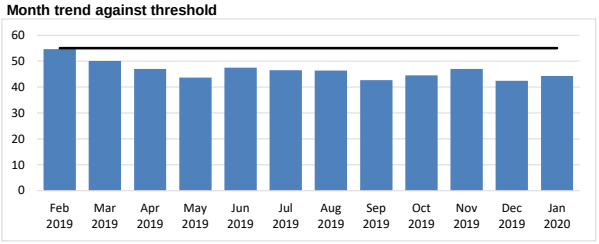
> Board Assurance

January 2020

Time to Fill Vacancy

Actual	44.2	(January 2020)	**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
✓	✓	✓	✓	✗	✓	✓
38.1	47.8	44.1	41.3	81.0	40.3	47.2

This indicator measures the average time it takes, in days, to fill a vacancy. It measures the time taken from the advertising date (on the TRAC Recruitment System), up to the day of unconditional offer. The graph shows an in month rate. 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 increased from 42.4 days to 44.2 days in January.

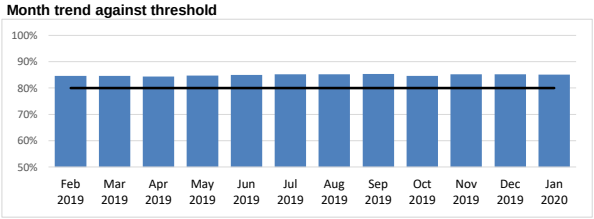
Actions

The Group's 'Time to Hire' for January, 2020 has increased this month from December's 42.4 days to 44.2 days. However, this is still significantly under the group target of 55 by 10.8 days. The 'Time to Hire' figure for medical staff has decreased significantly on December's figures and has moved from 80.39 days to an exceptional 71.0 days . The Medical and Dental staff group have a longer 'Time to Hire' due to the Medical Training Initiatives (MTI) where the Trust/College sponsors their GMC registration and Tier 5 (Temporary Worker) visa application and this can on average take between 2 -4 weeks.

Nurse Retention

Actual	85.1%	(January 2020)	**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
✓	✓	✓	✓	✓	✓	✓
86.2%	84.4%	87.2%	86.8%	85.3%	89.8%	83.2%

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 January 2020, Nursing and Midwifery retention stands at 85.1% which continues to be above the threshold of 80%.

Actions

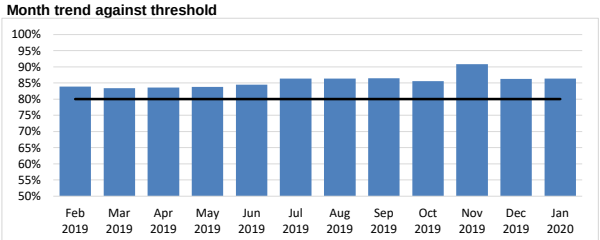
The retention threshold target for nursing and midwifery staff provides a strong indication of whether we are able to retain staff across the Trust and whether our polices, procedures and practices are supportive of the Trust being seen as a good place to work. The overall retention rate is good at 85.2%.

The Trust has commenced the NHSI Nurse Retention Improvement Programme. An action plan has been developed to progress and will be monitored by the NMAHP Professional Board led by the Corporate Director of Nursing.

BME Staff Retention

Actual	86.3%	(January 2020)	**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
✓	✓	✓	✓	✓	✓	✓
86.6%	86.2%	84.0%	89.8%	91.1%	85.7%	84.0%

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 January 2020, the BME retention rate is significantly above the Trust's threshold of 80% month on month at 86.3%.

Action

All Hospitals / MCS / LCO are tracking this KPI within their AOF and developing plans to address where negative gaps are being identified.

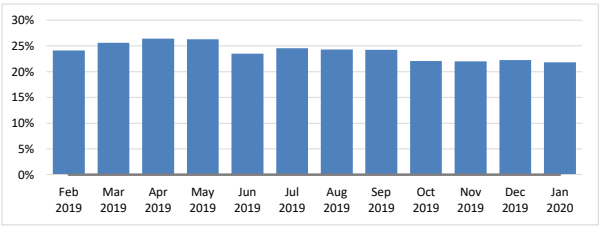
> Board Assurance

January 2020

% BME Appointments of Total Appointments

Actual	21.8%	(January 2020)	**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
-	-	-	-	-	-	-
25.0%	27.7%	20.7%	16.8%	53.6%	35.3%	24.1%

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

Almost one in four appointments is of black and minority ethnic origin (21.8%), which is consistent month on month.

Hospitals/MCS/LCO below the Group average are SMH (16.8%) and RMCH (20.7%).

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%.

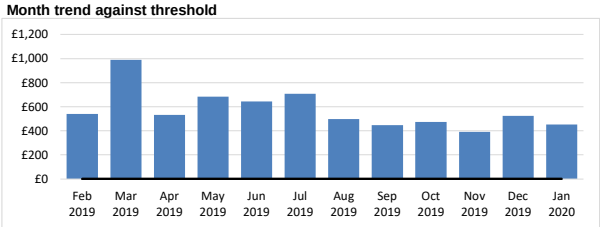
The Trust has launched the Removing the Barriers programme to increase the proportion of black and minority ethnic staff in senior leadership roles. The Programme sets out work comprising of four interlinked components and associated priorities:

- Leadership and cultural transformation.
- Positive action and practical support, including diverse panels and talent management.
- Accountability and assurance.
- Monitoring progress and benchmarking.

Medical Agency Spend

Actual	£452	(January 2020)	**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
-	-	-	-	-	-	-
-£0.4	£151.1	£75.9	£0.0	£63.6	£0.0	£176.6

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 January 2020 the total value of Medical and Dental agency staffing was £452k compared to £524k in December 2019.

Actions

January's spend reduced to a level of spend more consistent with recent months. Weekly and monthly spend meetings take place at each Hospital, to ensure all options have been considered prior to the approval of temporary staffing use.

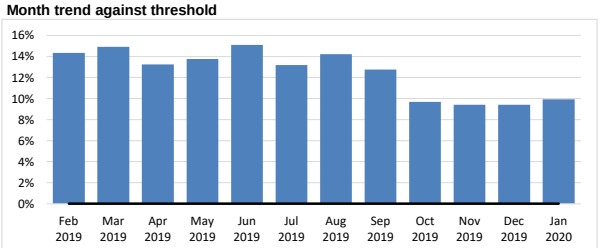
Work has begun to undertake targeted recruitment campaigns for those areas with hard to recruit to posts, to reduce the number of vacancies.

Review meetings with the Trust's Agency partners continue to take place to ensure, that when agency workers have to be engaged, efficient rates are paid.

Qualified Nursing and Midwifery Vacancies B5 Against Establishment

Actual	9.9%	(January 2020)	**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
-	-	-	-	-	-	-
7.9%	11.2%	7.1%	5.0%	9.4%	NA	12.6%

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

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

Key Issues

The majority of vacancies within Nursing and Midwifery are within the staff nurse (band 5) role. There have been 45.9 newly qualified band 5 staff nurses and midwives join the Trust during December 2019 followed by a further 95.5 nurses in January 2020. At the end of January 2020 there were 399.2wte (9.9%) staff nurse/midwife/ODP (band 5) vacancies across the Trust Group. This is a slight increase in vacancies from December 2019 when there were 368 wte (9.4%). However there is an additional 191.3wte band 5 staff nurses compared to the same time last year.

Actions

There are 76.4 nurses and midwives who commenced in post in January 2019 with a further 18 planned to start before the end of the financial year.

The Trust continues to recruit nurses from overseas. 40 international nurses (IR) started in January 2020 with a further 150 IR nurses planned to arrive before the end of March 2020.

A Group Resourcing Plan has been developed including a schedule of recruitment events to support the recruitment strategies implemented across all sites and managed services.

Finance

A.Roberts

Core Priorities	✓	◇	✕	No Threshold
	1	0	1	0

Headline Narrative

- Please see agenda item 5.2

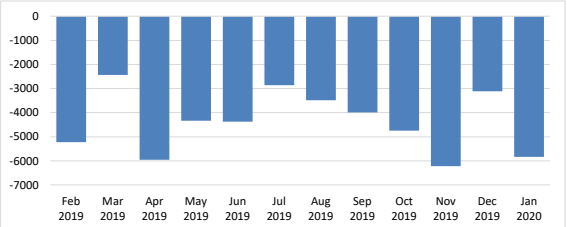
Finance - Core Priorities

Operational Financial Performance

Actual -£44,896 YTD (Apr 19 to Jan 20) **Accountability** A.Roberts

Threshold **Committee** TMB and Board Finance 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
◇	✕	✕	✕	✕	✕	✕

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

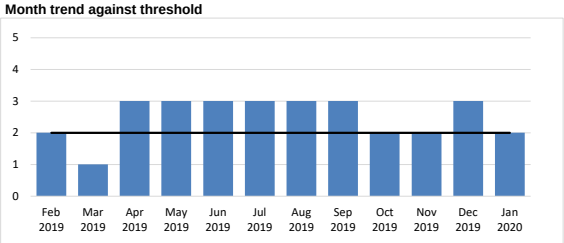
Please see the Chief Finance Officer's report for more detail.

Regulatory Finance Rating

Actual 2 (January 2020) **Accountability** A.Roberts

Threshold 2 (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:	Professor Cheryl Lenney, Group Chief Nurse/ Director of Infection Prevention and Control (DPIC)
Paper prepared by:	Julie Cawthorne, Assistant Chief Nurse Infection Prevention and Control/Clinical DIPC
Date of paper:	February 2020
Subject:	To update the Board on the progress in the management of patients who present with suspected COVID-19
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support ✓ • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	**1.** Patient Safety **2.** Patient experience **3.** Productivity and Efficiency
Recommendations:	The Board of Directors is asked to note the progress in the management of patients who present with suspected COVID-19
Contact:	Name: Julie Cawthorne, Assistant Chief Nurse Infection Prevention and Control/Clinical DIPC Tel: 0161 276 4042

1. Introduction

1.1 This paper provides an update on the Trust's progress to manage suspected cases of COVID-19.

2. Background

2.1 Coronaviruses are a large family of viruses with some causing less-severe disease, such as the common cold, and others causing more severe disease such as Middle East respiratory syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS). Generally, coronavirus can cause more severe symptoms in people with weakened immune systems, older people, and those with long term conditions like diabetes, cancer and chronic lung disease.

2.2 COVID-19 is a novel corona virus first identified in Wuhan China in late 2019. Whilst the latest figures suggest that the number of new cases in China continues to decrease there has been significant spread of the virus to other countries. Most recently large clusters have been identified in South Korea, Iran and Italy raising the risk of significant spread outside of China.

2.3 The severity of infection caused by COVID-19 ranges from mild symptoms of upper respiratory tract infection (with or without fever) to more severe symptoms including; fulminant pneumonia requiring hospitalisation and advanced respiratory support. The mortality rate for this virus is 1 - 2% compared to a rate of 0.05% for seasonal influenza.

2.4 The national position as of 24.02.2020 is 6536 tested of which 9 were tested positive for the virus.

3. The Trust's Preparedness to Manage Patients Who Present with Suspected COVID-19

3.1 The national response to the emerging situation is being led by NHS England. The Trust is actively engaged in following the patient pathway under the leadership of the Chief Nurse/Director of Infection Prevention and Control (DIPC). An Incident Management Team has been established and meets every week. This includes stakeholders from both acute and community settings. In addition there are daily update cross-site meetings.

3.2 Greater Manchester Health and Social Care Partnership (GMHSCP) are exploring the possibilities for community testing for COVID-19. In the interim suspected cases are being directed to their local acute healthcare facility for testing and further management. Assessment POD facilities have been installed outside of the Emergency Departments at MRI, RMCH, Wythenshawe Hospital and the Urgent Treatment Centre at Trafford Hospital for the purpose of assessing and testing suspected cases who may either self-present or be referred by 111.

3.3 At the time of writing there are no national requirements to provide data on the number of patients who present for testing or who are tested. Internally a daily return is sent to the Chief Nurse/DIPC on the number of tests undertaken. To date the number of those tested varies from zero to 12 per day split between Wythenshawe Hospital and the Oxford Road Campus.

3.4 All hospitals within the Group have identified additional capacity for patients who cannot self-isolate to await their test result. If a positive case should be confirmed the patient will follow the High Consequence Infectious Disease (HCID) pathway and would be transferred to a national isolation facility in Newcastle or London in accordance with national guidance.

3.5 The Consultant Virologist and Infection Prevention and Control (IPC) team have developed guidelines for staff that have been communicated at individual meetings and are available on the Trust IPC Intranet page. Information is regularly updated in line with changes to the national guidance

3.6 An extensive programme of fit testing for FFP3 respiratory masks and putting on removing personal protective equipment (PPE) is underway for clinical staff and support services across the Trust. The focus is on front facing areas where patients may present. The Procurement Team are closely monitoring and managing the availability of stock levels of PPE.

3.7 From 11th February, on site testing has been available at the Public Health England Laboratory based at the Oxford Road Campus for the North West Region. The service has reduced the turnaround time for results from 48 to same day/ 24 hours.

3.8 The Trust has been selected as a sentinel centre to undertake admission screening (commenced on 25th February), for COVID-19 for all patients who require extracorporeal membrane oxygenation (ECMO), and all patients with respiratory symptoms who require admission to Critical Care.

4. Summary and Next Steps

4.1 The outbreak of COVID-19 is a rapidly evolving situation. The focus across the UK currently remains at containment level. The Trust is working closely with NHS England and GMHSCP on a daily basis to achieve this goal.

4.2 The Trust is actively engaged in making contingency plans in anticipation of a national increase in spread of COVID-19 this includes; escalation plans for additional capacity to manage patients who present to be tested, review of potential isolation facilities in Critical Care Units and extending the programme for training staff to use enhanced PPE.

5. Recommendation

5.1 Board members are asked to note the Trust's plans and performance to date to manage patients who present with suspected COVID-19.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Adrian Roberts, Group Chief Finance Officer
Paper prepared by:	Ursula Denton, Group Director of Finance
Date of paper:	January 2020
Subject:	Financial Performance for 2019/20
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Maintaining financial stability for both the short and medium term
Recommendations:	The Board of Directors is asked to note that operating financial performance has been consistently worse than plan, with performance against operational income and expenditure budgets up to the end of month 9 now over £19m 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, Group Chief Finance Officer Tel: 0161 276 6692

Executive Summary

1.1	**Delivery of financial Control Total**	The financial performance to the end of December 2019 was **a bottom line deficit** on a control total basis (excluding Provider Sustainability Fund) **of £14.3m** (1.1% of operating income). Operating financial performance has now reached £19.1m 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 both the overall 2019/20 plan, and the demonstration of financial sustainability moving into 2020/21, demands further significant improvements to be embedded and sustained over the fourth quarter.
1.2	**Run Rate**	Financial performance in December continued to fall significantly short of Control Total requirements across Hospitals collectively, demonstrating that significant challenges to stabilise the month-on-month run-rate remain. Visible and sustained improvements need to be delivered across all areas over the remainder of the year to provide greater assurance of the Trust's continuing financial sustainability. Improved delivery in turn remains critical to the Board's ability to commit strategic investment decisions over the months ahead.
1.3	**Remedial action to manage risk**	Specific additional recovery actions have been agreed with each Hospital/MCS leadership team for delivery in quarter 4 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 regularly 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 December 2019 the Trust had a cash balance of £134.2m.
1.5	**Capital Expenditure**	A revised capital spending forecast of £82m has been agreed. The position reported below reflects the internal profiling of plan and that expenditure will be within this ceiling at year-end.

Financial Performance

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

	Year to date - Month 9					
	Annual Plan	Year to date budget	Variance from budget	Variance as % of budget	Variance to month 8	Year to date Actual
INCOME	£'000	£'000	£'000	%	£'000	£'000
Income from Patient Care Activities						
A and E	53,712	40,553	361		308	40,914
Non-Elective (includes XBD's)	304,268	228,750	2,293		1,525	231,043
Elective (includes Day Case & XBD's)	229,764	170,929	-5,553		-4,941	165,376
Out-Patients (includes First & Follow up)	188,113	139,723	-1,126		-1,242	138,597
Other NHS Clinical Income	448,281	334,913	-8,571		-8,850	326,342
Community Services (includes LCO)	122,996	88,256	300		262	88,556
Drugs (excludes Blood Products - HAEM)	146,417	109,812	1,527		2,064	111,339
Sub -total Income from Patient Care Activities	**1,493,551**	**1,112,936**	**-10,769**	**-1.0%**	**-10,872**	**1,102,167**
Private Patients/RTA/Overseas(NCP)	10,964	8,114	-1,279		-934	6,835
Total Income from Patient Care Activities	**1,504,515**	**1,121,050**	**-12,048**	**-1.1%**	**-11,806**	**1,109,002**
Training & Education	62,442	46,828	1,526		1,626	48,354
Research & Development	58,061	43,548	1,844		1,501	45,392
Misc. Other Operating Income	111,270	83,272	-5,065		-5,819	78,207
Other Income	**231,773**	**173,648**	**-1,696**	**-1.0%**	**-2,692**	**171,952**
Total Income	**1,736,288**	**1,294,698**	**-13,744**	**-1.1%**	**-14,498**	**1,280,954**
EXPENDITURE						
Pay	-1,022,813	-764,752	-7,789	-1.0%	-5,084	-772,541
Non pay	-655,130	-490,470	19,270	3.9%	17,753	-471,200
Total Expenditure	**-1,677,943**	**-1,255,222**	11,481	0.9%	12,669	**-1,243,741**
EBITDA Margin (excluding PSF)	**58,345**	**39,476**	**-2,263**	2.9%	**-1,829**	**37,213**
Interest, Dividends and Depreciation						
Depreciation	-27,927	-21,011	1,385		1,180	-19,626
Interest Receivable	444	333	486		436	819
Interest Payable	-40,848	-30,683	-121		-105	-30,804
Dividend	-3,261	-2,446	520		462	-1,926
Surplus/(Deficit) on a control total basis	**-13,247**	**-14,331**	7	0.1%	144	**-14,324**

Surplus/(Deficit) as % of turnover						**-1.1%**
PSF / MRET Income	**27,020**					**17,934**
Additional PSF from 18/19						**917**
Non operating Income						**3,713**
Depreciation - donated / granted assets						**-534**
Impairment						**-29,069**
	13,773					**-21,362**

Note: On 1 October 2019, Trafford community services (TLCO) transferred to MFT. The annual plan and year to date budget have been adjusted to take account of the additional funding and costs associated with TLCO. A comparison to the original plan submitted to NHSI is included as an appendix to this report on page 12.

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 9)			Control Total (YTD)	Variance to control total	
£000s					£000s	%	£000s	£000s	£000s	£000s
1,497	-867	239	-676	Clinical & Scientific Support	193	0.1%	-747	1,125	-932	244,331
1,855	4,614	-395	-1,345	Facilities, Research & Corporate	4,729	2.1%	3,328	0	4,729	294,222
-475	2,482	-167	-786	Manchester LCO / Trafford LCO	1,054	1.2%	127	1,050	4	119,459
-3,428	-1,454	-1,944	-19,689	MRI	-26,515	-9.6%	-8,957	-17,400	-9,115	367,517
-697	956	-377	-1,930	REH / UDH	-2,048	-3.3%	-883	-900	-1,148	84,012
-4,791	-1,106	792	0	RMCH	-5,106	-2.7%	-5,289	1,351	-6,457	251,762
-1,110	-521	342	-1,439	Saint Mary's Hospital	-2,728	-2.0%	-1,885	-599	-2,129	178,647
163	-530	-190	-8,082	WTWA	-8,639	-2.7%	-3,826	-4,576	-4,063	432,455
-6,986	**3,575**	**-1,701**	**-33,947**	**Trust position**	**-39,061**	**-2.6%**	**-18,131**	**-19,949**	**-19,112**	**1,972,404**

Key Run Rate Areas

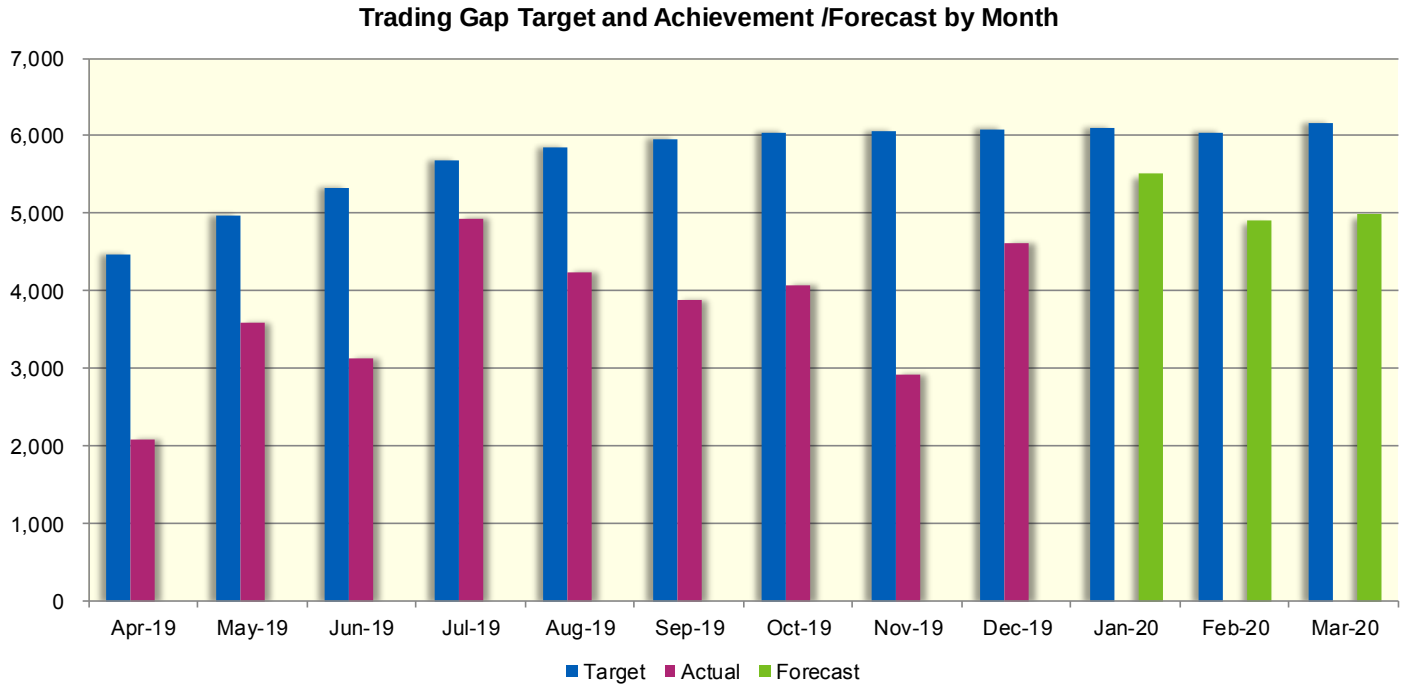
1. 2019/20 Trading Gap challenge

Theme Breakdown	Savings to date				Forecast to year-end			
	Target £'000	Achieved £'000	Variance £'000	Financial RAG	Target £'000	Forecast £'000	Variance £'000	Financial Forecast
Hospital Initiative	2,382	2,859	476	120%	2,986	3,649	663	122%
Contracting & income	17,015	13,485	(3,530)	79%	22,757	19,864	(2,892)	87%
Procurement	5,340	4,851	(489)	91%	7,495	7,367	(128)	98%
Pharmacy and medicines management	2,100	1,197	(902)	57%	3,001	2,153	(847)	72%
Length of stay	3,079	1,852	(1,226)	60%	4,338	2,821	(1,517)	65%
Outpatients	604	386	(218)	64%	902	615	(287)	68%
Theatres	1,321	375	(946)	28%	1,916	791	(1,126)	41%
Workforce - medical	2,379	2,877	498	121%	3,358	3,743	385	111%
Workforce - nursing	2,162	1,666	(496)	77%	3,204	2,429	(775)	76%
Admin and clerical	1,195	1,090	(105)	91%	1,604	1,461	(143)	91%
Workforce - other	2,952	2,507	(446)	85%	3,980	3,543	(437)	89%
Budget Review	475	380	(95)	80%	637	507	(130)	80%
Total identified (at or above level 3)	**41,004**	**33,526**	**(7,479)**		**56,178**	**48,942**	**(7,236)**	
Total identified (below level 3)	2,079	0	(2,079)		3,582	1,503	(2,079)	
Unidentified	7,768	0	(7,768)		8,992	0	(8,992)	
Grand Total	**50,851**	**33,526**	**(17,326)**	**66%**	**68,752**	**50,445**	**(18,307)**	**73%**

Financial RAG

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

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



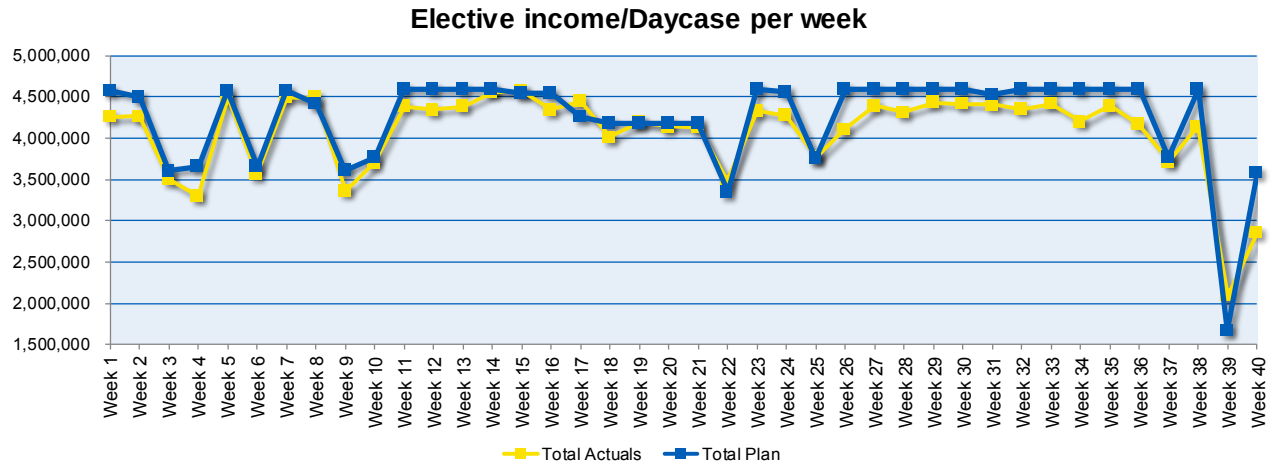
2. Agency spend by Staff Group and Hospital / MCS

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	Average M4-6 (19/20) £000's	Average M7-9 (19/20) £000's
Consultant	-452	-438	-258	-284	-268	-302
Career Grade Doctor	-48	-52	-38	-89	-29	-36
Trainee Grade Doctors	-685	-571	-352	-247	-253	-125
Registered Nursing Midwifery	-772	-637	-601	-574	-530	-511
Support to Nursing	-137	-150	-117	-48	-45	-18
Allied Health Professionals	-177	-93	-103	-83	-72	-109
Other Scientific and Theraputic	-177	-206	-135	-141	-105	-20
Healthcare Scientists	-164	-81	-105	-8	-73	-118
Support to STT / HCS	-89	-106	-41	-32	-39	-58
Infrastructure Support	-85	-90	-113	-101	-40	-165
Grand Total	**-2,786**	**-2,424**	**-1,863**	**-1,607**	**-1,454**	**-1,462**

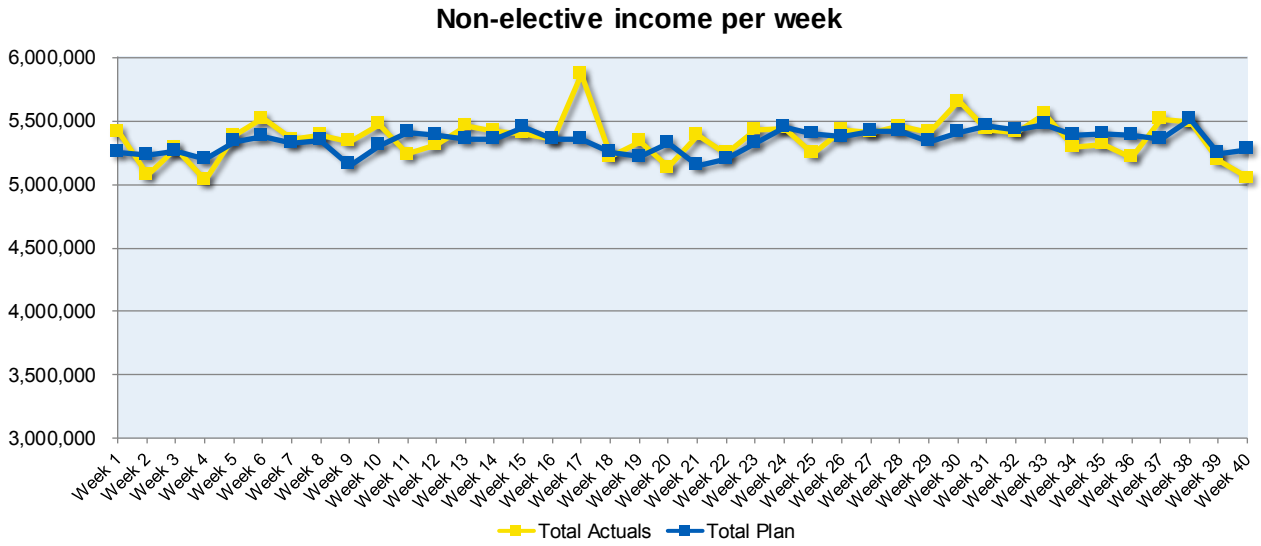
Hospitals	Average M1-6 (18/19) £000's	Average M7-9 (18/19) £000's	Average M10-12 (18/19) £000's	Average M1-3 (19/20) £000's	Average M4-6 (19/20) £000's	Average M7-9 (19/20) £000's
Clinical & Scientific Support	-444	-301	-271	-191	-218	-156
Manchester LCO	-47	-44	-61	-44	-43	-110
MRI	-924	-859	-524	-680	-534	-226
REH / UDH	-111	-117	-89	-82	-91	-82
RMCH	-144	-157	-142	-78	-94	-156
Saint Mary's Hospital	-36	-30	-38	-24	-36	-33
WTWA	-899	-697	-632	-412	-390	-532
Corporate	-164	-179	-101	-99	-40	-162
Research	-17	-40	-5	2	-8	-5
Total	**-2,786**	**-2,424**	**-1,863**	**-1,607**	**-1,454**	**-1,462**

Trust Total	Agency spend - YTD	Agency ceiling - YTD	Difference (£000)	% Above / (below) ceiling
	13,575	19,910	-6,335	(31.8%)

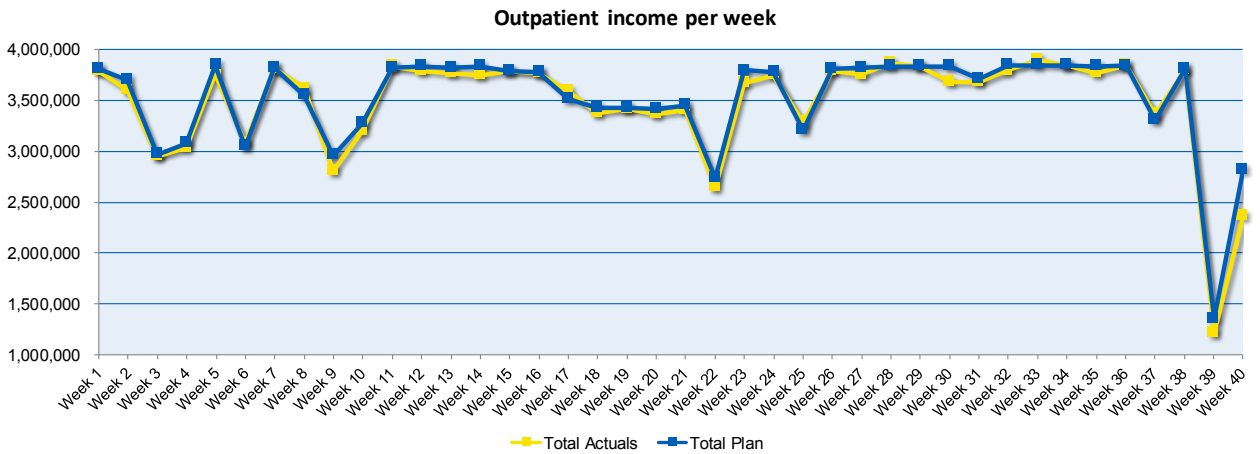
3. Elective / Daycase income: December 2019



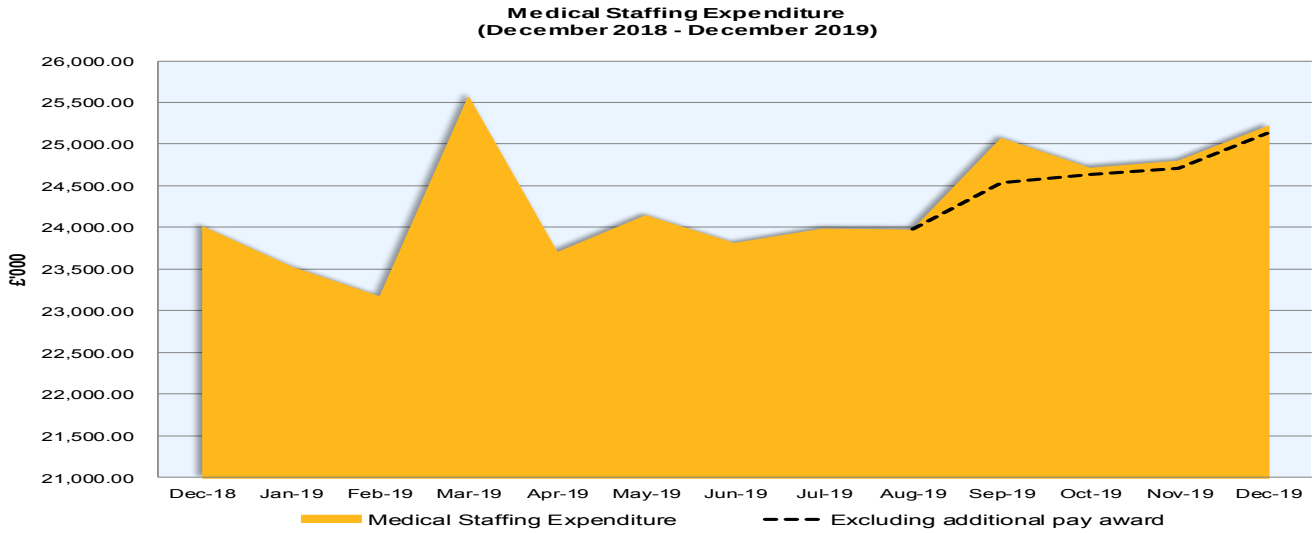
4. Non-Elective income: December 2019



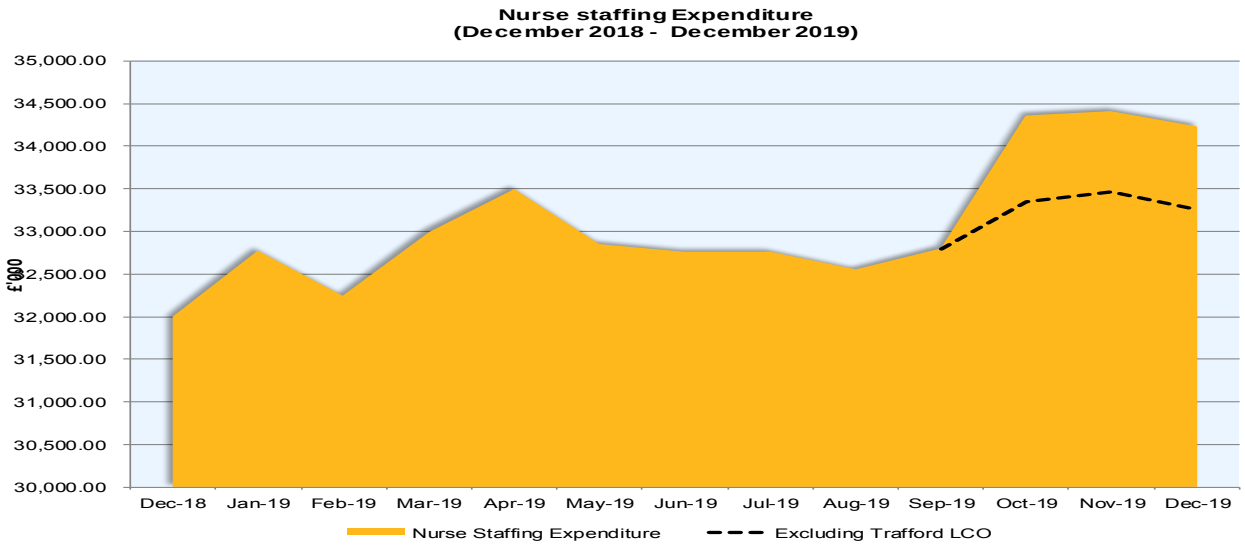
5. Outpatient income: December 2019



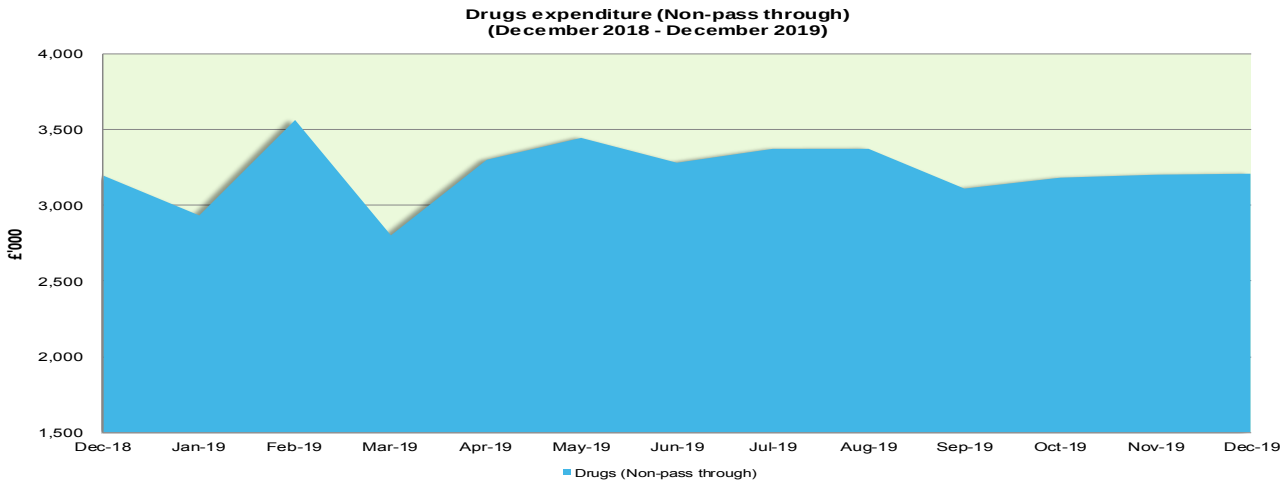
6. Medical Staffing: December 2019



7. Nurse staffing: December 2019



8. Prescribing: December 2019



NHS Improvement's KPIs

	Plan YTD		Actual YTD	
	Metric	Level	Metric	Level
Liquidity ratio	(2.3)	2	3.6	1
Capital servicing capacity	1.2	4	1.2	4
I&E Margin	0.3%	2	0.3%	2
I&E margin: Distance to financial plan	0.0%	1	0.0%	1
Agency spend Metric - above / (below) the agency ceiling	(8.8%)	1	(31.8%)	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	1.9	1
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	(10.1%)	1	(31.6%)	1
Use of Resource (UOR) metrics - Level 1 being highest		**2**		**2**

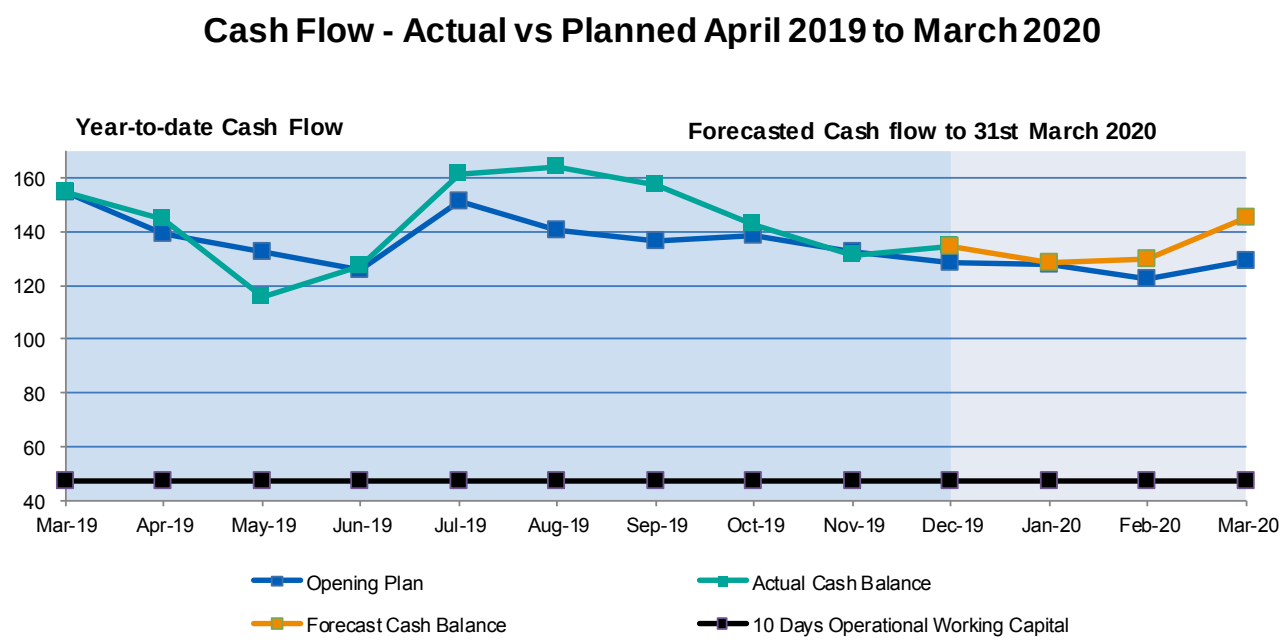
Narrative:

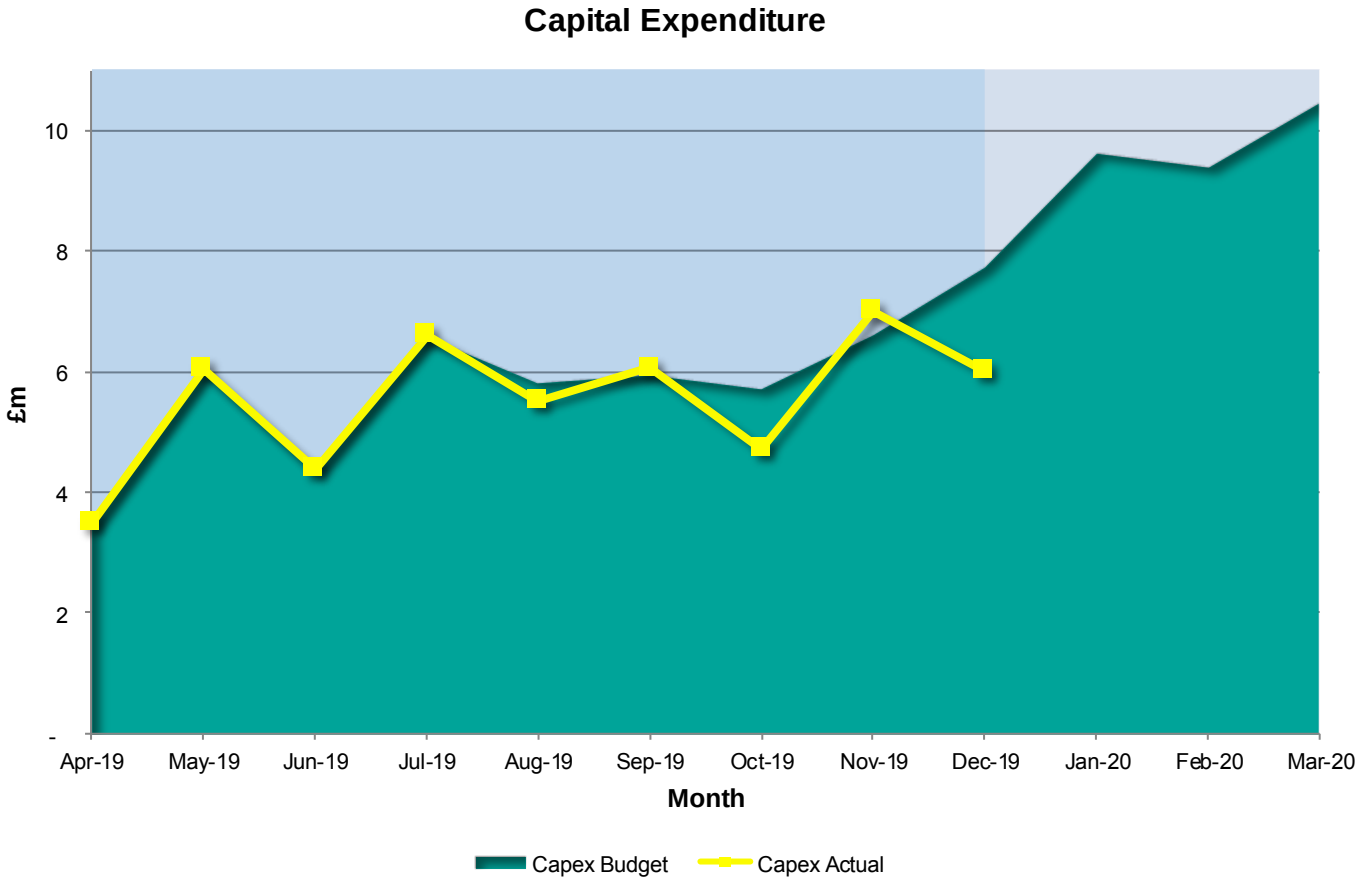
Overall, the Financial Risk Rating (FRR) for the trust is a '3' because the capital servicing capacity position is rated as a '4' (below acceptable). This metric underlines how any continuation of the current operating run-rate performance would fail to support any strategic investment decisions until significant improvement has been demonstrated over time.

Balance Sheet

	Opening Balance 01/04/2019 £000	Actual Year to Date 31/12/2019 £000	Movement in Year to Date £000
Non-Current Assets			
Intangible Assets	4,120	3,427	(693)
Property, Plant and Equipment	594,723	596,085	1,362
Investments	2,513	2,513	0
Trade and Other Receivables	4,969	4,770	(199)
Total Non-Current Assets	**606,325**	**606,795**	**470**
Current Assets			
Inventories	16,462	17,842	1,380
NHS Trade and Other Receivables	83,118	91,822	8,704
Non-NHS Trade and Other Receivables	45,816	31,933	(13,883)
Non-Current Assets Held for Sale	210	210	0
Cash and Cash Equivalents	154,563	134,244	(20,319)
Total Current Assets	**300,169**	**276,051**	**(24,118)**
Current Liabilities			
Trade and Other Payables: Capital	(4,242)	(9,350)	(5,108)
Trade and Other Payables: Non-capital	(171,403)	(175,133)	(3,730)
Borrowings	(19,780)	(20,369)	(589)
Provisions	(15,858)	(13,597)	2,261
Other liabilities: Deferred Income	(20,400)	(21,343)	(943)
Total Current Liabilities	**(231,683)**	**(239,792)**	**(8,109)**
Net Current Assets	**68,486**	**36,259**	**(32,227)**
Total Assets Less Current Liabilities	**674,811**	**643,054**	**(31,757)**
Non-Current Liabilities			
Trade and Other Payables	(2,600)	(3,114)	(514)
Borrowings	(407,793)	(395,215)	12,578
Provisions	(8,815)	(7,925)	890
Other Liabilities: Deferred Income	-	(2,559)	(2,559)
Total Non-Current Liabilities	**(419,208)**	**(408,813)**	**10,395**
Total Assets Employed	**255,603**	**234,241**	**(21,362)**
Taxpayers' Equity			
Public Dividend Capital	204,780	204,780	0
Revaluation Reserve	45,408	45,408	0
Income and Expenditure Reserve	5,415	(15,947)	(21,362)
Total Taxpayers' Equity	**255,603**	**234,241**	**(21,362)**
Total Funds Employed	**255,603**	**234,241**	**(21,362)**

Cash flow and capital expenditure





Scheme	Funding	Internal Plan £'000	Internal Plan YTD at 31st December 2019 £'000	Spend YTD at 31st December 2019 £'000	Spend in future months £'000	Forecast Year End £'000
Property and Estates schemes						
Cardiac MR Scanner	Charity	850	135	76	774	850
Diabetes Centre	Charity	1,649	1,109	1,290	359	1,649
Helipad	Charity	4,746	2,802	1,590	3,156	4,746
Other Charity Funded Projects	Charity	496	238	104	392	496
RMCH Atrium	Charity	200	152	5	195	200
Other Property & Estates (incl backlog maintenance)	Internal	22,401	15,152	14,971	7,430	22,401
MRI ED redevelopment	Internal	1,000	692	759	41	800
RMCH ED redevelopment	Internal	885	248	99	286	385
3rd MRI scanner	Internal	1,692	1,692	1,692	0	1,692
BMT	Internal	3,000	1,920	1,056	1,944	3,000
North Manchester HIP2	External	2,000	146	0	2,000	2,000
Property & Estates - sub-total		**38,919**	**24,286**	**21,642**	**16,577**	**38,219**
IM&T schemes	Internal	**17,625**	**14,178**	**13,280**	**4,345**	**17,625**
Equipment rolling replacement programme	Internal	6,500	4,419	6,110	390	6,500
Charity Equipment	Charity	234	0	0	234	234
Equipment additional	Internal	3,250	0	0	3,250	3,250
3rd MR Scanner - Equipment	Internal	1,101	1,101	1,101	0	1,101
CTCCU equipment	Internal	505	350	0	1,200	1,200
RMCH equipment	Internal	530	0	0	530	530
National Funding - Imaging Equipment	External	1,147	0	0	1,147	1,147
CFC Equipment	Charity	689	689	689	0	689
Equipment - sub total		**13,956**	**6,559**	**7,900**	**6,751**	**14,651**
Genomics *						
Genomics Intermediate Development	Internal	1,398	1,060	414	984	1,398
VAT reclaim to refund Genomics Intermediate Development	Internal	-434	-434	-434	0	-434
Genomics Laboratory Equipment	External	692	230	0	692	692
Genomics - sub total		**1,656**	**856**	**-20**	**1,676**	**1,656**
PFI Lifecycle		**9,813**	**7,257**	**7,064**	**2,749**	**9,813**
Total expenditure - per NHSI report		**81,969**	**53,137**	**49,867**	**32,098**	**81,964**
Genomics NW - LWH Cash payment - absorption of assets		500	0	0	500	500
Total expenditure		**82,469**	**53,137**	**49,867**	**32,598**	**82,464**

Appendix 1 – Financial performance against original NHSI plan

	Year to date - Month 9					
	Annual Plan	Year to date budget	Variance from budget	Variance as % of budget	Variance to month 8	Year to date Actual
INCOME	£'000	£'000	£'000	%	£'000	£'000
Income from Patient Care Activities						
A and E	53,712	40,553	361		308	40,914
Non-Elective (includes XBD's)	304,268	228,750	2,293		1,525	231,043
Elective (includes Day Case & XBD's)	229,764	170,929	-5,553		-4,941	165,376
Out-Patients (includes First & Follow up)	188,113	139,723	-1,126		-1,242	138,597
Other NHS Clinical Income	448,019	334,834	-8,492		-8,798	326,342
Community Services (includes LCO)	106,822	80,117	8,439		5,688	88,556
Passthrough drugs and devices	146,417	109,812	1,527		2,064	111,339
Sub -total Income from Patient Care Activities	**1,477,115**	**1,104,718**	**-2,551**	**-0.2%**	**-5,394**	**1,102,167**
Private Patients/RTA/Overseas(NCP)	10,964	8,114	-1,279		-934	6,835
Total Income from Patient Care Activities	**1,488,079**	**1,112,832**	**-3,830**	**-0.3%**	**-6,328**	**1,109,002**
Training & Education	62,438	46,827	1,527		1,627	48,354
Research & Development	58,061	43,548	1,844		1,501	45,392
Misc. Other Operating Income	110,272	82,704	-4,497		-5,487	78,207
Other Income	**230,771**	**173,079**	**-1,127**	**-0.7%**	**-2,359**	**171,952**
Total Income	**1,718,850**	**1,285,911**	**-4,957**	**-0.4%**	**-8,687**	**1,280,954**
EXPENDITURE						
Pay	-1,010,287	-758,562	-13,979	-1.8%	-9,259	-772,541
Non pay	-650,218	-487,873	16,673	3.4%	16,117	-471,200
Total Expenditure	**-1,660,505**	**-1,246,435**	**2,694**	**0.2%**	**6,858**	**-1,243,741**
EBITDA Margin (excluding PSF)	**58,345**	**39,476**	**-2,263**	**2.9%**	**-1,829**	**37,213**
Interest, Dividends and Depreciation						
Depreciation	-27,927	-21,011	1,385		1,180	-19,626
Interest Receivable	444	333	486		436	819
Interest Payable	-40,848	-30,683	-121		-105	-30,804
Dividend	-3,261	-2,446	520		462	-1,926
Surplus/(Deficit) on a control total basis	**-13,247**	**-14,331**	**7**	**0.1%**	**144**	**-14,324**

Surplus/(Deficit) as % of turnover						**-1.1%**
PSF Income	**27,020**					**17,934**
Additional PSF from 18/19						**917**
Non operating Income						**3,713**
Depreciation - donated / granted assets						**-534**
Impairment						**-29,069**
	13,773					**-21,362**

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:	March 2020
Subject:	Strategic Development Update
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	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 Issues • Greater Manchester Issues • MFT Issues
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

Anchor Programme

Anchor institutions are large, public sector organisations that are unlikely to relocate and have a significant stake in a geographical area. Employment and procurement are two important parts of an anchor's role but there are others such as use of land and estates and environmental sustainability.

There is growing national interest in the role of hospitals as anchor organisations in their regional economies and their role in supporting improvements in population health for their local communities. MFT hosted NHS England and NHS Improvement (NHSE/I) and the Health Foundation on 22 January 2020 to present on MFT's track record in this area, which included discussions on the workforce strategy, procurement and commissioning for social value, use of capital and estates, environmental sustainability, and partnership working.

3. Greater Manchester Issues

Improving Specialist Care (ISC) Programme

The ISC Programme has continued at pace during 2019 and in to 2020 and has reached the business case stages in several of the workstreams. Following approval by the Greater Manchester Joint Health & Care Commissioning Board (JCB) in September, the first wave of PCBCs will be for breast, vascular and benign urology and these are now being staggered over the course of 2020/21.

The following is a summary of the status of other workstreams considered by the JCB:

- Neuro-Rehabilitation services – in implementation. Lead provider is Salford.
- Paediatric Surgery services - in progress to a Pre-Consultation Business Case. This work will need to re-align with proposals for Paediatric Medicine which are currently in development.
- Respiratory services – NHSE, Great Manchester Health Scrutiny and the Joint Commissioning Board supported the proposed model of care and agreed the changes were beneficial to patients and did not amount to a requirement to undertake public consultation. In progress to a Decision-making Business Case.

Rapid Diagnostics Centres (RDC)

Rapid Diagnostic Centres (RDCs) are designed to speed up cancer diagnosis and deliver improved patient experience and better outcomes for patients. There are currently pilots in place at Wythenshawe and Royal Oldham Hospital. The national programme aims to create RDC services for patients with vague symptoms and for tumour-site-specific referrals. The plan is for there to be two RDCs in Greater Manchester based on the existing pilots.

MFT's delivery plan for RDCs was presented and approved by the MFT Cancer Committee in January. It was subsequently signed off by the GM Cancer Alliance and submitted to NHS E/I for approval. The presentation to the cancer committee detailed the plan for the delivery of a number of vague symptoms and tumour specific clinics over the next five years.

The MFT programme team are drafting a governance structure and business case setting out the proposed spending of the allocated GM Transformation Fund for 2020/21. The plan is expected to be approved by NHS E/I by the end of March 2020.

4. MFT Issues

MFT Clinical Service Strategy Programme - Engagement

We are undertaking an overarching Equality Impact Assessment (EQIA) on twelve key themes which emerged from the service strategies. As part of this process we are holding two workshops to understand the impact of these themes on our patients, particularly those with protected characteristics. The first workshop was held on 19 February and the follow-up session is planned for 10 March. The content of the workshop will be used to populate the EQIA and to develop implementation guidance for Hospitals and MCS.

Service-specific EQIAs will be completed on a specialty by specialty basis, starting with Trauma and Orthopaedics.

5. Actions / Recommendations

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

National Issues

- Anchor programme

Greater Manchester Issues

- ISC Programme
- Rapid Diagnostic Centres

MFT Issues

- Clinical Service Strategy Programme

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Peter Blythin, Group Executive Director of Workforce and Corporate Business.
Paper prepared by:	Emma Panchaud, Transaction Manager, Single Hospital Service.
Date of paper:	February 2020
Subject:	Progress report on the Manchester Single Hospital Service.
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Failure to deliver the Manchester Single Hospital Service Programme effectively will potentially present risks to the Trust priority – '*to deliver the merger of the two organisations with minimal disruption whilst ensuring that the planned benefits are realised in a timely manner.'*
Recommendations:	The Board of Directors is asked to: • Receive this report and note progress being made with the transaction process. • Support the strategic direction of the programme.
Contact:	Name: Peter Blythin, Group Executive Director of Workforce and Corporate Business Tel: 0161 701 0190

1. Purpose

1.1. The purpose of this paper is to provide an update on the Single Hospital Service (SHS) Programme with particular reference to the proposed acquisition of North Manchester General Hospital (NMGH) and the associated re-development of the NMGH site.

2. Background

2.1. NHS England / Improvement (NHS E/I) set out a proposal for MFT to acquire NMGH as part of an overall plan to dissolve Pennine Acute Hospitals NHS Trust (PAHT) and formally transfer the remaining hospital sites at Bury, Rochdale and Oldham to SRFT. The intention for MFT to acquire NMGH is consistent with the Manchester Locality Plan.

2.2. The inclusion of NMGH within MFT has the potential to deliver significant benefits for patients and staff, alongside wider strategic opportunities for North Manchester.

3. Acquisition of North Manchester General Hospital

3.1. The hospital sites and services owned by the PAHT are currently operated and managed by Salford Royal Hospitals NHS FT (SRFT) under a management agreement. This agreement is due to expire on 31st March 2020.

3.2. Due to the complexity of the acquisition process and the significant challenges discovered at PAHT, NHS E/I have decided that it will not be possible to complete the proposed transactions by 1st April 2020 and that it would not be acceptable to extend the current arrangement further. Alternative interim arrangements have therefore been agreed to run the PAHT hospitals after the end of March 2020.

3.3. From 1st April 2020, NMGH will be managed by MFT under a new management agreement, and a new NMGH leadership team will be based at NMGH as part of the MFT Group. Fairfield General Hospital, The Royal Oldham Hospital and Rochdale Infirmary will continue to be managed by SRFT under a revised management agreement.

3.4. This arrangement will provide certainty for the staff who work across PAHT hospitals and the population they serve. A briefing outlining these arrangements has been circulated to all staff as part of a wider communications and engagement plan for the programme. Staff at NMGH are receiving regular updates via internal communication methods including the monthly *'Team Talk'* forum. Similar activities are in progress for MFT colleagues.

3.5. The new management agreements will need to be put into place by the end of March 2020. NHS E/I are progressing this work with the full support of all partner organisations who are committed to the delivery of safe, quality services for the local communities. Formal transactions to make these arrangements permanent will be completed by April 2021 at the latest.

4. Governance arrangements

4.1. Discussions around the content of the management agreement for NMGH are underway. Responsibilities are being agreed and governance arrangements are being put into place to ensure the safe transition of services from 'Day One' (April 1st 2020).

4.2. An independent Board is being re-established for PAHT, to oversee the functioning of the management agreements in place with MFT and SRFT. The Board will also oversee the disaggregation of corporate and clinical services and support the completion of the two transactions. Membership of the Board will be consistent with statutory requirements and will include an independent chair and non-executive directors. A Chief Executive, Director of Finance plus a Medical and Nurse Director will make up the formally constituted Board. Sub-committees will be established that will report to the Board.

5. Integration Planning

5.1. Whilst there is more work to be done to agree the detail of the management agreements, the Trust is progressing the development of plans for taking on responsibility for NMGH. The emphasis of this work will be to ensure a safe and effective transfer of responsibilities on 'Day One', with minimal disruption to staff or patients. These plans will be influenced by the content of the proposed management agreement.

5.2. A North Manchester Implementation Plan (NMIP) has been developed. The plan outlines proposed leadership and governance arrangements, programme risk management and monitoring, a process for required partnership working with SRFT, and formulation of an approach to 'Day One' planning.

5.3. As part of this work MFT is in the process of establishing a NMGH leadership team that will take responsibility for the operation of the site and the management of the clinical services. The team will participate in all the normal MFT governance arrangements. The North Manchester Chief Executive has been announced as Dena Marshall, formerly Chief Executive of the Royal Manchester Children's Hospital.

6. The North Manchester Proposition and the redevelopment of the NMGH site

6.1. The North Manchester Proposition has been shared with the Board previously. It presents an opportunity for a broader integration health offer i.e. health as the basis for major urban change. It focuses on the development of stronger integrated care, delivery of community-based services, the promotion of healthy lifestyle choices thereby providing an opportunity to influence the wider determinants of health, including employment, education and social cohesion.

6.2. The opportunity to redevelop the NMGH site is significant. Following the inclusion of the NMGH in the Government's Health Infrastructure Plan (HIP), MFT has committed to deliver an ambitious programme of work on a capital business case for the redevelopment of the NMGH site. This follows the Prime Minsters announcement in October 2019 that NMGH is one of a number of hospitals earmarked to receive capital funding.

6.3. This programme of work has commenced and planning for the site is underway in line with the ambitions of the proposition. This will include the re-development of the acute hospital facilities, a health and wellbeing centre, an education and training centre for staff (but also offering adult education space), nursery, and research and innovation accommodation.

6.4. The redevelopment of mental health facilities at Park House on the NMGH site is another key element of the strategy for the site. This is funded via capital already allocated to Greater Manchester Mental Health NHS Foundation Trust (GMMH).

6.5. An implementation plan has been developed to achieve the completion of an Outline Business Case by November 2020. As part of this plan, the Strategic Outline Case was submitted to the NHS E/I and the Department of Health and Social Care (DHSC) on 31st January 2020. The Outline Business Case is now be progressed.

6.6. The focus now is to progress the masterplan and design of the site. This will be completed with the input of clinical and corporate services. Collaborative working arrangements are also being put into place to ensure that the design remains faithful to the proposition, GM programmes, MHCC commissioning intentions and MFT strategies.

6.7. To help guide the process governance arrangements have been put into place. A North Manchester Health Infrastructure Plan Task and Finish Group led by the Group Chief Finance Officer will provide appropriate assurance to the process by monitoring the overall progress of the programme.

6.8. The Task and Finish Group reports to the North Manchester Transaction Board chaired by the Group Executive Director of Workforce and Corporate Business. This Board will provide assurance on the overall transaction to the recently formed North Manchester Scrutiny Committee.

7. Next Steps

7.1. Negotiations will continue to finalise the management agreement ready for Board consideration.

7.2. Work will also continue to develop plans for taking on responsibility for NMGH, with the objective of ensuring a safe and effective transfer of responsibilities on 'Day One' of a management agreement, with minimal disruption to staff or patients.

7.3. Plans for the regeneration of the hospital site and the surrounding area will continue to be finessed as part of the formal planning processes required to deliver a scheme such as the rebuilding of NMGH.

8. Recommendations

8.1. The Board of Directors is asked to:

- Receive this report and note progress being made with the transaction process.
- Support the strategic direction of the programme.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Michael McCourt, Chief Executive MLCO
Paper prepared by:	Tim Griffiths, Assistant Director Corporate Affairs, MLCO
Date of paper:	March 2020
Subject:	**Local Care Organisation Update**
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Leading on the development and implementation of integrated care.
Recommendations:	Board of Directors is asked to note the contents of the report.
Contact:	Name: Tim Griffiths, Assistant Director Corporate Affairs Tel: 07895448165

1. Introduction

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

- Urgent care and system resilience;
- Trafford Community Services; and,
- Integrated neighbourhood working.

2. Urgent care and system resilience

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

2.2 To ensure that MLCO delivers against its priorities in regards to hospital flow, the Chief Executive continues to hold a weekly System Resilience Group consisting of executive and senior MLCO leads.

2.3 MLCO continues to utilise its weekly operational call to deliver on improving co-ordination between services and unblocking challenges in patient pathways. The call is well represented by MLCO senior managers. This is now supported by a weekly data review meeting, led by senior leadership within the MLCO.

2.4 Supporting the operational delivery of the discharge programme, MLCO has established a robust programme infrastructure that looks to continue oversight of:

- Continued implementation and development of the MRI Integrated Discharge Team. Full discharge mapping and system wide improvements planned for session with site and MLCO teams 27th February 2020.
- Support the wider deployment of system improvement across the North and South Integrated Discharge Teams.
- Supporting flow changes across the wards to support timely discharges
- The establishment of a fully established Control Room for the MLCO. MLCO has committed resources to support providing further capacity into the team. The control room will have an identified location to fully support live interactive assessment of system pressures.
- The integration of Mental Health services across the discharge pathway.

2.5 Despite an enhanced offer and presence by MLCO, length of stay and the number of stranded and super stranded patients continues to be an issue across the hospital sites.

2.6 The number of patients staying in hospital over seven days remains particular challenging that requires continual and ongoing redress, with Manchester experiencing higher numbers than others areas within Greater Manchester. The reduction of these numbers is a key focus area for MLCO resilience planning. In support of this MLCO continues to actively participate in Ward Length of Stay reviews.

2.7 Despite ongoing work led by MLCO to support the alleviation of these pressures, a sustained period of focus is still required to maintain the reduction in the numbers of stranded patients that has been recently achieved, as it still remains above the target set by NHSI/E.

2.8 As previously updated MLCO continue to track all Manchester and non-Manchester resident patients who are admitted at the MRI and have a LOS of 70 or above days. As the Integrated Discharge Team at MRI becomes mobilised MLCO will maintain an overigsht of a braoder cohort of patients.

2.9 As of 20th February 2020 MLCO had facilitated the discharge of 319 people with excessive length of stay at MRI of which 239 have been Manchester residents. Up to the point of discharge these patients had accumulated a combined length of stay in excess of 27,712 days. However, despite the continued success in supporting people with excessive lengths of stay, many of whom have complex support requirements, into alternative care settings, there has been no discernible impact on average length of stay. As part of this work MLCO continues to monitor Manchester patients that have been identified as having elongated length of stay.

2.10 Despite initial analysis showing that there have been more discharges across the three sites facilitated by MLCO than at the same time last year, the number of DTOC remains higher than the target that has been agreed, although has returned to the levels seen in November following a peak in January.

2.12 As Board are aware in November MLCO Partnership Board requested that MLCO bring forward a short term to respond to continued and escalating pressures within the health and care system in Manchester.

2.13 The plan focussed on five key areas set out below:

Aim & key deliverables
1.Standing up the control room function including care brokerage Using 'a single version' of the MLCO position, this team will be responsible for working with IDTs to target actions on stranded patients.
2. Increasing deflection activity through MCR and avoiding admissions This work will build on the MCR model to increase deflection activity and to target health and care support into care homes • Increasing primary care referrals in MCR • Expansion of MCR to include medical input and a service for PC to review patients being considered for admission

Aim & key deliverables
3. IDT implementation (MRI focus and city wide) and improving D2A • To create an integrated discharge team in MRI and improvement city wide IDT to improve MLCO contribution to mandated urgent care targets
4. Market stabilisation To stabilise the care market across Winter • Embedding home care mobilisation • Putting in place relationship managers for homes • Stabilising Care Homes with 'requires improvement' ratings • Targeted clinical support interventions Increasing GP input into nursing and care homes where required
5.Data to drive care decisions, targeting and assurance This will create on version of the truth of MLCO performance, from which operational decisions will be made and information to the rest of the system will flow.

2.14 Work continues to progress against each of the five work streams described.

2.15 As well as delivering programmes of work to support the movement of people out of hospital MLCO is working to have a substantial impact on keeping people away from hospital. This is delivered through two programmes of work; firstly through High Impact in Primary Care (now Manchester Case Management); and, secondly through Manchester Crisis Response (MCR).

2.16 Manchester Case Management is currently delivered across three neighbourhoods, but will roll out to a further three in 2020 and across the city by 2021. The service to date has reduced multiple presentations to A&E, reduced lengths of stay by nearly a quarter for those under its care and reduced the overall use of secondary care for cohorted patients by 13.5%.

2.17 Manchester Community Response has had a significant impact on avoidable admissions, both through reducing the numbers attending A&E (by ambulance) and keeping frail, older people in their home or close to home care settings. Since January 2019, MCR has avoided 4,686 admissions to hospital. This means that a significant number of people who would otherwise have ended up in hospital have been supported by MLCO into alternative care settings.

2.18 In addition to the numbers of avoided admissions, the MCR services support a significant number of discharges out of hospital settings. Between January 1st 2019 and February 16th 2020 MLCO supported a significant number of people into alternative care settings (including their own homes) via MCR, with the three MCR services facilitating 4,434 discharges.

2.19 In relation to improving care closer to home or near to home, there have been improvements in the utilisation of reablement to support people at home, significant increases in the number of referrals, and week on week increases in the number of people being supported.

3. Trafford Local Care Organisation

3.1 As Board are aware Trafford Community Health Services moved to MLCO and MFT. TLCO as it became is now moving into its sixth month of operation.

3.2 Board are reminded that the organisation of health and care delivery in Trafford looks slightly different to that which can be seen in Manchester, with TLCO being underpinned Section 75 agreement that enables it to deliver integrated services.

3.3 There are three layers to how health and social care service developments take place in Trafford - a plan for Trafford as a locality, an alliance to help develop and oversee many parts of this plan and a partnership organisation to be the building block for integrated management and delivery of care. These are:

- **Trafford Together Locality Plan**: This is the single plan for the reform and sustainability of health and social care in Trafford. Led by Trafford Council and NHS Trafford Clinical Commissioning Group (CCG), it is owned by colleagues, partners and stakeholders across the borough. This five-year approach is supported by delivery plans which will be refreshed year on year and is based on the needs of Trafford's population, its people and the places served. The current year is badged as a year of engagement. Service developments are taking place but there is also significant engagement planned alongside this with the public, staff and partner organisations

- **Trafford Local Care Alliance**: The Alliance is a group of public sector partners that are independently chaired and work together to develop and oversee many of the plans that form the Trafford Together Locality Plan. Currently these partners are: Trafford Council, Trafford CCG, Greater Manchester Mental Health NHS Foundation Trust, MFT, Mastercall, the five Trafford Primary Care Networks and Thrive (representing the third sector)

- **Trafford Local Care Organisation**: The subject of this report. It jointly manages and delivers services which provide the community care people need. This is currently made up of community health and adult social care. There is also now starting to be much closer working with the five new Primary Care Networks which sit in the four neighbourhoods of Trafford.

3.4 It should be noted that whilst TLCO is a component part of Trafford Local Care Alliance, it is not the Trafford Local Care Alliance.

3.5 There has been a close strategic and working relationship between community health and social care services in Trafford for over 10 years. The purpose of this was to deliver improved care to local residents through joined up care offers (service integration). A Section 75 Partnership Agreement had been in place between Pennine Care and Trafford Council for two and half years prior to the transfer. As Board are aware a new one was developed and signed on 1st October 2019 as part of the transfer.

3.6 The approach to the first six months of operation is characterised by two distinct phases. The first to oversee the safe and effective transfer of services and the second concerned with a comprehensive review of services and developing an operational plan for 2020 / 21.

3.7 A detailed implementation plan was developed to support the safe transfer of services. This is consistent with the agreement that services will transfer over on an 'as is' basis with a focus on safety and agreed improvement gains made within existing resourcing.

3.8 Progress in regards to delivering the PTIP has been positive, with detailed work being undertaken on the model of governance to ensure that the services transferring over were appropriately aligned to existing MLCO arrangements. This has included a comprehensive review of the risk register which is now overseen through the MLCO Risk Management Committee.

3.9 In addition, a full review of community health services is in the process of being undertaken following a regulatory inspection framework. This is the same approach that was undertaken when Manchester Local Care Organisation was established. It is anticipated that this work will conclude at the end of April 2020.

3.10 The final part of phase 2 is working with commissioners to agree the transformation programme for 20/21 and further. The transfer of contracts was always predicated on the need to transform.

4. Integrated Neighbourhood Working

4.1 The focus of our work to develop integrated neighbourhood teams in 2019/20 was to build on and optimise the foundations that had been built during 2018/19.

4.2 This has included the formal recruitment of the INT leadership teams, continuing to co-locate our health and social care teams in 12 neighbourhood hubs, the formalisation of governance and agreement of 12 neighbourhood plans, the roll out of the NESTA 100 day challenge programme in each neighbourhood, developing our approach to support the delivery of the Bringing Services Together for People in Places programme and the delivery of the ASC Improvement Plan.

4.3 In regards to their development a small number of high level indicators have been utilised to oversee their development. An overview of progress against the 12 is set out below:

Descriptor	Rationale
Neighbourhood Leadership quintet in place	A measure of whether leadership structures are being aligned to support integrated working.
Neighbourhood governance model in place	A measure of whether decision making is aligned across organisations and the conditions are in place for a culture of integrated neighbourhood working to grow.
Teams co-located in a hub	A measure of whether the infrastructure is in place for INTs (given co-location can only happen if estates and IM&T solutions have been delivered)
Neighbourhood plan in place	A measure of whether INTs are responding to the needs of the local population

Neighbourhood	Quintet in place	Governance in place	Co-located	Neighbourhood plan
Ancoats, Clayton and Bradford	Yes	Yes	Cornerstone Centre	Yes
Miles Platting, Newton Heath, Moston and City Centre	Yes	Yes	Victoria Mill	Yes
City Centre	Yes	Yes	Yes (as part of MP,NH & M Neighbourhood)	Yes
Cheetham and Crumpsall	Yes	Yes	Cheetham PCC	Yes
Higher Blackley, Harpurhey and Charlestown	Yes	February 2020	Harpurhey DO	Yes
Ardwick and Longsight	Yes	Yes	MAVallance Centre	Yes
Gorton and Levenshulme	Yes	Yes	Gorton South DO	Yes
Chorlton, Whalley Range and Fallowfield	Yes	Yes	Chorlton HC	Yes
Hulme, Moss Side and Rusholme	Yes	Yes	Moss Side HC	Yes
Fallowfield (Old Moat) and Withington	Yes	Yes	Burnage HC	Yes
Didsbury East and West, Burnage and Chorlton Park	Yes	Yes	Withington Hospital	Yes
Wythenshawe (Baguley, Sharston, Woodhouse Park)	Yes	Yes	Parkway Green	Yes
Wythenshawe (Brooklands) and Northenden.	Yes	Yes	Etrop Court	Yes

4.4 As can be seen significant progress has been made to optimise our neighbourhood model during 2019/2020 and this is demonstrated by:

- 12 Integrated Neighbourhood Teams (INTs) established, each with a leadership team comprising an INT lead, a lead GP, a lead social worker, a lead nurse, a mental health lead and a Health Development Coordinator;

- 8 out 12 INTs are now co-located;

- Monthly Multi-Disciplinary Team meetings (MDT)s established in GP practices and will be fully rolled out by March 2020;

- The Coordinated Care Pathway developed and rolled out by March 2020 in each neighbourhood;

- Weekly Multi-agency meetings (MAMs) are being established in each neighbourhood and the extension of the model will start on 29th January in Old Moat & Withington for a 12-week test period with a citywide roll out plan to be developed;

- Each neighbourhood has a bi-monthly Partnership meeting; this forum engages stakeholders & supports the development & delivery of the things that matter to the local communities. This is the place where partners from the VCSE engage with our INT leadership teams;

- Each neighbourhood has a delivery plan for 2019/2020 focused on the delivery of a population health driven approach and optimisation of the foundations of neighbourhood working, built from the needs of the local population;

- Health Development Coordinators (HDC) connect services to wider community assets and drive a population health focus in our neighbourhoods, whilst Care Navigators connect residents to key services and support flow through our community services;

- Mobilised the NESTA challenges in all 12 neighbourhoods in 3 phases; phases one and two are complete and the whole programme will be delivered by March 2020; and,

- The 12 INT leads have worked to develop closer working alignment with the MCC neighbourhood and ward teams and we have engaged with elected members through specific briefing sessions and through their ward meetings.

4.5 Wider work has also taken place in our neighbourhoods delivered by the Prevention Programme, which has supported the INTs to design and deliver services with a population health focused approach. Each neighbourhood has a Health Development Coordinator, who are experienced in community development and engagement. They support neighbourhoods to identify priorities and opportunities, co-design local solutions and access resources to build community capacity.

4.6 MLCO will continue to optimise and develop our neighbourhood model in partnership with the health and social care teams, our partners, stakeholders and residents during 2020/21. In recognition of the importance placed on this way of working, one of our priorities for the year is to consolidate and strengthen our neighbourhood approach supporting our 12 INTs to make an impact in their communities.

4.7 MLCO is in the process of finalising its Operating plan for 2020/21 and this will include our deliverables for the next 12 months. The plan has been developed through and from our community health and social care services working with the neighbourhood partnerships and will be published in March 2020.

4.8 As part of this process, MLCO has been reviewing the work that has been delivered across the neighbourhoods to inform the work that needs to be taken forward during 2020/21.

4.9 Each of the neighbourhoods has reviewed and refreshed their neighbourhood plan and this refresh has taken into account relevant ward and PCN plans. The plans outline what has been delivered to date in each place and their planned priorities for 2020/21. The priorities are based on an increasing understanding of the demographics and needs of each place as evidenced through MHCC and MCC intelligence and data sources, but also what partners and stakeholders in place are sharing as priority areas for the residents.

4.10 As part of their development the INT leads are engaging with elected members on the development of the plans through the ward coordination teams across the city to identify opportunities for joined up approaches and sharing of information.

4.11 As such, there are some work areas that will be taken forward in all neighbourhoods and these include:

- Contribute toward the delivery of the citywide population health prevention programme;
- Contribute toward the delivery of the citywide childhood obesity strategy;
- Establish and embed INT through CCP and MCM in INT, INT OD plan, co-locate remaining INTs, strengths-based assessment, ASC improvement plan, systematic review of neighbourhood flow and gaps across neighbourhood organisations, inc VSC sector;
- Support residents in care homes;
- Consolidate connections to PCNs and Digital First and support delivery of PCN contractual requirements through mobilisation of social prescribing and support to deliver integrated and urgent primary care;
- MH and primary care links and commissioning of service;
- Increased follow up for people at risk of avoidable presentation at / admission to hospital; and,
- Develop, enhance and standardise existing community services and continued community engagement events.

4.12 However, each of the plans have priorities and deliverables that are specific to that place. To understand the detail in the plans, it is advised that each of the neighbourhood plans is reviewed on publication.

4.13 Key to the work of the neighbourhood model is the ability of MLCO and its partners to measure the efficacy of the interventions that they make. Significant work has been undertaken in 2019/20 with the information team at MHCC to both develop information and data at a neighbourhood level to inform the planning process. Again, with colleagues at MHCC, significant work has been undertaken to identify outcome measures, utilising the MLCO outcomes framework that was developed in 2017. This work will form the basis of a suite of measures that will be used to understand how effective the plans are especially in the context of supporting a shift in population health outcomes and big system measures including activity metrics.

5. Recommendations

5.1 Board of Directors is asked to note the contents of the report.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Professor Cheryl Lenney, Chief Nurse
Paper prepared by:	Sue Ward, Group Deputy Chief Nurse Lynne Birchall, Head of Nursing – Quality & Patient Experience Claire Horsefield, Head of Customer Services
Date of paper:	February 2020
Subject:	Quarter 3 Complaints Report 2019/20
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Patient and Staff Experience
Recommendations:	The Board of Directors is asked to note the content of the report and the progress of the Complaints Transformation Programme.
Contact:	Name: Lynne Birchall, Head of Nursing – Quality & Patient Experience Tel: 0161 701 7679

Manchester University NHS Foundation Trust (MFT)
Complaints Report 1st October 2019 – 31st December 2019

1. Executive Summary

1.1. Members of the Board of Directors are asked to note the Quarter 3, 2019/20 Complaints Report for Manchester University NHS Foundation Trust (MFT), covering the period 1st October 2019 to 31st December 2019 (Q3). In this quarter the Trafford Local Care Organisation (TLCO) joined the Manchester Local Care Organisation (MLCO); this change is reflected in this report.

1.2 The report provides an overview of the Complaints and PALS performance for Q3. Due to new reporting capabilities to refresh and cleanse previous data, the data provided in this report for the periods prior to this quarter differ slightly to the data presented in previous reports.

1.3 A total of 1,482 PALS concerns were received in quarter 3 compared to 1,404 in the previous quarter; representing a 5.6% increase.

1.4 A total of 413 new complaints were received compared to 438 new complaints received in the previous quarter, which is a 5.7% decrease.

1.5 The total number of complaints closed this quarter was 472, which is an increase of 67 cases compared to the previous quarter.

1.6 The number of complaints closed within 25 days increased, with 289 closed compared to 251 in the previous quarter; however there was a decrease in the number of complaints closed in 26-40 days.

1.7 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 100% compliance with this Key Performance Indicator during Q3.

1.8 In accordance with the agreed schedule, the Complaints Scrutiny Group, which is chaired by a Non-Executive Director, met once during Q3. The Management Team from Manchester Royal Infirmary (MRI), Renal Transplant Service presented a case at the November 2019 meeting. The learning identified from the case presented is detailed in Section 5 of this report.

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

1.10 The Board of Directors is asked to note the information within the report, which demonstrates an increase in PALS concerns and a decrease in formal complaints. The previous improvement in the timeliness of closing complaints has continued during this quarter.

2. Overview of Quarter 3, 2019/20 Performance: PALS

2.1 There was an increase in the number of PALS concerns received with 1,482 PALS concerns being received, compared to 1,404 in the previous quarter. This represents a 5.6% increase compared to the previous quarter and is a numerical increase of 78 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 to formal investigation during Q3, this is an increase when compared to the 9 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, 4 complaint cases were de-escalated during this quarter compared to 2 cases being de-escalated during the previous quarter.

2.3 As in previous reports, the Hospital/MCS/LCO with the highest number of PALS concerns received was Wythenshawe, Trafford, Withington and Altrincham (WTWA) with 494 cases, followed by MRI with 352 cases, representing 33.3% and 23.8% respectively of the total number of PALS concerns received. Numerically, this is an increase of 32 cases for WTWA and a decrease of 15 cases for MRI when compared to Q2. To support the Hospital/MCS/LCO senior management teams to understand the reasons for PALS concerns, the Corporate PALS team continue to provide quarterly thematic PALS reports to WTWA and MRI. Analysis has identified 'Outpatient Appointment Delay/Cancellation' 'Treatment/Procedure' and 'Communication' as the most common themes from PALS concerns received at both WTWA and MRI. The information continues to provide the Hospital teams with the detail to identify focussed areas for improvement. It should be noted that these themes are broad and used nationally and as such further interrogation is required at hospital level to provide wider learning.

2.4 The majority of PALS concerns related to Outpatient areas, which accounted for 1,143 (77.1%) of the 1,482 contacts received. This compares to 1,080 (76.9%) 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 last four quarters.

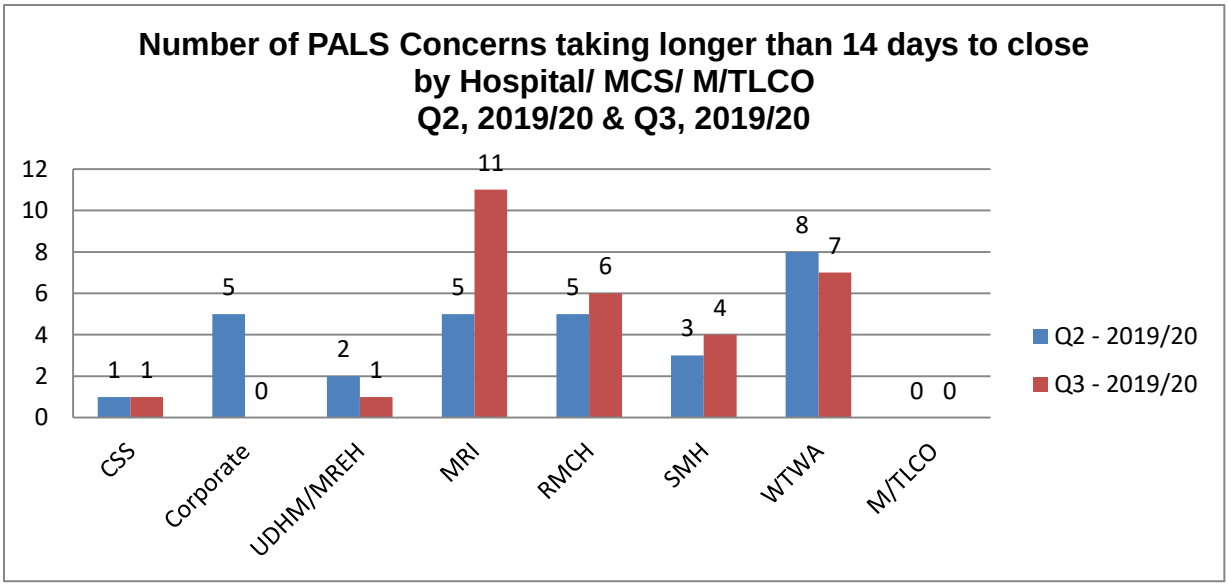
Table 1: Closure of PALS concerns within timeframes.

	Quarter 4, 2018/19		Quarter 1, 2019/20		Quarter 2, 2019/20		Quarter 3, 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	1134	77.5%	1111	66.8%	1006	70.7%	1095	71.6%
8-14	432	20.7%	516	31.0%	387	27.2%	404	26.4%
15+	21	1.8%	37	2.2%	29	2.0%	30	2.0%

2.6 All open PALS cases at 12 days continue to be escalated to the PALS Manager, and this earlier escalation process continues to be successful in reducing the time taken to resolve PALS concerns. Across MFT, resolution within 14 days or under was 98.1% in Q3, which is in line with timeframes achieved in each of the previous quarters shown in Table 1.

2.7 Delays in resolving PALS concerns are monitored by the Corporate PALS team who escalate delays to the Hospital/MCS/LCO Senior Leadership Teams and provide them with weekly reports detailing their unresolved PALS concerns. Graph 1 shows that MRI had the highest number of PALS cases that took longer than 14 days to resolve in Q3. Of the 30 cases that exceeded this timeframe, themes were identified as 'Appointment – Delay/Cancellation'; 'Outpatients' and 'General Care - Medical'. This information is used by the management team to inform specific improvements, such as wok undertaken to improve the outpatient experience.

Graph 1: Number of PALS concerns taking longer than 14 days to close by Hospital/ MCS / M/TLCO Q2, 2019/20 and Q3, 2019/20.

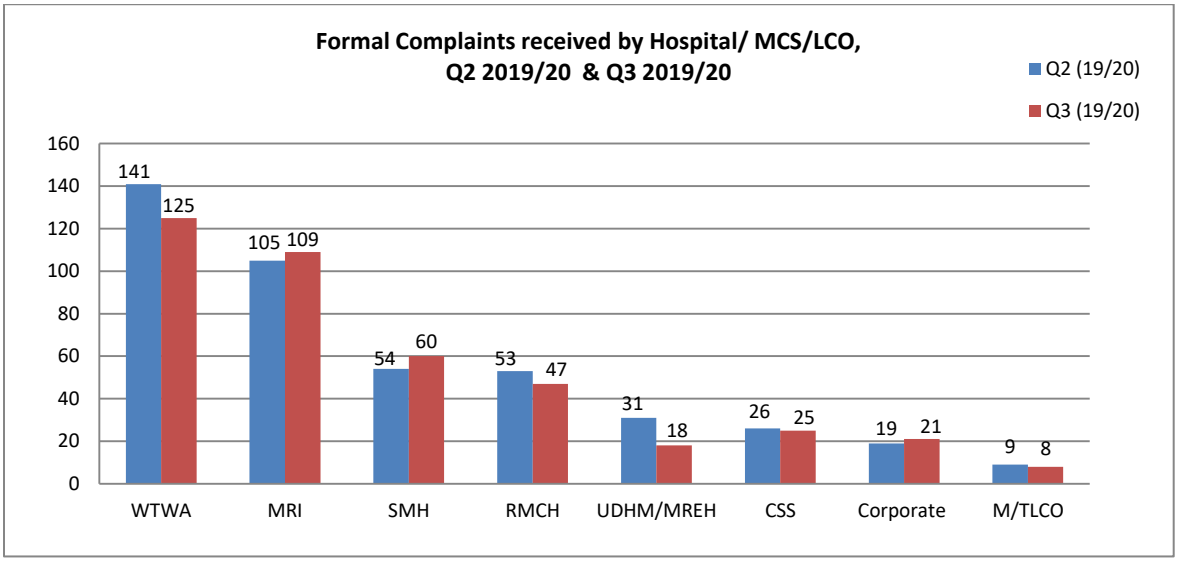


New Complaints

2.8 There was a total of 413 new formal complaints acknowledged this quarter. This compares to 438 in Q2, 2019/20, 356 in Q1, 2019/20 and 393 in Q4, 2018/19. This represents a 5.7% decrease in formal complaints (decrease of 25 in number) when compared to the previous quarter. On a monthly basis there continues to be a variation within normal limits of new and re-opened complaints received with 159 in October 2019, 133 in November 2019 and 121 in December 2019, totalling 413.

2.9 **Graph 2**, below compares the total number of new complaints acknowledged by Hospital/ MCS/LCO in Q2, 2019/20 and Q3, 2019/20.

Graph 2: Total number of New Complaints Acknowledged by Hospital/ MCS/LCO



2.10 Whilst the highest number of new complaints was received by WTWA (125), this quarter, Saint Mary's Hospital (SMH) received the highest percentage increase with 60 new complaints compared to 54 last quarter representing a 11.1% increase. Although, it should be noted that smaller numbers result in higher percentages. The largest decrease in the number of new complaints in this quarter compared to the previous quarter was at WTWA which had a reduction of 16 cases (11.3%).

2.11 Trust-wide, out of the total of 413 complaints there were 137 new complaints relating to inpatient services and 177 relating to outpatient services. For inpatient services, this represents an increase of 4 cases (3.0%) and for outpatient services, this represents a decrease of 16 cases (8.3%). The area with the highest number of outpatient complaints was WTWA with a total of 62 of the 177 complaints (35.0%). Themes identified for outpatient services were 'Treatment/Procedure', 'Communication and 'Clinical Assessment'. Themes for inpatient services were 'Treatment/Procedure', 'Communication' and 'Discharge/Transfer'. As with PALS concerns, the themes are broad and attempts continued throughout this quarter to align the themes to the Trust values and behaviours (see section 4.6).

2.12 The national statutory requirement for the acknowledgement of formal complaints, according to the NHS Complaints Regulations (2009), is to acknowledge 100% of all complaints no later than 3 working days after the complaints are received. The Trust achieved **100%** compliance with this key performance indicator (KPI) during this quarter.

Current Complaints

2.13 In accordance with the NHS Complaint Regulations (2009) the Trust has set complaint response timescales as; 25 working days, 26-40 working days and 41 days and above.

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 was fully devolved to the Hospital/MCS/LCO Chief Executives in 2018/19 and performance continues to be monitored at a Group level via the Accountability Oversight Framework (AOF).

2.16 There were 210 complaints open at the end of quarter 3, compared to 223 at the end of the previous quarter. This is a 5.8% decrease equating to a numerical decrease of 13 complaints. The 210 ongoing complaints comprised of 140 which had been assigned a 25 working day timescale, 36 which had been assigned a 40 working day timescale and 34 which had been assigned a 60 working day timescale. At the end of this quarter 94.0% of ongoing cases were being managed within the planned timescales, agreed with the complainant, with the lowest performance relating to complaints with a 60 day timeframe, reflecting the complexity of this group of complaints, which often require multi-agency involvement. **Table 2** shows a breakdown by the agreed working day timescales.

Table 2: Details of ongoing cases at 31st December 2019 by allocated timescale.

	No of ongoing cases	In timescale	Number not responded to in assigned timescale
25 working day timescale	140	133 (95.0%)	7 (5.0%)
40 working day timescale	36	36 (100%)	0 (0.0%)
60 working day timescale	34	28 (82.4%)	6 (17.6%)
Total	210	197 (94.0%)	13 (6.0%)

2.17 WTWA had the highest number of open cases in Q3 with 70 cases, all of which were within the timescale agreed with the complainant. Of the open cases 46 were within 0-25 days, 11 were within 26-40 days, and 13 were over 41 days. This compared to 64 open cases in Q2 and 63 open cases in Q1.

Resolved Complaints

2.18 The oldest complaint case closed during this quarter was registered within MRI on 10th January 2019 and was 213 days old when closed on 12th November 2019. The complaint involved a high level review within MRI, which involved two meetings between the complainant, Complaints Case Manager and members from the Hospital team prior to and following completion of the investigation. The complainant was kept updated and fully supported throughout this process.

2.19 **Table 3** provides a comparison of complaints resolved within each timeframe from Q4, 2018/19 to Q3, 2019/20. This data shows that 79.2% of complaints closed in Q3 were resolved within the agreed timeframe compared to 75.8% in the previous quarter.

2.20 In Q3, there was a (positive) increase of 38 cases resolved within 0-25 working days and a decrease of 17 cases resolved between 26-40 days, however, the number of cases resolved at 41+ days increased by 46 cases compared to the previous quarter. Overall, the number of complaints resolved within timescale increased by 3.4% compared to Q2 of 2019/20 but has shown a significant improvement of 25.1% when compared to Q4 of 2018/19.

Table 3: Comparison of complaints resolved by timeframe

		Quarter 4 2018/19	Quarter 1 2019/20	Quarter 2 2019/20	Quarter 3 2019/20
Resolved in 0-25 days	New	133	190	208	246
	Reopened	20	30	43	43
Resolved in 26-40 days	New	61	84	65	53
	Reopened	21	16	20	15
Resolved in 41+ days	New	78	69	54	92
	Reopened	27	11	15	23
Total Resolved	New	272	343	327	391
	Reopened	68	57	78	81
Total resolved		340	400	405	472
Total resolved in timescale		184	263	307	374
% Resolved in agreed timescale		54.1%	65.7%	75.8%	79.2%

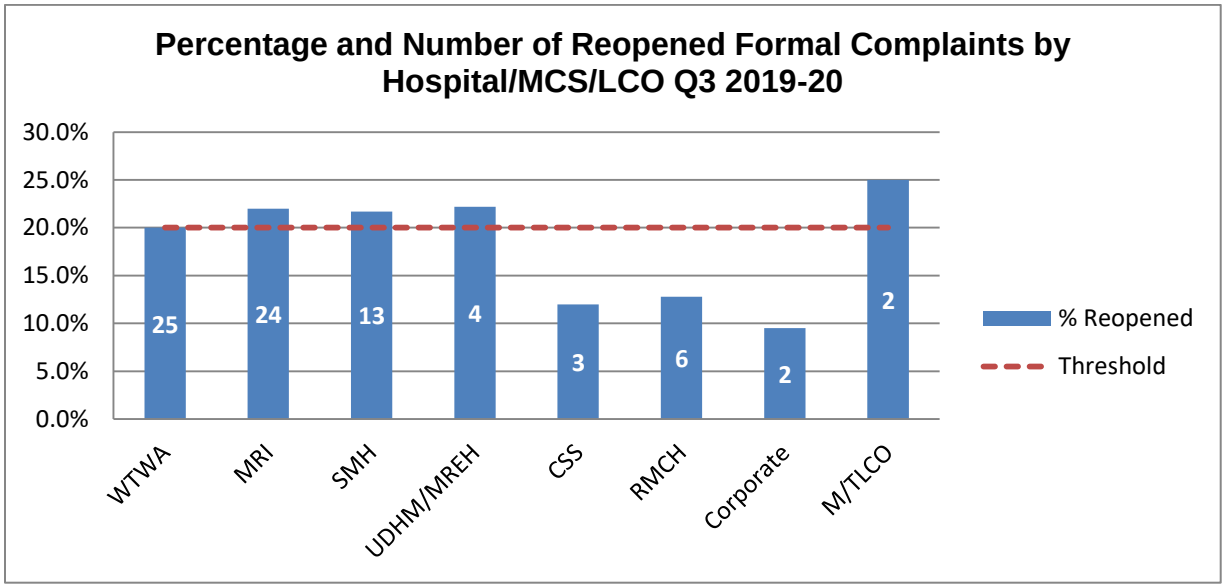
Re-opened Complaints

2.21 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 79 complaints re-opened in this quarter compared to 96 in the previous quarter. This improvement represents a 21.5% decrease in re-opened complaints. Overall re-opened cases accounted for 19.1% of all complaints received compared to 21.9% in the previous quarter.

2.22 The highest number of re-opened cases was received by WTWA (25 cases), remaining equivalent to the last quarter. Of the 25 re-opened complaints received by WTWA the predominant reason was due to unresolved issues, not all issues being addressed or a request for a local resolution meeting. The Corporate Complaints team letter writing training programme will be delivered across the Trust during quarter 4 to support improvements in the content and quality of responses.

2.23 **Graph 3** illustrates Hospital/MCS/LCO performance against the 20% threshold in Q3 with; MRI 22.0% (24 re-opened cases), SMH 21.7% (13 re-opened cases), University Dental Hospital of Manchester (UDHM) and Manchester Royal Eye Hospital (MREH) 22.2% (4 re-opened cases), and the LCOs 25.0% (2 re-opened cases) exceeding the 20% threshold during Q3; with all the other Hospitals/MCS 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/LCO or Corporate Service can result in large percentage changes for those areas with overall low numbers of complaints. Complaint management training continues to be offered to all Hospital/MCS/LCO teams focused on the quality of complaint responses as part of the educational sessions detailed in Section 9.4 of this report.

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



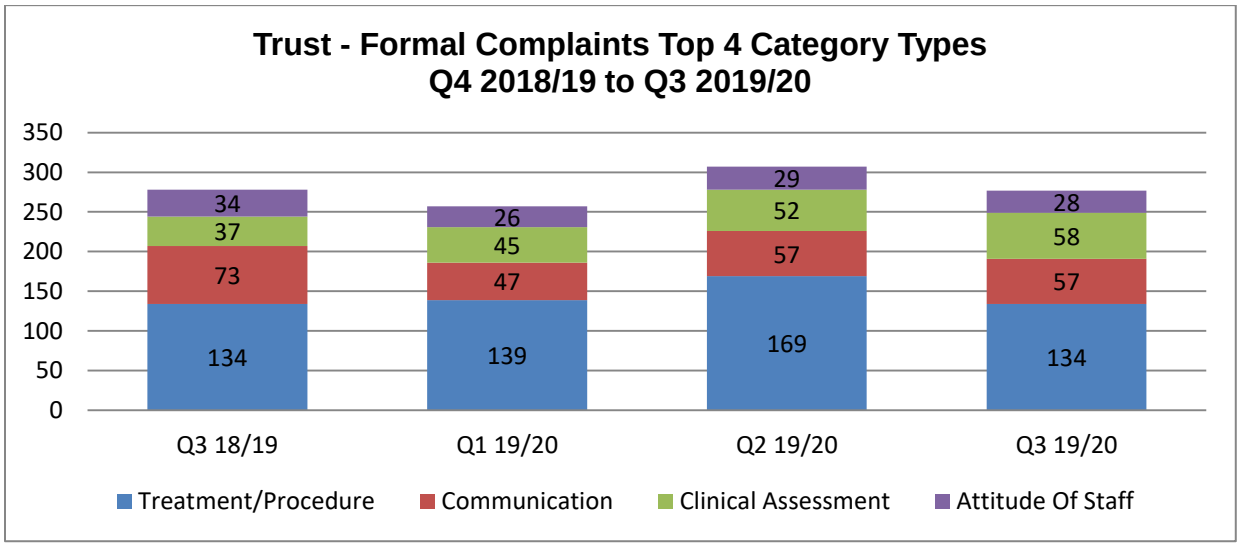
3. Themes from Complaints and PALS concerns

3.1 In Q3, the medical staffing group was cited in 39.5% of all PALS concerns and 60.0% of all complaints, compared to 47.8% and 52.5% respectively 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 it is not unusual for medical staff, as the lead practitioner for many episodes of care, 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/LCO. In addition, the MFT Head of Customer Services continues to provide educational input with regard to customer service and complaints management on the Newly Appointed Consultants Programme (NACS).

3.2 The top category types for formal complaints from Q4, 2018/19 to Q3, 2019/20 are shown in **Graph 4.**

3.3 'Treatment/Procedure', 'Clinical Assessment' and 'Communication' remain in the top three categories in Q3, 2019/20.

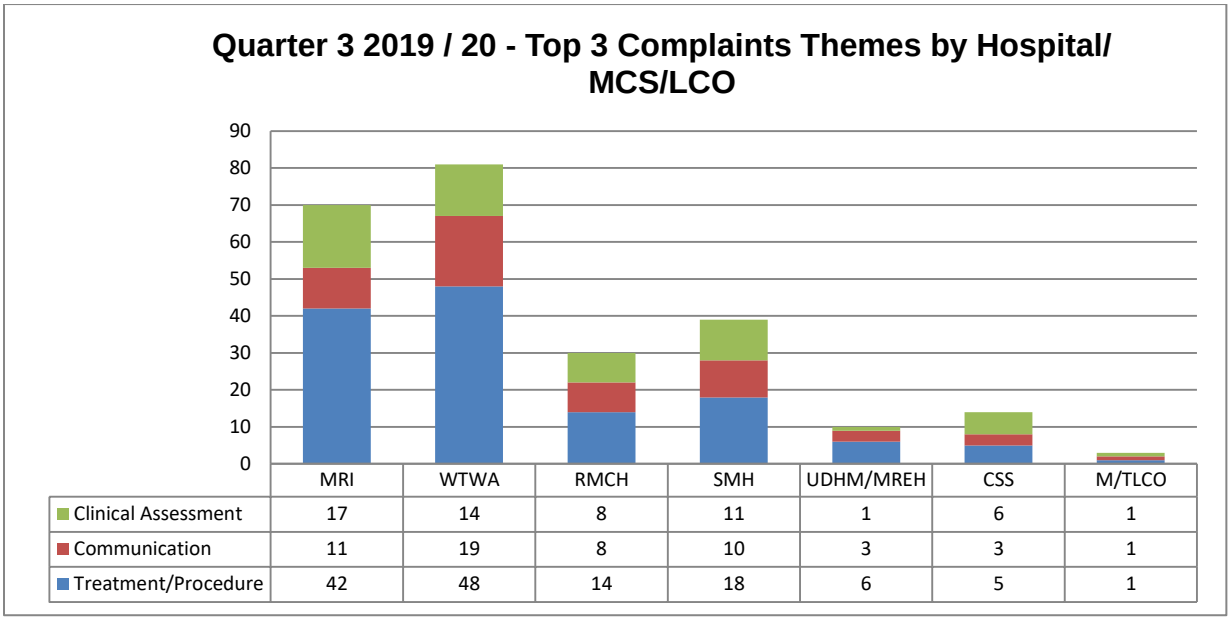
Graph 4: Formal Complaints – Top Categories Quarter 4, 2018/19 to Quarter 3, 2019/20



3.4 **Graph 5** illustrates the total number of top 3 categories by Hospital/MCS/LCO in Q3 2019/20.

3.5 In Q3 the top category, 'Treatment/Procedure' (134) was cited in 38.4% of WTWA's complaints, 38.5% of MRI's complaints, 29.7% of RMCH's complaints, 30.0% of SMH's complaints, 33.0% of UDHM and MREH, and 20.0% of CSS's complaints.

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



	MRI	WTWA	RMCH	SMH	UDHM/MREH	CSS	M/TLCO
Clinical Assessment	17	14	8	11	1	6	1
Communication	11	19	8	10	3	3	1
Treatment/Procedure	42	48	14	18	6	5	1

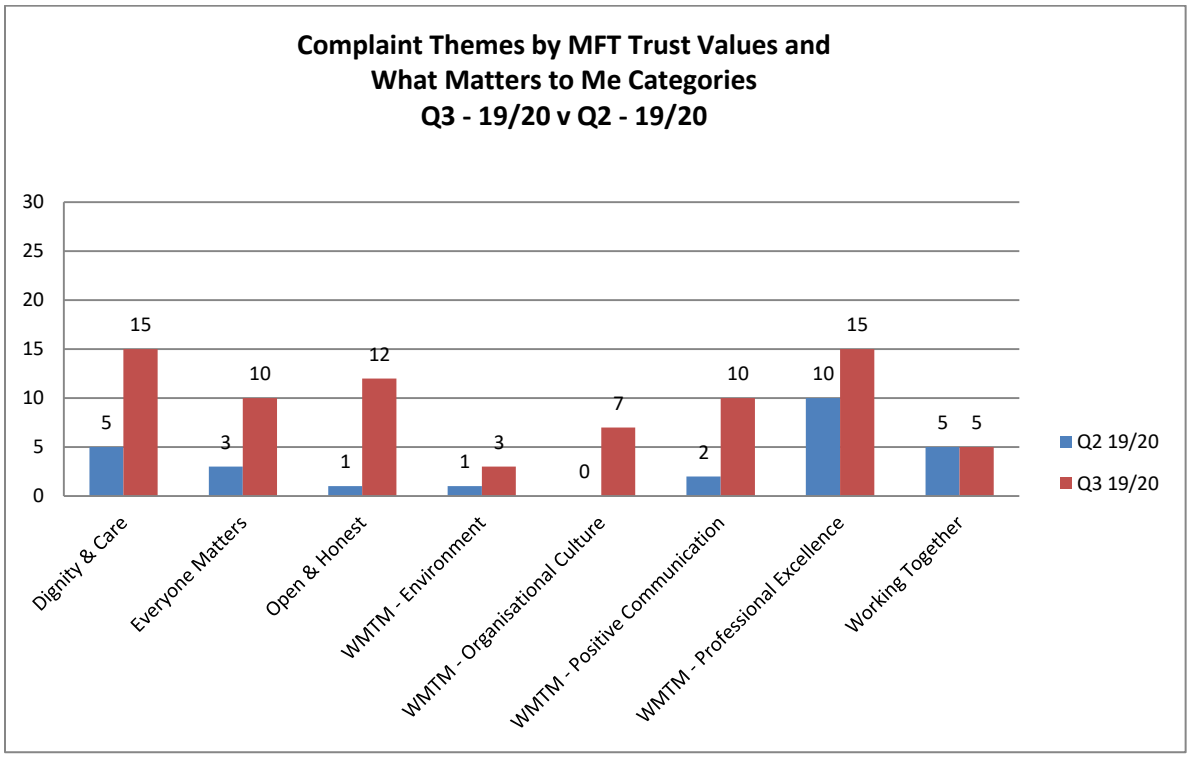
Theming Complaints

3.6 Work continues to theme the concerns raised in complaints against the MFT ***What Matters to Me*** categories and Trust Values; ***Everyone Matters, Working Together, Dignity & Care & Open and Honest.***

The Trust-wide themes drawn from the concerns identified in complaints that relate to the MFT Values and What Matters to Me (WMTM) categories for this quarter are shown in **Graph 6**. This is the fifth quarter that this information has been gathered and the graph demonstrates that collection of this data continues to be challenging. The Head of Customer Services has reviewed the collection of this data and continues to support the Complaint Case Managers in identifying and capturing the Trust Values and What Matters to Me issues within each complaint.

This quarter 77 of the 413 new complaints, contained concerns which aligned with the MFT Trust Values compared to 27 out of 438 new complaints received in Q2, 2019/20.

Graph 6: Complaints – Theming of complaints to MFT Trust Values and WMTM categories for Quarter 2, 2019/20 and Quarter 3, 2019/20



4. Care Opinion and NHS Website feedback

4.1 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.

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

4.3 This quarter, 69.6% of the NHS Website and Care Opinion feedback comments received were positive. This represents an increase of 4.6% compared to Q2 when the overall positive comments represented 65% of the total. Negative comments equated to 21.7% of the overall total received this quarter, which compared to 25% during Q2 reflects a decrease of 3.3%.

4.4 This quarter a total of 32 positive comments were received; this is a decrease of 5 compared to the last quarter but is consistent with the overall reduction in the number of comments in Quarter 3.

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

4.6 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/ M/TLCO in Q3, 2019/20.

Number of Postings received by Hospital/ MCS/ M/TLCO Q3, 2019/20			
Hospital/ Managed Clinical Service (MCS)	**Positive**	**Negative**	**Mixed**
Manchester Royal Infirmary	**7**	**3**	**0**
Wythenshawe, Trafford, Withington and Altrincham	**15**	**4**	**3**
Clinical Scientific Services	**1**	**1**	**0**
Corporate Services (Estates and Facilities)	**0**	**0**	**1**
Manchester Royal Eye Hospital / University Dental Hospital of Manchester	**3**	**0**	**0**
Manchester & Trafford Local Care Organisation	**0**	**0**	**0**
Royal Manchester Children's Hospital	**2**	**0**	**0**
St Mary's Hospital	**4**	**2**	**0**
Overall MFT Total	**32 (69.6%)**	**10 (21.7%)**	**4 (8.7%)**

4.7 **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 Q3, 2019/20.

Quarter 3 , 2019/2020
Phlebotomy, Altrincham General Hospital
Patient gave the Phlebotomy Service at Altrincham General Hospital a rating of 4 stars. I recently went for my annual blood tests. Due to the new appointment service I literally waited ten minutes before I was seen, however the phlebotomist that took my blood left me with horrific bruising on my arm. It was also very uncomfortable whilst the phlebotomist took the blood. I had had blood work done the day before at Wythenshawe Hospital and never felt a thing and no bruising. I have been having bloods done for 30 years and have never had such bruising. Visited in September 2019. Posted on 01 October 2019
Response
Thank you for your feedback. We are sorry to learn that your experience was not as positive as we would hope on your attendance at Altrincham Hospital Phlebotomy Department. It is important to us that comments are shared with staff and seen as an opportunity to make changes and improvements wherever possible to services at the hospital. The Medical Day Unit Ward Manager explains that bruising can occur due to the nature of the procedure and reactions occur on an individual basis dependent upon many contributing factors which may lead to a person experiencing bruising who has never bruised previously. The Ward Manager has discussed your experience with the phlebotomy staff and reiterated the need to be more understanding of how a patient is feeling when they are having their bloods taken, offer an explanation of what to expect regarding bruising and discomfort, especially if the extraction has been particularly difficult.

Accident & Emergency, Manchester Royal Infirmary
I would just like to thank the paramedics and A&E staff for looking after my daughter so well when she was admitted in October with severe food poisoning. We were a long way from home but the service and care we received from you all was great. You are all doing an amazing job in difficult circumstances. Once again a massive thank you. Visited in October 2019. Posted on 13/10/2019
Response
Thank you for your comments posted on the NHS website regarding the care your daughter received at the Accident and Emergency Department at Manchester Royal Infirmary. It was very kind of you to write and compliment the staff as it is always good to receive positive feedback that reflects the hard work and dedication of our staff. It was reassuring to hear that you had such a positive experience in an unfamiliar environment. I can assure you that we have passed on your thoughts to the Lead Nurse who will share your comments the staff involved.

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 Q3 2019/20. MRI's Renal Transplant Service presented one case at the November 2019 meeting.

5.2 The learning identified from the case 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 Q3, 2019/20.

Hospital/ MCS	Learning	Actions
MRI (Renal Transplant)	Delay in escalation/delay in implementation of Zero Tolerance Policy/Behavioural Contract	To be reviewed through the Complex Patient Pathway improvement work
	Limited recognition/understanding of how best to manage inappropriate behaviours and needs of complex patients	
	Consideration to be given to develop a process for dedicated named consultant for long term in-patient management	

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 9 cases under the review of the Parliamentary and Health Service Ombudsman at the end of Q3 compared to 7 under review at the end of Q2.

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/ MCS.

Table 7: Overview of PHSO Cases open as at 31st December 2019

Hospital/ MCS	Case/s	PHSO Investigation Progress
MRI (2)		
GI Medicine & Surgical Specialties	1	Awaiting draft report
Cardio-Vascular Specialties	1	Awaiting final report
WTWA (5)		
Heart & Lung (Cardiology)	1	Awaiting final report
Surgery (General)	1	Awaiting draft report
Heart & Lung (Respiratory)	1	Awaiting draft report
Heart & Lung (Cardiology)	1	Awaiting draft report
Surgery (Oral)	1	Awaiting draft report
RMCH (1)	1	Awaiting draft report
SMH (1)	1	Awaiting draft report
Total	**9**	

6.3 The PHSO closed 1 case in this quarter; this case was not upheld. The Trust was not asked to pay any financial redress in this quarter. This compares to £1,200 financial redress (2 cases) in the previous quarter and no financial redress in Q1.

Table 8: PHSO closed case in Quarter 3, 2019/20 presented by outcome.

Hospital/ MCS	Outcome	Date original complaint received	PHSO Rationale/ Decision	Recommendations
WTWA (Medicine)	Not upheld	16/04/18	No failings identified	None

7. Learning from Feedback

Implementing Learning to Improve Services

7.1 All Hospital/MCS/LCOs regularly receive their complaint data and review the outcomes of complaint investigations at the Hospital/MCS/LCO 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/MCS/LCO.

Table 9: Examples of the application of learning from complaints to improve services, Q3, 2019/20

Hospital/ MCS	Learning & Improvements
RMCH	**Communication:** A complaint was received from a patient's mother raising concerns that following her son's attendance in the Paediatric Emergency Department

	(PED) in October 2019 and following an X-ray the doctor in PED did not diagnose a fractured jaw and the patient was discharged with the advice and exercises for his jaw. **As a result of the complaint and to avoid a similar incident happening in the future the following actions were agreed**: ▪ A new electronic protocol for referrals to a Max Fax clinic from PED has been implemented. ▪ The PED doctor who initially interpreted the patient's X-ray has reviewed their practice and reflected on the case. Discussions have taken place with the doctor's supervisor and learning points have been documented in their portfolio.
MRI (GI Medicine & Surgical Specialties)	**Communication:** The mother of a deceased patient raised a formal complaint regarding communication. The patient had mild learning disabilities and the patient's mother questioned if, following the patient's death, a Learning Disability Mortality Review (LeDer) been carried out. The patient's mother asked for a copy of the review and the actions taken as a result. **As a result of the complaint the following actions were agreed:** ▪ A retrospective LeDer review to take place and to include a review of why the patient's learning disability was not originally flagged on the hospital system (which would be the usual process). ▪ Once completed a copy detailing the key findings and planned improvement actions will be shared with the patient's mother.
MLCO (Central)	**Patient Experience:** A patient was referred to the Macmillan Team for advanced care planning by their GP who advised the patient that the Macmillan Team would undertake their blood tests. The GP was not aware that members of the Macmillan Team did not have venepuncture training/skills and were unable to take blood. This led to frustration for the patient and resulted in the patient's son making a formal complaint. The patient's son also felt that the seriousness of the patient's diagnosis was not explained properly to him whilst attending hospital appointments. **As a result of the complaint the following actions were agreed:** ▪ All clinical members of the Macmillan Team to undertake venepuncture training. ▪ A daily huddle has been introduced with representation from the District Nursing Team, Macmillan Team and medical consultant input to discuss individual patient care. An invite is extended to GPs. ▪ Weekly Specialist Palliative Care Multidisciplinary Team meetings are held with the Hospital Palliative Care Team which increases awareness of admission/discharge planning issues for patients and their families. ▪ Continuing Healthcare training is in place for all Community Macmillan Nurses.
MREH	**Patient Experience:** A patient complained as the appointment letter did not explain what her

	appointment was for. The patient asked a Nursing Assistant who should have been able to look into the patients query and find out which specific clinic the patient was booked to attend. The Nursing Assistant was not found to be helpful. The patient felt she was not listened to and not treated compassionately. **As a result of the complaint the following actions were agreed:** ▪ The MREH has an Outpatient Improvement Board. The intention of this Board is to review current working practices across all areas of responsibility. By reviewing existing processes in full, MREH will look at improvements that need to be made, to provide effective support for patients and improve the patient experience. The Matron for Outpatients is part of this Board and will ensure that the patient experience of attending clinic is considered as part of the improvement programme. ▪ Outpatient Department Unit Manager to ensure that all nursing staff will learn from the complaint and training for the staff member reinstated. ▪ Letters to patients to be revised to include information regarding pupil dilation.
UDHM	**Patient Experience:** The patient's daughter complained regarding her mother's regular attendances in the Oral Maxillofacial Surgical Department. She raised concerns as each appointment attended with her mother was between 2- 3 hours behind the given appointment times and no consideration was given to patients for their discomfort, pain or inconvenience during these waits. She was also concerned that patients were asked to attend 15 minutes before their appointment time which also added to the waiting time. **As a result of the complaint the following actions were agreed:** ▪ Assign a Waiting Times Champion who will ensure that patients and the reception staff are always aware of any delays ▪ Provide feedback from the patient to the Outpatient Letter Improvement Board ▪ Explore options for drinking water to be available to patients at all times during clinics
CSS	**Trust Values: Open and Honest** The Mother of a deceased patient asked the MP to raise a formal complaint because HM Coroner was waiting for the post-mortem report. **As a result of the complaint the following actions were agreed:** ▪ All deaths under investigation, including post mortem examinations to be monitored to ensure all post mortem reports are released to the Coroner in a timely manner.
WTWA (Division of Medicine)	**Patient Experience:** The patient's wife raised concerns regarding her husband's nutritional needs not being met during his stay in hospital and staff not following Speech and Language Therapy (SALT) guidelines. **As a result of the complaint the following actions were agreed:**

	▪ Food ordering process changed in line with Hospital's process. ▪ Raising awareness of new food order process. ▪ SALT training provided to all nursing staff. ▪ Chef employed to ensure continuity of service within the kitchen team.

8. Equality and Diversity Monitoring Information

8.1 **Table 10** provides Equality and Diversity information gathered from complainants for this quarter. During this quarter in accordance with the Equality Act 2010 and Service Equality Monitoring and in addition to the use of the Equality Monitoring Form, Complaint Case Managers have started to utilise the patient's electronic records to obtain this information if available.

Table 10: Quarter 3, 2019/20 Equality and Diversity Monitoring Information

Disability	**No.**
Yes	31
No	55
Not Disclosed	327
Total	**413**
Disability Type	
Long-Standing Illness Or Health Condition	0
Learning Difficulty/Disability	19
Mental Health Condition	3
No Disability	0
Other Disability	1
Physical Impairment	4
Sensory Impairment	4
Not Disclosed	382
Total	**413**
Gender	
Man (Inc. Trans Man)	174
Woman (Inc. Trans Woman)	234
Non Binary	0
Other Gender	0
Not Specified	5
Total	**413**
Sexual Orientation	
Heterosexual	84
Lesbian / Gay/Bi-sexual	1
Do not wish to answer	0
Other	0
Not disclosed	328
Total	**413**
Religion/Belief	
Buddhist	1
Christianity (All Denominations)	44
Do Not Wish To Answer	0
Muslim	8
No Religion	24

Other	6
Sikh	0
Jewish	0
Hindu	1
Not disclosed	329
Total	**413**
Ethnic Group	
Asian Or Asian British - Bangladeshi	1
Asian Or Asian British - Indian	5
Asian Or Asian British - Other Asian	4
Asian Or Asian British - Pakistani	12
Black or Black British - Black African	10
Black or Black British - Black Caribbean	2
Black or Black British - other Black	1
Chinese Or Other Ethnic Group - Chinese	1
Mixed - Other Mixed	0
Mixed - White & Asian	3
Mixed - White and Black African	2
Mixed - White and Black Caribbean	0
Other Ethnic Category - Other Ethnic	3
White - British	193
White - Irish	7
White - Other White	6
Not Stated	163
Total	**413**

9. Quality Improvements

Improvements Q3, 2019/20

9.1 In-house Complaints Letter Writing Training Package

Work continued during this quarter refining the Complaint Response Writing training package and this will be fully piloted during Quarter 4. Roll out of the training course is planned for Quarter 1, 2020/21 following dissemination of the training package to the Complaints Case Managers.

9.2 PHSO Research

Frontline Complaint Handling – 'Complaints Standards Framework for NHS Staff'

The PHSO's work to develop a Complaints Standards Framework in partnership with stakeholders from across the NHS continues. During this quarter the PHSO held further workshops to get more feedback on the Framework and the Shelford Group Complaints Leads were asked to join the PHSO to give their feedback on the first draft of the Framework, and to make helpful suggestions to enhance it.

The PHSO is now in the process of gathering the feedback received from Complaints Managers and other stakeholders and plans, in Spring, to hold a public consultation on the final version of the Framework.

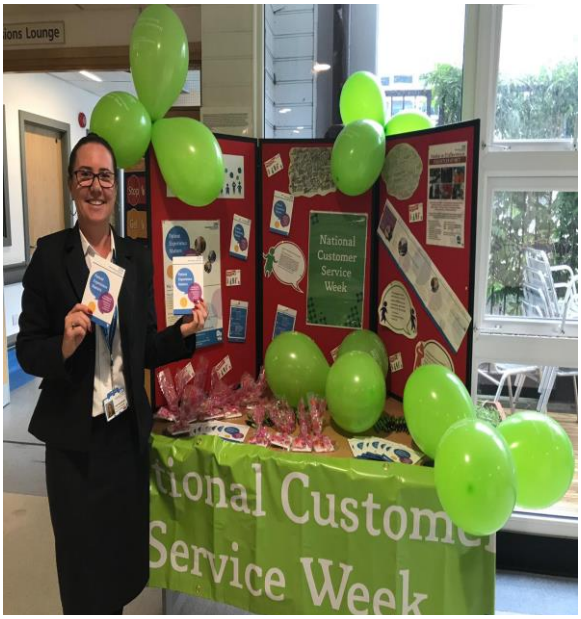
Image 1: PHSO Complaints Standards Framework Logo

9.3 National Customer Service Week

National Customer Service Week

During this quarter the PALS and Complaints team celebrated the importance of customer service and that of the staff who care and support its patients, relatives and carers on a daily basis.

Promotional stands were set up across the Oxford Road Campus and Wythenshawe and Trafford Hospitals raising awareness of customer service and the vital role it plays in delivering a good patient experience.



Picture 1: Complaints Case Manager, Toshi McDwyer promoting National Customer Service Week

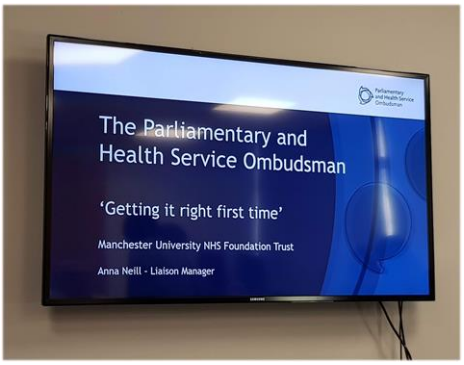
9.4 Educational Sessions

Following the previous successful educational sessions for staff involved in responding to complaints during this quarter a number of further sessions have been delivered:

- The PHSO facilitated a further educational session at Wythenshawe Hospital.

Image 2: Trust Flyer promoting PHSO Education Session

- The PHSO also provided an education session to the matrons participating in the Trust's Making Matrons Matter Leadership Programme.



Picture 2: Parliamentary and Health Service Ombudsman presentation at Matrons Matter

- The Head of Customer Services also facilitated an educational session to the senior staff of the Trust's Safeguarding team.

Further complaint educational sessions will continue throughout Q4, 2019/20 and 2020/21.

9.5 **Newcastle Hospital Peer Visit**

During this quarter the Associate Director of Nursing and the Head of Patient Experience, from Newcastle upon Tyne Hospitals NHS Foundation Trust met with representatives of the Patient Services Team.

Their visit was to learn about the delivery of the Trust's PALS, complaints, patient experience, and interpretation and translation services.

The visitors expressed their gratitude for the visit and were complementary in relation to the Trust's approach to delivering outstanding patient experience.

9.6 **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/ M/TLCO and during this quarter 56 responses to the survey were received compared to 19 responses in the previous quarter.

Survey results for Quarter 3, 2019/20 indicate:

- 76.36% of complainants felt that they received acknowledgement of their complaint within an acceptable timeframe.
- 71.15% of complainants felt they were informed of a timescale for the Trust to respond to their complaint and were satisfied with this, with a further 13.46% being informed of a timescale, but were not satisfied with this.
- 62.26% of complainants felt they received the outcome of their complaint within the given timescales.
- 61.82% of complainants felt the outcome of their complaint was explained to them in a way that they could understand.
- 61.11% of complainants felt they had a single point of contact at the Trust who they could approach if they had any questions.
- 57.14% of complainants felt they were taken seriously when they first raised their complaint.

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

- 34.55% of complainants felt that when they made their complaint they were not made aware of the support available to them from another organisation e.g. advocate.
- 20% of complainants sought an additional response for the points that were not addressed.

Comments received during Quarter 3, 2019/20 include the following:

- Very quick, supportive and informative.
- The improvements that were to be made showed that there was a genuine care for patients and changes would reflect on the experiences of patients, so that future mistakes or negligence could be prevented. This was really reassuring and most satisfactory solution.
- Felt as if my complaint was undermined. Felt as if the same reasons were given, and my points not addressed correctly.
- I now feel confident I can get answers and support in a timely manner.
- The doctor looking after me at my next appointment properly explained things instead of brushing things and rushing the appointment.
- Impressive as you highlight actions to be taken.
- I felt the response was quite defensive and not appreciate of the emotional impact.
- This was the second attempt and it worked well, this time round, compared to the first.

Future Planned Improvements

9.7 **Education and Training**

In-house Customer Service e-learning package

Following the successful application for funding for the development of the non-medical workforce from Health Education England (HEE), during Q3 work commenced and will continue during Q4 to develop an e-learning Customer Service package tailored specifically to meet the needs of the Trust.

Upon completion the e-learning package will be available to all staff within the Trust at two levels, allowing a blended approach, which in turn will ensure staff will be upskilled in the most effective way possible.

9.8 **Communications – External and Internal**

Clearly displayed and easily accessible complaints information

The NHSI Patient Experience Improvement Framework (2018) recommends complaints information is clearly displayed on the Trust's website and available within two clicks. With this in mind during this quarter a full review of the resources available on the Trust's website for PALS and complaints has been undertaken. Whilst it is recognised there are good levels of accessibility on the website, continuous improvement is always fundamental and modifications are planned to the 'PALS & Complaints' section during Q4 and throughout Q1, 2020/21.

In addition to these modifications and the Trust's continued approach to make MFT's website more accessible to the Deaf community, the Head of Customer Services will be working closely with the Trust's Inclusion Programme Manager throughout 2020/21 creating a short British Sign Language video replicating the PALS & Complaints information on the Trust website.

New MFT Trust intranet

As part of the Trust's ongoing work migrating departmental information from the pre-existing intranet site to MFT's brand new modernistic site, during this quarter the PALS team updated and transferred all information on to the new 'PALS & Complaints' section on the brand new intranet site.

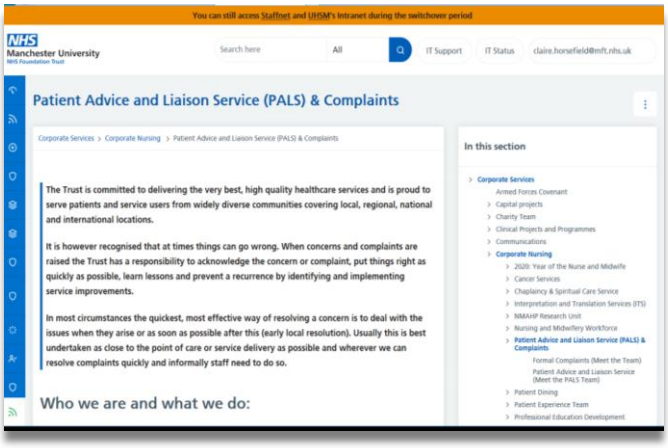


Image 3: The Trust's Intranet page promoting the Trust's PALS & Complaints Service

Further updates to this section of the intranet will continue throughout Q4, 2019/20 and 2020/21.

9.9 **Standard Operation Procedures (SOPs)**

Review and updating of the Complaints and PALS SOPs will continue during the remainder of 2019/20 and throughout 2020/21.

10. Conclusion and recommendation

The 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/LCO 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, the Trust will:

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

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Professor Cheryl Lenney, Chief Nurse
Paper prepared by:	Anne-Marie Varney, Assistant Chief Nurse (Workforce)
Date of paper:	March 2020
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 • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	(Impact of report on key priorities and risks to give assurance to the Board that its decisions are effectively delivering the Trust's strategy in a risk aware manner) 1. Patient Safety 2. Patient Experience 3. Productivity and Efficiency
Recommendations:	The Board of Directors is asked 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 September 2019 outlining the trusts position against the NQB standards. This paper will provide analysis of the Trust nursing and midwifery workforce position at the end of **December 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. The report will also include the first summary of the Allied Health Professions (AHP) workforce as per the NHSI guidance.

1.3 Nationally nursing and midwifery workforce supply remains challenging with the shortfall in registered nurses being well-documented across all NHS providers. NHS Trusts are reporting a shortage of almost 145,000 staff, representing 1 in 11 posts. Forecasts suggest this gap could reach almost 250,000 by 2030 if current trends continue without significant action. There are **41,000** vacancies in nursing which equates to 1 in 8 posts 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[3].

1.4 At the end of December 2019 there was a total of **537.5wte (7.1%)** qualified nursing and midwifery vacancies across the Group compared to **820.3wte (11.6%)** at the end of June 2019. This is a reduction in the overall nursing and midwifery vacancies of **282.8wte (4.5%)** since June 2019**.** The majority of vacancies are within the Staff Nurse (band 5) workforce. At the end of December 2019 there were **368.0wte (9.2%)** compared to **567.1wte (14.2%)** at the end of June 2019. This is a reduction of **199.1wte (5%)** nursing and midwifery band 5 vacancies.

1.5 Trust wide recruitment campaigns continue to attract experienced nurses as well as newly qualified nurses and midwives due to qualify in September 2020. There are currently **224** nurses and midwives with conditional job offers whose appointments are being processed through the Trust recruitment process. There are **90** candidates due to commence in post over the next 3 months with **134** due to graduate in September 2020.

[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
[3] State of Maternity Services Report 2108- England

1.6 A total of **233** international nurses have commenced in post since April 2019 with a further **148** nurses expected to arrive before the end of March 2020 bringing the total to **381** for 2019/20. This is a significant increase on the number of nurses recruited in previous years.

1.7 The first cohort of **67** Nursing Associates have been working within the trust since Jan 2019, across general ward and community-based areas with a further **70** trainees due to qualify in June 2020. Significant work has been undertaken to enhance the skills of the Nursing Associates and to ensure the role is safely and appropriately embedded within the nursing workforce. The hospitals are continuing to review ward/team establishments and skill mix as the NA workforce continues to grow and be introduce into clinical areas.

1.8 The Trust has seen an improved workforce position since April 2019 in comparison to the previous year however, it is acknowledged that this improvement has been largely achieved due to the increase in IR nurses **(300** additional nurses) joining the Trust over the last 12 months. Whilst the improved position supports the hospitals/MCS to achieve their workforce plans there is recognition that more work is required to maximise domestic recruitment and specifically nurse retention.

1.9 In December 2019, the sickness absence rate for the registered nursing and midwifery staff group was reported at **5.30%**. This is above the Trust target of 3.60%, and is a slight increase on the December 2018 position when the registered nursing and midwifery sickness absence was reported at **5.22%.** WTWA have seen the biggest improvement in registered nurse sickness absence which has reduced from 6.6% in December 2018 to 5.4% in December 2019. Managing sickness absence continues to be a key priority within each individual hospital/MCS. The electronic Absence Manager System is currently used by WTWA and has recently been rolled out to SMH, CSS and Corporate Services. There is a plan to launch the system across the remaining hospitals/MCS (REH, RMCH and MRI) before the end of March 2020.

1.10 The Trust is committed to the delivery of safe staffing levels. An annual programme to review inpatient ward nursing establishments has commenced across the hospitals/MCS. Reviews will be undertaken using an evidence based approach and applying the Safer Nursing Care Tool (SNCT) to ensure staffing levels meet the acuity and dependency of patients within each ward environment. There are **61** wards (out of 71) across WTWA, MRI and RMCH where the SNCT tool is valid to support establishment reviews. Census data from these areas has been analyzed and each ward area will complete a detailed establishment review undertaken by the senior nurse to consider the SNCT results together with patient quality and safety outcomes.

1.11 There are **39** wards where the funded establishment is within 10% of the recommended SNCT establishment. It is recommended that the funded establishment remain unchanged for these areas to account for any seasonal variation and increase in patient activity/flow. There are **10** wards where the recommended establishment is 10% greater than the existing funded establishment.

The Heads of Nursing are undertaking a detailed workforce assessment of these areas to consider the census data, skill mix, patient outcomes and ward staff feedback. Data from **12** wards has been found to be inconsistent and unreliable and as such these wards will be required to complete census collections in January and June 2020 before undertaking an establishment review.

1.12 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. The Trust has seen some improvement in nursing and midwifery turnover the number of newly qualified nurses and midwives leaving the Trust remains high with **38%** leaving the Trust are within the first two years in post, with half of these leaving within the first 12 months. This is an improved position compared to the same period in 2018 when 45% of nurses were leaving the trust within the first 2 years of joining.

1.13 In October 2019, MFT was selected to join the NHSI/E Direct Support Retention programme. NHSI/E will work with the Trust through a targeted, clinically-led support model to support the trust to improve turnover rates. Through the use of learning resources the Trust have access to good practice and case studies implemented by other Trusts. A Corporate retention plan in line with the NHSI programme guidance has been developed and will focus on the band 5 nursing and midwifery workforce. It is expected that investment in these areas will reduce the reliance on the use of bank and agency staff and support financial sustainability.

1.14 There is currently no recognised national shortfall within generalist AHP therapists for adult services however speciality posts such as acute Occupational Therapists (OT), paediatric specialist OTs, Dietetic (DT) and Speech and Language Therapists (SLT) due to lack of paediatric training in pre-registration courses. There are **69wte (4.2%)** vacancies across the AHP workforce with most vacancies in the MLCO/TLCO. Several Trust wide initiatives have been introduced to support the development of the AHP workforce and creating new opportunities and roles.

1.15 The Board of Directors are asking to receive this paper and note progress of the work undertaken to address the nursing, midwifery and AHP vacancy position across the Group.

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 report will provide analysis of the Trust nursing and midwifery workforce position at the end of **December 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. The report will also include the first summary of the Allied Health Professions (AHP) workforce as per the guidance.

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/MLCO Boards. The December 2019 reports have been presented to the hospitals/MCS/MLCO Boards and inform this report.

3. National Context and Guidance

3.1 Nationally nursing and midwifery workforce supply remains challenging with the shortfall in registered nurses being well-documented across all NHS providers. NHS Trusts are reporting a shortage of almost 145,000 staff, representing 1 in 11 posts. Forecasts suggest this gap could reach almost 250,000 by 2030 if current trends continue without significant action. There are **41,000** vacancies in nursing which equates to 1 in 8 posts 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 increased demands for health and social care together with an unprecedented political landscape presents an ever increasing challenge in addressing nursing workforce shortages and growth:-

- High number of nurses leaving the NHS and the profession every year, equating to 7,000 staff members year on year.
- An aging workforce with an increase of nurses and midwives predicted to reach retirement age within the next 5 years.
- A growing population which is expected to increase a further 11% to 62 million by 2041.

[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

- An aging population, as well as evolving healthcare needs, such as the increase in cases of obesity, diabetes and antibiotic resistance.
- Increasing acuity and dependency of patients with many patients required enhanced supervision.
- Advances in medicine and technology requiring a wider range of healthcare services to be provided.

3.3 The demand for staff to support these factors exceeds the supply available to many Trusts who are competing to recruit from the same supply of nurses. Ensuring the Trust meets safe staffing levels continues to be a big challenge.

3.4 In 2019 the Universities and Colleges Admissions Service (UCAS) have reported an increase of 6.7% in the number of applications to join nursing programmes with a 6.4% increase from 2018 in acceptances onto Nursing programmes in England alone. The rise in applicants is driven by 10% increases in those aged 18,19 and 35 years or over. This suggests a change in demand following two years of falling applicant numbers following the reform in financial support and withdrawal of the bursary for nursing and midwifery programmes in August 2017. The rise in applicants also comes after the recent recruitment campaigns by the NHS.

3.5 The government has pledged to train, recruit and retain an additional 50,000 nurses by 2024/25. To support this ambition, it has announced that from September 2020[8] students studying the nursing, midwifery and allied health subjects will receive a non-repayable and non-means tested grant of at least £5,000 a year, in addition to existing mainstream student support. In addition, the government advised there will be up to £3,000 further funding available to attract students to the highest priority subjects based on the government's assessment of vulnerability and workforce priorities. The government has advised the funding will be offered to existing students as well as new course entrants.

3.6 In October 2018, NHSI published The Developing Workforce Safeguard's Guidance[9] 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.

3.7 In January 2019, NHS England published the NHS Long term Plan (LTP)[10] 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[11] was published in June 2019 and commits to a workforce implementation plan to lay the

[8] https://www.gov.uk/government/news/nursing-students-to-receive-5-000-payment-a-year
[9] NHSI 2018, Developing Workforce Safeguards: Supporting providers to deliver high quality care through safe and effective staffing. NHS Improvement, London
[10] DH (2019) NHS Long Term Plan. Department of Health, London

[11] DH (2019) Interim NHS People Plan. Department of Health, London

foundations to achieve this ambition. The full NHS People Plan is due to be published in April 2020. The MFT People 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.

3.8 In Feb 2019, NHSI launched a national Safe Staffing Fellow programme in collaboration with The Shelford Group and supported by the Chief Nursing Officer for England. The programme has been designed to support organisations develop evidence-based approaches to effective staffing decisions, taking into account all elements that contribute to safe, effective care and quality patient experience. The Chief Nurse has supported 2 senior nurses within the Trust to join the faculty which aims to build a team of experts that will sustain best practice and embed their knowledge and skills to develop safe and effective workforce solutions.

3.9 The Trust has been invited to undergo a table top analysis by NHSE/I to support a national review to understand the extent to which the recommendations in '*Developing Workforce Safeguards'* have been implemented and if there are any key areas for focus which may arise requiring further consideration at a national level. This review will be supportive in nature providing an opportunity for the Trust to review their current position against the recommendations prior to the Annual Governance Statement process which will take place in 2020 in all Trusts. Following the assessment a work programme will agreed to support achieving the recommendations, and outcomes will be monitored through NMAHP Professional Board and HR Scrutiny Committee.

4. Greater Manchester Context

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

4.2 GM Provider organisations and 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 **10.8%** in the number of nursing and midwifery students commencing a programme of education in September 2019 in comparison to September 2018; which equates to an additional 132 students. The HEIs anticipate they will be able to recruit to the additional numbers requested by the GM Chief Nurses for their programmes that commence in January/February 2020. 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 £450,000 additional placement infrastructure funding from NHSI; to grow pre-registration nursing clinical placement capacity for the 2019 intake, and support students in practice. MFT have utilised their allocation of 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 in the current academic year.

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 the new programmes commenced from September 2019.

4.6 Following the success of the GM Nurse Recruitment campaign, 'Be a Greater Manchester Nurse'[12] phase 3 of the campaign commenced January 2020 utilising impact evaluation intelligence from the previous campaigns. Following conclusion 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 nurses to return to practice *'We are Returning Nurses',* a specifically targeted GM project for the recruitment of Return to Practice (RTP nurses has commenced to develop a GM wide Employer Led RTP model in association with Manchester Metropolitan University (MMU).

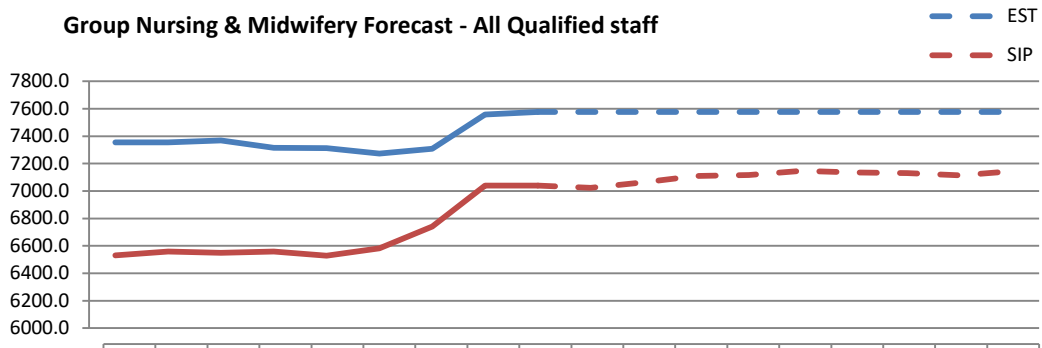
5 MFT Workforce Position

5.1 At the end of December 2019 there was a total of **537.5wte (7.1%)** qualified nursing and midwifery vacancies across the Group compared to **820.3wte (11.6%)** at the end of June 2019. This is a reduction in the overall nursing and midwifery vacancies of **282.8wte (4.5%)** since June 2019**.**

5.2 **Graph 1** provides the overall nursing and midwifery vacancy trajectory until the end of Quarter 2 (2020/21). The nursing and midwifery vacancy position is much improved from the previous year with an additional **204wte** nurses and midwives in post in December 2019. Recent workforce modelling predicts there will be **430.9wte** nursing and midwifery vacancies at the end of September 2020 which will be a reduction of **230wte** vacancies compared to the same period in 2019. The vacancy position is expected improve in Q3 following the graduation of newly qualified nurses and midwives.

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

Graph 1

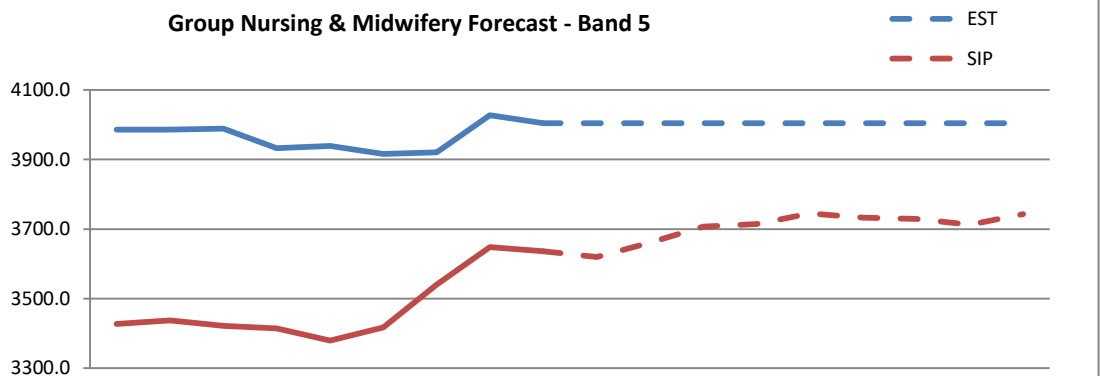


	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
EST	7353.	7353.	7368.	7316.	7312.	7272.	7309.	7557.	7576.	7576.	7576.	7576.	7576.	7576.	7576.	7576.	7576.	7576.
SIP	6529.	6559.	6548.	6557.	6527.	6581.	6740.	7040.	7038.	7022.	7063.	7109.	7117.	7147.	7135.	7131.	7115.	7145.
Vacancies	824.1	794.0	820.3	758.3	784.9	691.1	568.6	517.6	537.5	553.8	512.2	466.2	459.1	428.9	440.4	444.8	461.0	430.9

5.3 The majority of vacancies are within the Staff Nurse (band 5) workforce. At the end of December 2019 there were **368.0wte (9.2%)** compared to **567.1wte (14.2%)** at the end of June 2019. This is a reduction of **199.1wte (5%)** nursing and midwifery band 5 vacancies.

5.4 **Graph 2** illustrates the Group-wide band 5 workforce position until the end of Q2 (2020/21). The Band 5 nursing and midwifery vacancy position is much improved from the previous year with an additional **208wte band 5** nurses in post in December 2019. The workforce modelling predicts there will be **237.5wte** band 5 nursing and midwifery vacancies at the end of September 2020 which will be a reduction of **230wte** vacancies compared to the same period in 2019. The vacancy position is expected improve following the graduation and appointment of newly qualified nurses and midwives in Q3.

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	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
EST	3985.	3985.	3988.	3932.	3939.	3915.	3920.	4027.	4004.	4004.	4004.	4004.	4004.	4004.	4004.	4004.	4004.	4004.
SIP	3426.	3437.	3421.	3414.	3379.	3417.	3540.	3648.	3636.	3619.	3661.	3707.	3714.	3744.	3733.	3728.	3712.	3742.
Vacancies	558.6	548.4	567.1	518.8	560.3	498.9	380.2	379.1	368.0	384.3	342.7	296.7	289.5	259.4	270.8	275.3	291.5	261.4

5.5 The continuing success of the Trust International Recruitment Programme (IR) in 2019/20 has resulted in an additional 266 nurses arriving to work in the Trust with an additional 110 nurses due to arrive before the end of March 2020.

5.6 MFT have 68 NAs registered with the NMC who are working across the hospitals and community settings. In June 2020, the second cohort of 67 trainee NAs will graduate bringing the total number of NAs working in the trust to 135. The hospitals are continuing to review ward/team establishments and skill mix as the NA workforce continues to grow and be introduce into clinical areas.

Nursing and Midwifery Turnover

5.7 At the end of December 2019, the 12 month rolling turnover rate for Nursing and Midwifery was **12.4%** and **15.0%** within the band 5 workforce (the national turnover rate for band 5 nursing and midwifery is **21.5%**). This is an improving position over the last 12 months when RN annual turnover was **13.2%** and band 5 turnover was **16.4%.**

5.8 Whilst the trust has seen some improvement in nursing and midwifery turnover the number of newly qualified nurses and midwives leaving the Trust remains high with **38%** leaving the Trust are within the first two years in post, with half of these leaving within the first 12 months. This is an improved position compared to the same period in 2018 when 45% of nurses were leaving the trust within the first 2 years of joining. Over 35% of leavers are recorded as going to another NHS Trust, with 11% leaving with no employment and 3% going to private healthcare.

5.9 In October 2019, MFT was selected to join the NHSI/E Direct Support Retention programme. NHSI/E will work with the Trust through a targeted, clinically-led support model to support the trust to improve turnover rates. Through the use of learning resources the Trust have access to good practice and case studies implemented by other Trusts. A Corporate retention plan has been developed and will focus on the band 5 nursing and midwifery workforce. Outcomes from the programme will be reported and monitored by NMAHP Professional Board. The Hospital/MCS Directors of Nursing (DONs) and HR Directors (HRDs) will continue to develop retention schemes within their own hospitals specific to their workforce requirements.

5.10 The retention plan will include the following key themes:-

- Diagnostics, reporting and monitoring
    - Understanding why staff leave
    - Review the exit interview process
- Engaging with staff
- Guaranteed job offer for MFT trained student nurses and midwives
- Providing opportunities for staff to stay
    - internal transfer scheme
    - retire and return
- Guaranteed job offer for MFT trained student nurses and midwives

Impact of EU Withdrawal

5.9 Following the recent parliamentary decision to support the EU withdrawal on 31st January all 'no deal' governance reporting has now ceased and therefore at present it is unclear what implications there may be for EU staff and the NHS.

5.10 The Trust currently employs **299.5wte** registered nurses and midwives from the EU which equates to 4.4% of the registered nursing and midwifery workforce. Over the past year, the Trust has reported a turnover rate of 20.3% (25.7% in 2018-19) within the EU national nursing and midwifery staff group against an average turnover of 12.2% for UK nationals. The Trust will continue to monitor turnover within this staff group as part of the nursing workforce planning.

Sickness Absence

5.11 In December 2019, the sickness absence rate for the registered nursing and midwifery staff group was reported at **5.30%**. This is above the Trust target of 3.60%, and is a slight increase on the December 2018 position when the registered nursing and midwifery sickness absence was reported at **5.22%.**

5.12 Managing sickness absence has been of high importance across the Trust and within each individual hospital/MCS. The electronic Absence Manager System is currently used by WTWA and has recently been rolled out to SMH, CSS and Corporate Services. The electronic system has provided managers with a streamlined process in managing everyday HR processes, highlighting a reduction in nursing and midwifery sickness rates across wards/departments. There is a plan to launch the system across the remaining hospitals/MCS (REH, RMCH and MRI) before the end of Mar 2020.

6. Recruitment

Domestic Recruitment

6.1 Trust wide recruitment campaigns continue to attract experienced nurses as well as newly qualified nurses and midwives due to qualify in September 2020. There are currently **224** nurses and midwives with conditional job offers whose appointments are being processed through the Trust recruitment process. There are 90 candidates due to commence in post over the next 3 months with 134 due to graduate in September 2020.

6.2 Following the recent launch of the Trusts recruitment branding 'All here for You' the Trust has developed a new nursing and midwifery attraction strategy to engage more candidates to careers within the organisation. The new branding is being developed to support hospitals/MCS recruitment campaigns and will be used at future recruitment events.

International Recruitment

6.3 There has been 522 band 5 overseas nurses join the Trust since May 2015. A total of **233** nurses have commenced in post since April 2019 with a further **148** nurses expected to arrive before the end of March 2020 bringing the total to 381. This is a significant increase on the number of nurses recruited in previous years.

6.4 The international recruitment campaign will focus on hard to recruit areas to support service delivery plans. A cohort of 38 nurses is due to arrive before the end of March 2020 to take up posts in Theatre areas and will undertake an in-house theatre practitioner training programme. This approach will be adopted to support other clinical services/areas as required.

6.5 When comparing the turnover of IR nurses compared to domestic nurses the turnover rate is 1.3% as compared to 15% for a domestic recruited nurses. The attrition rate is less than 1% within the first 3 years of joining the Trust. The Trusts improved nursing vacancy position over the last 12 months is as a direct result of the increase in IR nurses employed in the Trust as the number of band 5 domestic nurses joining the trust has remained unchanged for a third year. The workforce predictions and continuing improved vacancy position is dependent on continuing to recruit c300 IR nurses in 2020/21.

7. Nursing Associates

7.1 The first cohort of **67** Nursing Associates have been working within the trust since Jan 2019, across general ward and community based areas. Significant work has been undertaken to enhance the skills of the Nursing Associates and to ensure the role is safely and appropriately embedded within the nursing workforce.

7.2 The hospitals are continuing to review ward/team establishments and skill mix as the NA workforce continues to grow and be introduce into clinical areas. The NA role is to be introduced in theatre areas following a Quality Impact Assessment (QIA) and agreed competency training framework.

7.3 There are currently **236** Trainee Nursing Associates (TNAs) across the Trust of which **70** (cohort 2) are due to qualify in June 2020. Cohort 6 will commence on the TNA programme in March 2020. 9 out of the 64 recruited within this group have been allocated to complete the learning disability pathway. The trust will continue to train NAs through an apprenticeship model where affordable but is currently working in partnership with both Manchester Metropolitan University and University of Bolton on a self-funded Foundation degree programme that is due to commence in March 2020.

7.4 Nationally there are approximately 7000 NAs undertaking a validated programme. Health Education England (HEE) committed to recruit 7500 trainee nursing associates in 2019 with a commitment to recruit an additional 7500 in 2020. This recruitment strategy will support the plan to increase the Nursing Associate workforce further.

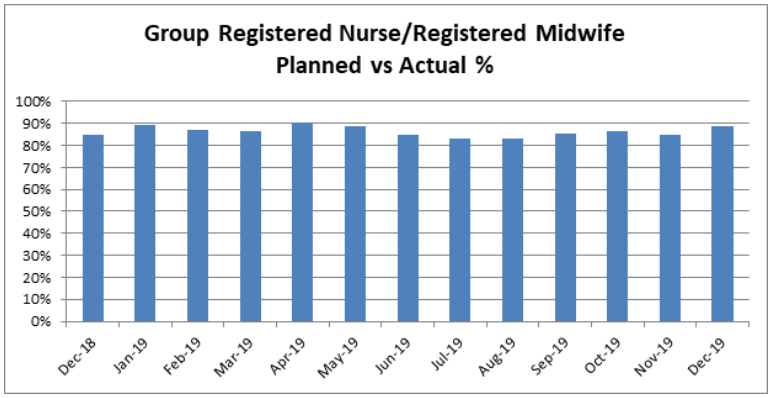
7.5 There are 5 NAs who have commence the shorted pre-registration student nurse training. The NAs will graduate in 18 months-time and intend to return to the Trust as registered nurses.

8. Safe Staffing

8.1 NHSI's Developing Workforce Safeguards Guidance (2018) builds upon the NQB Safe Staffing Guidance (2016) and is designed to help Trusts manage workforce problems. The recommendations focus on accountability and monitoring of nursing establishments and responding to unplanned changes in daily staffing. The guidance supports a triangulated approach to staffing decisions, combining evidence based tools such as the Safer Nursing Care Tool (SNCT), professional judgement and outcomes that are based on patient needs, acuity, dependency and risks.

8.2 A 'Safe Staffing Report' is submitted monthly to NHSI detailing the planned and actual staffing levels and care hours per patient day (CHPPD) which is extracted from the Health Roster System. **Graph 3** details the Trust registered nursing and midwifery fill rate which shows an average of 86.8**%** across the Trust over the last 12 months. The Trust continues to exceed the 80% fill rate target each month.

Graph 3



8.3 National guidance advises that boards must have local dashboards that cross checks quality metrics. The Hospitals/MCS receive a monthly report which provides a comparison of nursing and midwifery workforce and safe staffing data against quality outcomes. This allows the DONs to triangulate the data to influence decisions made around daily staffing and to support establishment reviews. On review of the planned staffing fill rate, there has been little direct correlation found between wards with a lower fill rate and nurse sensitive indicators including patient falls, pressure ulcers and venous thrombo-embolism.

9. Care Hours Per Patient Day (CHPPD)

9.1 Care Hours per Patient Day (CHPPD) is a nationally comparable metric for recording and reporting nursing and care staff deployment. CHPPD is calculated by dividing the number of actual nursing/midwifery (both registered and unregistered) hours available on a ward over a 24 hour period by the number of patients occupying a bed. It is widely acknowledged that CHPPD does not take into account hour by hour fluctuations in ward activity which can be more limiting to wards that have a high level of day case patient flow activity. However the CHPPD does provide a consistent figure for benchmarking nurse staffing levels against other Trusts.

9.2 The Trust refers to NHSI's Model Hospital in order to benchmark CHPPD against peers. **Table 1** outlines the Trust's CHPPD against the national average and peers in the Shelford Group over recent months. Comparing CHPPD to similar organisations can be helpful; however this is undertaken with caution when completing workforce reviews due to the configuration of services within each individual organisation. Very low CHPPD figures may indicate a potential patient safety risk, the Trusts current CHPPD figures provides assurance that the wards/departments are safely staffed.

Table 1

Month	Trust Average	National Average	Peer Average
Jun 19	8.9	8.1	8.1
July 19	9.2	8.3	8.2
Aug 19	9.5	8.2	8.1
Sept 19	9.0	8.0	7.9
Oct 19	9.0	8.2	8.2
Nov 19	9.3	8.1	8.1
Dec 19	9.5	8.1	8.0
Average	**9.2**	**8.1**	**8.0**

10. Daily Staffing

10.1 Daily staffing levels continue to be assessed across each shift to ensure they are adequate to meet patients' nursing needs, as recommended by NICE (2014). Reviews of staffing requirements are undertaken by senior nursing and midwifery staff at the daily 'staffing huddles' within each hospital/MCS. Escalation processes are in place to mitigate the impact of when planned staffing levels are not achieved to ensure the safe delivery of care. The Allocate SafeCare tool is utilised within the Hospital/MCS senior nurse staffing huddles to match daily staffing levels to patient acuity on each ward or department.

10.2 Both NICE and NQB guidance recommends Trusts have a mechanism to capture 'red flag' events to highlight shortfalls in daily staffing and omissions in care. Red flags are inputted within the Allocate SafeCare tool as risks to staffing are highlighted by ward staff. This provides senior nurses with immediate warning when a problem has been identified that could be a potential risk to the safety of patients, staff or both. A total of 1,335 red flags have been reported across the Trust since June 2019.

10.3 There are 7 wards/departments across the Trust that had a registered nurses vacancy factor above 25%. Workforce plans are in place to improve recruitment to these areas. Established escalation and monitoring processes are in place to ensure delivery of safe and effective staffing levels that meet the acuity and dependency of the patients in these areas.

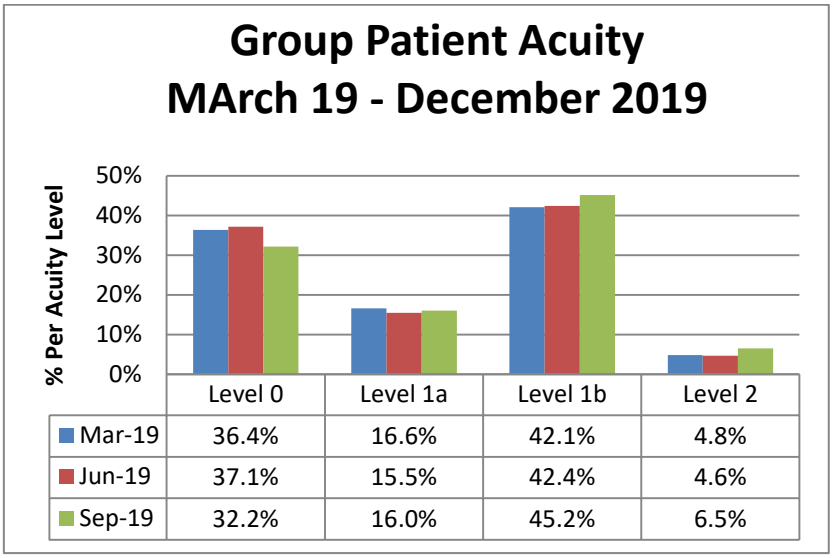
11. Nursing Establishment Reviews – Safer Nursing Care Tool (SNCT)

11.1 The SNCT was developed by the Shelford Chief Nurses and is endorsed by NQB and NHSI. The tool 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. The Trust has previously not used the tool in its intended manner and establishment reviews undertaken in previous years did not include this data.

11.2 NHSI recommends that establishment setting should be completed annually with a bi-annual review. The Hospitals/MCS have started to complete their annual establishment reviews using a triangulated approach, comparing SNCT data with quality outcomes and professional judgement within each inpatient ward department. A Standard Operating Procedure (SOP) has been developed to support senior nurses with this.

11.3 **Graph 4** demonstrates that acuity and dependency has remained relatively static over the last year amongst inpatient ward areas. The data 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 more dependent on nursing care to meet most or all of their activities of daily living and in many instances these patients are 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. This data enables senior nurses to make decisions relating to nurse establishment settings and appropriate skill mix reviews.

Graph 4



	Level 0	Level 1a	Level 1b	Level 2
Mar-19	36.4%	16.6%	42.1%	4.8%
Jun-19	37.1%	15.5%	42.4%	4.6%
Sep-19	32.2%	16.0%	45.2%	6.5%

11.4 The Shelford Chief Nurses have recently commissioned a review of the SNCT descriptors and tool to reflect an increase in patient acuity and new roles within the workforce such as the Nursing Associates. The SNCT for Emergency Departments (EDs) is under development and expected to be launch in 2020. This tool will support workforce decisions in EDs through assessment of patient acuity and activity within the department.

11.5 Over the last 12 months, the Hospitals/MCS have developed a wider understanding around the SNCT. Following completion of 3 census data collections there are **61** wards (out of 71) across WTWA, MRI and RMCH where the SNCT tool is valid to support establishment reviews. Census data from these areas has been analyzed and each ward area will require a detailed establishment review undertaken by the senior nurse to consider the SNCT results together with patient quality and safety outcomes. There are **39** wards where the funded establishment is within 10% of the recommended SNCT establishment. It is recommended that the funded establishment remain unchanged for these areas to account for any seasonal variation and increase in patient activity/flow. There are **10** wards where the recommended establishment is 10% greater than the existing funded establishment. The Heads of Nursing are undertaking a detailed workforce assessment of these areas to consider the census data, skill mix, patient outcomes and ward staff feedback. Data from **12** wards has been found to be inconsistent and unreliable and as such these wards will be required to complete census collections in January and June 2020 before undertaking an establishment review (see Hospital/MCS workforce summaries for further detail).

11.6 Future census collection periods will take place 6 monthly (Jan and Jun), to mitigate for seasonal variation. This will provide an adequate amount of data to support future establishment reviews.

Safe Staffing in Maternity services – Birth Rate Plus

11.7 Maternity and Neonatal care have been placed front and centre in the NHS Long Term Plan. The NHS Long Term Plan maintains the commitment to the Maternity Transformation Programme (MTP) and the key pledges around Continuity of Carer for most women by March 2021 along with halving the rates of stillbirths, neonatal and maternal deaths by 2025. In addition there are a number of important new aims for maternity, such as targeting Continuity of Carer at women from Black Asian and Minority Ethnic (BAME) backgrounds and other vulnerable groups; increasing access to perinatal mental health services; and new smoking cessation pathways for mothers and their partners. There is also an increased focus on digital solutions, including enabling 100,000 women to access their maternity record digitally from 2019/20, with expansion to the whole of England by 2023/24.

11.8 In 2017 the NQB published an improvement resource to support safe staffing of maternity services. The guidance endorses Birth-Rate Plus (BR+) Midwifery Workforce Planning Tool 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 with a higher clinical need. A BR+ study assesses the midwifery workforce based upon the needs of women and records data for a minimum of 3 months on all aspects of care provided by midwives from pregnancy through to postnatal care.

11.9 The Obstetric Strategy for Managing Capacity and demand has used local intelligence based on activity levels (births), length of stay, bed usage and professional judgement and cross referenced the outputs with the Birth Rate Plus ratio to agree midwifery establishments. The current uplift for SMH MCS is 21%, this does not include maternity leave and is lower than the Birth Rate plus recommendation (23-26%).

11.10 Saint Mary's Hospital MCS has worked alongside the Greater Manchester and East Cheshire Maternity Services to support funding to undertake a full review of midwifery staffing using the Birth Rate plus tool on both of the maternity sites. The data gathering has been commenced and an early indication of the position is anticipated in April 2020. This work will be monitored through the SMH MCS Executive Board and an update provided to NMAHP Professional Board. The Birth Rate plus team will also be considering the SMH and GM workforce against the Continuity of Care module.

Safe Staffing in Allied Health Professions – AHP Optimised Staffing Tool (APOST)

11.11 The Trust is working in collaboration with NHSI and the Shelford AHP Group to develop an evidence based workforce tool to determine optimal AHP staffing requirements. The tool will support the delivery of safe and high-quality patient care in line with level of dependency / acuity of the patient cohort. The AHPOST tool is being developed to describe AHP patient therapeutic care levels (priority & acuity), as well as dependency to determine safe staffing levels.

11.12 The Trust have been chosen alongside Imperial College Healthcare NHS Trust London to be a pre-pilot site to test the draft AHPOST tool together with the SNCT review and refresh process. After some initial testing the tool requires further development and therefore testing has been placed on hold. Progress on the work will be reported to the NMAHP Professional Board and an update provided to the Board of Directors in September 2020.

12. Hospitals and Managed Clinical Services Workforce

12.1 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. The breakdown of workforce data by ward is provided in the detailed workforce report (see appendix 1).

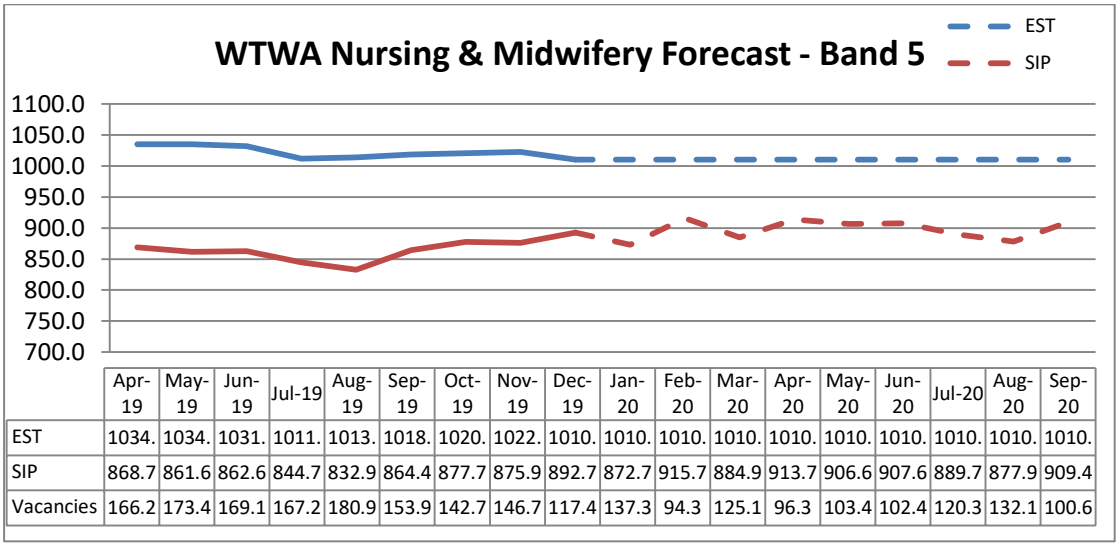
13. Wythenshawe, Trafford, Withington and Altrincham Hospitals (WTWA)

Workforce Position

13.1 At the end of Dec 2019, there was a total of **154.1wte (8.2%)** qualified nursing vacancies across WTWA. This is a reduction in overall nursing vacancies of **61.5wte** since June 2019. The Hospitals vacancy position is expected to improve by the end of Q2 when it is predicted there will be **109.1wte (5.8%)** vacancies. This will be a reduction of **87wte** vacancies when compared with the same period in the previous year.

13.2 The majority of the vacancies are within the Staff Nurse (band 5) workforce. **Graph 5** illustrates the WTWA band 5 workforce position until Sept 2020. At the end of Dec 2019 there was **117.4wte (11.4%)** band 5 vacancy which is a reduction of **50.8wte** vacancies since Dec 2018. The vacancy position is expected to improve by the end of Q2 when it is predicted there will be **100.6wte (9.5%)** vacancies. This will be an improvement on the same period in the previous year and a reduction of **53.3wte** vacancies.

Graph 5



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
EST	1034.	1034.	1031.	1011.	1013.	1018.	1020.	1022.	1010.	1010.	1010.	1010.	1010.	1010.	1010.	1010.	1010.	1010.
SIP	868.7	861.6	862.6	844.7	832.9	864.4	877.7	875.9	892.7	872.7	915.7	884.9	913.7	906.6	907.6	889.7	877.9	909.4
Vacancies	166.2	173.4	169.1	167.2	180.9	153.9	142.7	146.7	117.4	137.3	94.3	125.1	96.3	103.4	102.4	120.3	132.1	100.6

13.3 There are **46** Band 5 Staff Nurses currently in the domestic recruitment pipeline to start at WTWA before the end of March 2020. In addition, 56 IR nurses are due to start in the hospital before the end of March 2020 with 14 nurses specifically employed to work in theatres. The hospital is finalising workforce plans for 2020/21 to determine skill mix and workforce requirements. The improved band 5 vacancy position predicted at the end of Q2 is dependent on the hospitals continuing to source an additional 60-70 nurses through IR recruitment due to the reduced supply of domestic nurses in this period.

13.4 Respiratory, elderly medicine, orthopaedics and theatres continue to be difficult to recruit to areas within the hospital which is aligned to the national trend. The greatest challenge is within general and cardiothoracic theatres where there are 11.2% registered nurse vacancies and newly qualified staff in training. Bespoke recruitment events have been held to target candidates for these areas. A cohort of 14 IR nurses are due to arrive before the end of March 2020 have been employed to work across theatre specialties at Wythenshawe and Trafford hospitals.

13.5 Building upon the success of the newly appointed Nursing Associates (NA's) and measuring the impact of their role on the skill mix opportunities across clinical services is a key area of focus for WTWA. There are 22 NA's have employed in ward areas across the hospital. The impact of the NA role and contribution to the nursing workforce is being included within establishment reviews and workforce plans for 2020/21. The second cohort of Trainee Nursing Associates (TNA's) is due to quality in April 2020, with 27 allocated to inpatient and theatre areas across WTWA. Additional areas to introduce the NA role are being considered and includes Bronchoscopy, Endoscopy, the North West Ventilation Unit and the Rapid Diagnostic Service for Lung Cancer. To support this expansion of the NA role, TNAs are now being allocated on placements within these areas to test the modelling and inform how to maximise the support for and flexibility of the role.

13.6 The rolling 12 month turnover for nursing is **12.3%** across WTWA with the highest turnover rate in the Division of Medicine (17.7%). The turnover for band 5 Staff Nurses is currently **17.2%** (23% in the Division of Medicine). The turnover position remains unchanged over the last 6 months with the number of band 5 domestic nurse leavers exceeding the number recruited.

13.7 The most frequently stated reasons for leaving across all WTWA Divisions and pay bands are work life balance and relocation. The Divisional Heads of Nursing monitor this information through exit interviews and to support retention work programmes.

13.8 Sickness absence within the registered nursing and midwifery staff group at WTWA continues to be above the Trust threshold at **4.9%.** There has been some improvement in the registered sickness rate since June 2019 when the sickness rate was 5.9%. Reducing sickness absence remains a key area of focus, particularly on the Trafford hospital site. In recognition of this, additional HRBP resource has been recruited on a 12 month secondment to support the HR function at Trafford, with a key focus on sickness absence management. Additionally, WTWA will work closely with HR in the review of the Absence Manager dashboards; in analysing trends within the data and compliance with completion of 'Call Backs' and Return to Work interviews, with the understanding that increased compliance has a direct positive impact on sickness and absence episodes and length of absence.

13.9 Staff wellbeing and development has been a focus in 2019/20. A pastoral support programme and senior nurse engagement sessions have been introduced to support newly qualified band 5 staff. The 'nurse in charge' competencies and band 7 development programme has been introduced to support and develop leadership capacity. A senior nurse night rota has been established across Wythenshawe and Trafford hospitals to provide senior nurse visibility and leadership to junior staff at night time.

WTWA Safe Staffing

13.10 Across ward areas **85.6%** of planned Registered Nurse shifts were filled in the last 6 months period. 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.

13.11 Safer Nursing Care Data has been collected from 30 wards over 3 census periods during 2019. Following validation and analysis of the results 23 wards have sufficient data to inform their establishment reviews with 17 wards identified as being within 10% of the recommended establishment **(table 2)**. Reviewing the data has highlighted 5 ward area where the recommended establishment is more than 10% above the funded establishment. These wards include elderly medicine and surgery where the patient acuity and activity (surgery) is high. The Heads of Nursing are undertaking a detailed workforce assessment of these areas to consider the census data, skill mix, patient outcomes and ward staff feedback. Census data from **8** wards has been found to be inconsistent and as such these wards will be required to complete the next census collection in January 2020 before undertaking an establishment review.

Table 2

Within 10% of recommended establishment (n=17)	Below 10% of recommended establishment (n=5)	Wards require further census data collections required (n=8)
Ward 2 (T)	Ward 4 (T)	AMU (T)
Ward 6 (T)	A4	F1
Ward 11 (T)	A5	F2
A1	A6	F3
A3	A7	Wilson
F9		F12
AMU (W)		F14
A9		F4
F7		
F15		
Opel House		
Doyle		
F5		
F6		
Jim Quick		
Pearce		
POU		

13.12 The hospital has established a robust nursing establishment review approval process to provide professional nursing and HR Director approval and oversight of any proposed establishment/skill mix review changes following Divisional approval. There are 10 ward/theatre establishments are in the process of being reviewed through this process, with the remaining wards being completed during Q4 2019/20. A structured approach to establishment reviews following biannual SNCT census periods will be introduced from 2020/21.

Key Actions

13.13 There has been significant progress in attaining a more detailed understanding of the current workforce challenges across WTWA. 2019/20 has seen the development of Divisional workforce delivery plans to support service delivery and transformation. Key work streams have been identified by the Director of Nursing and will be led by the Deputy Director of Nursing. Work will focus on exploration and delivery of the following:-

- Establish a Nursing Workforce Operational Group reporting to WTWA Nursing Workforce Meeting chaired by Deputy Director of Nursing.
- Develop a Nursing Workforce Strategy during Q4 prioritising band 2-5 recruitment and retention and reducing sickness absence.
- Lead Nurse Workforce and Education to oversee WTWA recruitment events to maximise opportunities for domestic recruitment, including bespoke recruitment events for hard to fill areas.

- Evaluate the effectiveness of existing Divisional retention plans, share best practice and develop a suite of retention initiatives, particularly focused on Band 5 registrants.
- Develop pastoral support programmes to meet the needs of specific nursing groups supporting induction, on the job-learning and career development
- Undertake skill mix review of the current workforce in each ward area to expand the Nursing Associate workforce.
- Align all education and professional development programmes across WTWA to ensure the workforce are supported and developed to undertake their roles safely, confidently and competently and to include new roles e.g. IR nurses and Nursing Associates.
- Explore the development opportunities within the advanced practitioner workforce.
- Undertake Band 2 engagement sessions with during Q4 to inform retention plans for unqualified staff.
- Maximise coproduction within service review and design, to engage the workforce in the development of the service they deliver.

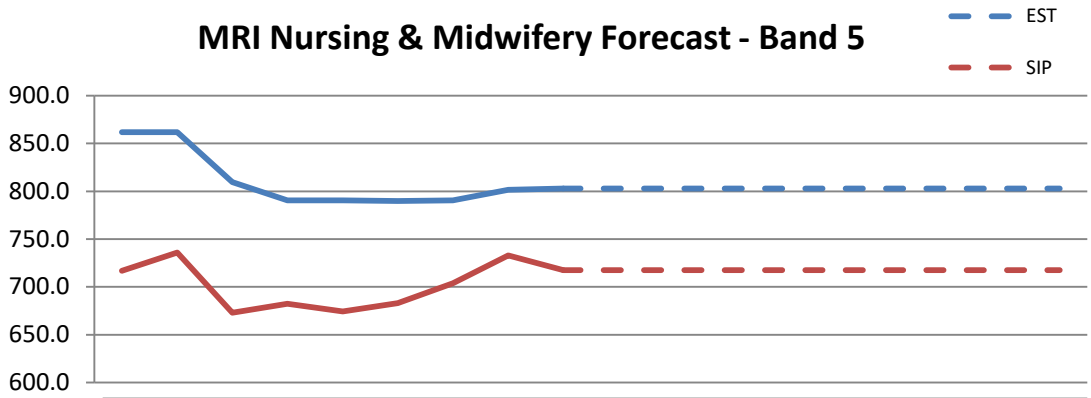
14. Manchester Royal Infirmary (MRI)

MRI Workforce Position

14.1 At the end of Dec 2019, there were a total of **148.9wte (9.9%)** registered nursing vacancies across MRI. This is a decrease in overall nursing vacancies of **63.8wte** since June 2019. The hospital vacancy position is predicted to improve in Q2 when it is predicted there will be **96.6wte (6.5%)** vacancies by September 2020 which will be a reduction of **95.1wte** vacancies compared to the same period in the previous year.

14.2 The majority of the vacancies are within the staff nurse (band 5) workforce**. Graph 6** illustrates the MRI workforce position until Sept 2020. At the end of Dec 2019 there were **85.5wte (10.6%)** band 5 vacancies, which is a reduction of **51wte** vacancies since June 2019. The vacancy position is predicted to improve during Q1-2 when it is predicted that there will be **42.2wte (5.3%)** vacancies by September 2020 which will be a reduction of **64.7wte** vacancies compared to the same period in the previous year.

Graph 6



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
EST	861.8	861.8	809.5	790.5	790.5	789.9	790.5	801.5	802.9	802.9	802.9	802.9	802.9	802.9	802.9	802.9	802.9	802.9
SIP	717.0	736.0	673.0	682.3	674.3	683.0	703.9	732.9	717.4	717.4	717.4	717.4	717.4	717.4	717.4	717.4	717.4	717.4
Vacancies	144.8	125.8	136.5	108.2	116.2	106.9	86.6	68.6	85.5	85.5	85.5	85.5	85.5	85.5	85.5	85.5	85.5	85.5

14.3 There are **46** Band 5 Staff Nurses currently in the domestic recruitment pipeline to start at MRI due to start in post before the end of March 2020. Between April and November 2019, the hospital have welcomed 84 IR nurses into the MRI workforce, with a further **50** nurses due to start before the end of March 2020. A cohort of 12 IR nurses have been employed to work in theatres. The additionality that IR recruitment provides has supported the overall reduction in vacancies across the hospital and has enabled the hospital to support the provision of additional capacity for activity and demand.

14.4 The hospital is developing a workforce plan for 2020/21 to determine skill mix and workforce requirements. The improved band 5 vacancy position predicted at the end of Q2 is dependent on the hospitals continuing to source additional 60-70 IR nurses during this period when the supply of domestic nurses is reduced.

14.5 There are 24 Nursing Associates working in MRI. The hospital continues to evaluate the role and skill mix to explore opportunities to introduce the role in new areas including theatre specialities. A further 24 NAs have been recruited and will commence in post on completion of their training programme in April 2020. The hospital is in the process of advertising externally for trained Nursing Associates across all ward areas and theatres.

14.6 Within the MRI, vacancies continue to be of concern in theatres, HPB Service (Ward 7), Orthopaedic Wards 1&2 and the Respiratory Wards AM1 and 2. There are a number of factors identified as impacting on the vacancy situation across these areas including the dependency and case mix of patients within these areas and the difficulties in attracting staff. 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. Work is ongoing to support staff with the use of the zero tolerance policy against violence and aggression to improve the patient and staff environment. The opening of the Major Trauma Ward in early December 2019 has supported the retention of staff within orthopaedics, with a small number of staff from this speciality being transferred to support the opening of the Surgical Assessment Unit.

14.7 The 12 month turnover for nursing within MRI is **12.3%** with the highest turnover in the Division of Medicine (16.2%). The turnover within the Staff Nurse workforce is **15.9%** with the highest turnover in the Medicine (**19.1%**). The 12 month rolling turnover rate has improved over the last 6 months when band 5 turnover was **18.1%** in June 2019.

14.8 Registered Nurse sickness absence levels have seen an overall improving trend. Registered nurse sickness absence has reduced from 6.6% in December 2018 to 5.4% in December 2019. It is acknowledged that collaborative working between the Senior Nursing Team and Human Resource Team members will influence the improvement in Nurse sickness absence by delivering some focused staff engagement sessions in areas with the highest sickness rates. It is anticipated that the roll out of Absence Manager early in 2020 will also see an improvement in sickness absence. The Head of Nursing for Workforce and CSU Lead Nurses continue to work with the HR teams to review absence trends within nursing to understand actions that can be put in place to improve attendance within this staff group.

MRI Safe Staffing

14.9 Across MRI wards and departments, **85%** of planned Registered Nursing shifts were filled in the last 6 months. In order to ensure wards are maintaining safe staffing levels within MRI the Senior Nursing Team undertake a daily staffing review to ensure safe staffing levels and skill mix is achieved within the MRI.

14.10 Safer Nursing Care Data has been collected from 23 wards over 3 census periods during 2019. Following validation and analysis of the results 19 wards have sufficient data to inform their establishment reviews with 17 wards identified as being within 10% of the recommended establishment (**table 3**).

Reviewing the data has highlighted 2 double ward areas where the recommended establishment is more than 10% of the funded establishment. These wards are surgical wards where the patient acuity and patient activity and turnover is high. The Head of Nursing is undertaking a detailed workforce assessment of these areas to consider the census data, skill mix, patient outcomes and ward staff feedback. The next census data collection will be completed in January 2020 followed by an establishment review of the four remaining wards.

Table 3

Within 10% of recommended establishment (n=17)	Below 10% of recommended establishment (n=2)	Wards require further census data collections required (n=4)
AM1	Ward 9 & 10	Ward 30
AM2	Ward 11 & 12	Ward 3
AMU		Ward 4
Ward 6		Head and Neck Surgical Unit
Ward 31		
Ward 32		
Ward 45		
Ward 46		
AM3		
AM4		
Ward 36/37		
Ward 5		
Ward 44		
Ward 8		
MVC		
Ward 1 & 2		
ETC Urology		

Key Actions

14.11 Key work streams have been identified by the Director of Nursing and will be led by the Deputy Director of Nursing and Head of Nursing for Workforce. Work will focus on developing the workforce and retention of staff:-

- Band 5 Focus Groups, to capture overall issues around retention; this will be an ongoing focus group meeting, actions from the initial meeting captured above.
- Development of an MFT transfer process which would support staff who wish to change areas for development or career progression to be retained within MRI/MFT.
- Developing a “career guardian” scheme which would allocate all new starters with an independent mentor/buddy, who will be identified at appointment (during the pre-employment stage).
- The implementation of an improved MRI Nursing Recruitment and Retention Plan with the Director of HR & OD.

- Implementation of MRI Director of Nursing listening events with newly qualified nurses and midwives to be established to provide feedback.
- Development of Pharmacy Technician roles throughout MRI following the successful implementation of this role in Wards 1&2 and Renal Transplant to support the administration of medications across ward areas.
- An improved Nursing Assistant recruitment process across MRI which ensures that senior nursing teams are fully involved with recruitment, selection and allocation of posts in line with current vacancies.
- Opportunities to introduce the NA role into new areas to expand NA workforce.
- Identify Preceptorship Champions in each clinical area to support newly qualified RN's and NA's to access the Trust Preceptorship Programme.
- Expand the Advanced Clinical Practitioner workforce.
- Explore the development of Allied Health Professional posts to support safer ward staffing and a blended skill mix/workforce.
- Following on from the success of introducing Band 3 Dialysis assistants into haemodialysis units, there will be a scoping exercise planned for other areas, where this model could be applied.

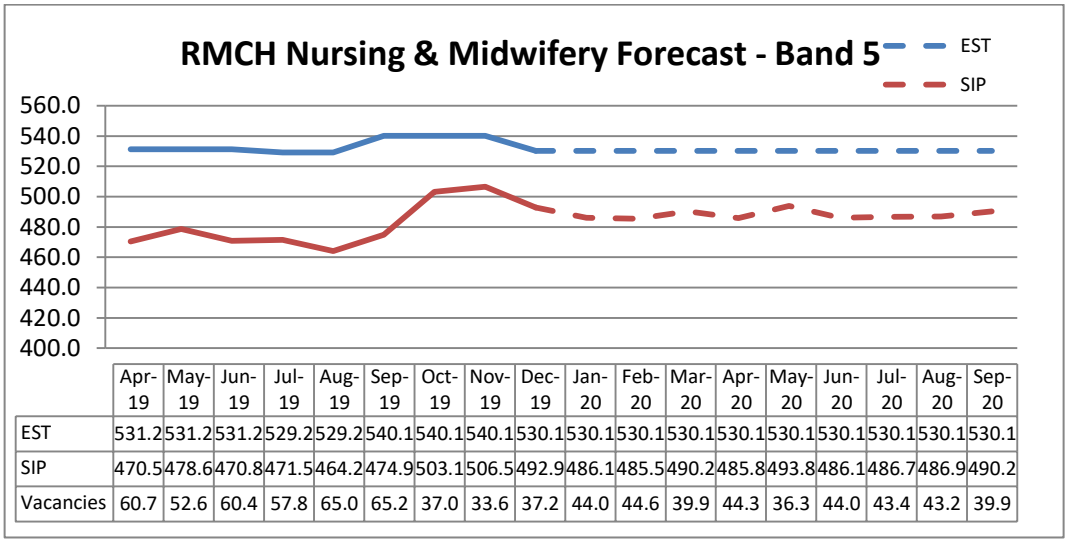
15. Royal Manchester Children's Hospital (RMCH)

RMCH Workforce Position

15.1 At the end of Dec 2019 RMCH had a total of **39.8wte (4.3%)** Registered Nurse vacancies. This is a reduction in overall nursing vacancies of **34wte** since June 2019. The hospital vacancy position is predicted to remain static during Q1-2 when it is predicted there will be **32.0wte (3.5%)** in September 2020. This is an improvement for the same period in the previous year when there was **76.9wte** vacancies.

15.2 The majority of the vacancies are within the Staff Nurse (band 5) workforce**. Graph 7** illustrates the workforce position in RMCH until Sept 2020. At the end of Dec 2019 there was **37.2wte** band 5 nursing vacancies which is a reduction of **23.2wte** vacancies since June 2019. There is expected to be a small increase in vacancies during Q1-2 however this position will improve in September 2020 when the newly qualified graduate nurses will commence in post.

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	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
EST	531.2	531.2	531.2	529.2	529.2	540.1	540.1	540.1	530.1	530.1	530.1	530.1	530.1	530.1	530.1	530.1	530.1	530.1
SIP	470.5	478.6	470.8	471.5	464.2	474.9	503.1	506.5	492.9	486.1	485.5	490.2	485.8	493.8	486.1	486.7	486.9	490.2
Vacancies	60.7	52.6	60.4	57.8	65.0	65.2	37.0	33.6	37.2	44.0	44.6	39.9	44.3	36.3	44.0	43.4	43.2	39.9

15.3 There are **30** Band 5 Staff Nurses currently in the domestic pipeline who will commence in post during Q1-2. There are 6 IR nurses due to commence in post before the end of March 2020 to work in theatre. A hospital recruitment open day is planned to take place in March 2020 to recruit student nurses who will graduate in September 2020.

15.4 There are 11 Nursing Associates employed across ward areas in RMCH. Following a skill mix review the hospital have identified 30 new NA posts of which 6 trainee NAs have been recruited and will commence in post in April 2020 on completion of their training. The remaining posts will be advertised.

15.5 Paediatric Critical Care (PHDU and PICU) continue to hold the highest registered nursing vacancy rate of **11.8%,** with additional staffing pressures caused by a high number of staff on maternity leave. Recruitment into this area is a challenge due to the lack of available qualified nurses however IR nurse recruitment has helped to reduce registered nurse vacancies.

15.6 The 12 month rolling turnover for nursing across RMCH has seen some improvement. The registered turnover rate was **11.6%** in December 2019 with an annual turnover of **13.4%** (14.3% in June 2019) within the band 5 staff nurse workforce. There has been a focus within the hospital on caring for and valuing staff which is reflected in the improved position reported in the the 2019 Staff Survey responses. A formal programme of work is being developed to develop this work through the delivery of the hospital Nursing and Midwifery Strategy.

15.7 Registered Nurse sickness absence levels has increased since June 2019 (3.6%) with 5.4% reported in December 2019. 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 support staff well-being and self-care both for physical and mental health. It is anticipated that the roll out of Absence Manager in Q1 will see an improvement in sickness absence.

RMCH Safe Staffing

15.8 Across RMCH wards and departments, **87.9%** of planned Registered Nurse shifts were filled since June 2019.

15.9 Safer Nursing Care data has been collected on 8 wards over 3 census periods during 2019. Following validation and analysis of the results the wards have sufficient data to inform their establishment reviews with 5 wards identified as being within 10% of the recommended establishment (**table 4**). There are 3 wards where the recommended establishment is more than 10% of the funded establishment. The Lead Nurses will undertake a detailed workforce assessment in these areas to consider the establishment census data, skill mix and patient outcomes. The next census data collection will be completed in January 2020 followed by an establishment review in these areas.

Table 4

Within 10% of recommended establishment (n=5)	Below 10% of recommended establishment (n=3)	Wards require further census data collections (n=0)
Ward 77 Starlight Unit Ward 81 Ward 83 BMTU	Ward 75 Ward 78 Ward 85	

Recruitment and Retention

15.10 The Director of Nursing together with the Head of Nursing will oversee and deliver key actions to address a continued reduction in vacancies levels and turnover. The key actions include:

- To actively recruit to vacant posts to support service developments and winter pressures within RMCH/MCS and utilise all available resource e.g. International Nurses, Nursing Associates.
- To promote RMCH as a centre of excellence and desirable place to work though utilisation of social media, celebration of success, twice yearly open days and review of keeping in touch process.

- Director of Nursing/Head of Nursing engagement events with newly qualified nurses.
- To ensure attendance at Local and National recruitment events to attract Band 5 registered nurses and also publicise new role opportunities.
- Exploration of introduction of new roles within clinical areas to support the workforce such as the employment of RMNs to deliver appropriate care to the increasing number of patients admitted to all clinical areas under CAMHS.
- Undertake workforce reviews in identified areas in Quarter 4.
- Communicate and support processes where staff can raise concerns, i.e. Freedom to Speak Up Champions.
- Continue to recruit to and promote the role of the Mental Health First Aiders.
- To develop a sustainable workforce who can meet the needs of the patient group through programmes facilitated by the hospital education team, for example – Communication Skills, Band 5 and 6 Development Programme and Clinical Skills Workshops.
- Support staff to attend National Conferences for professional development, networking opportunities and promotion of RMCH.
- Implementation of New Starter Induction and Well Being Guides.

16. St Mary's Hospital MCS

SMH MCS Nursing and Midwifery Workforce Position

16.1 At the end of Dec 2019, there were a total of **56wte (5.2%)** qualified nursing and midwifery vacancies across SMH MCS. This is a reduction of 66wte nursing and midwifery since June 2019. The Hospital vacancy position it set to continue to improve in Q1-2 when it is predicted there will be **39.1wte (3.7%)** vacancies.

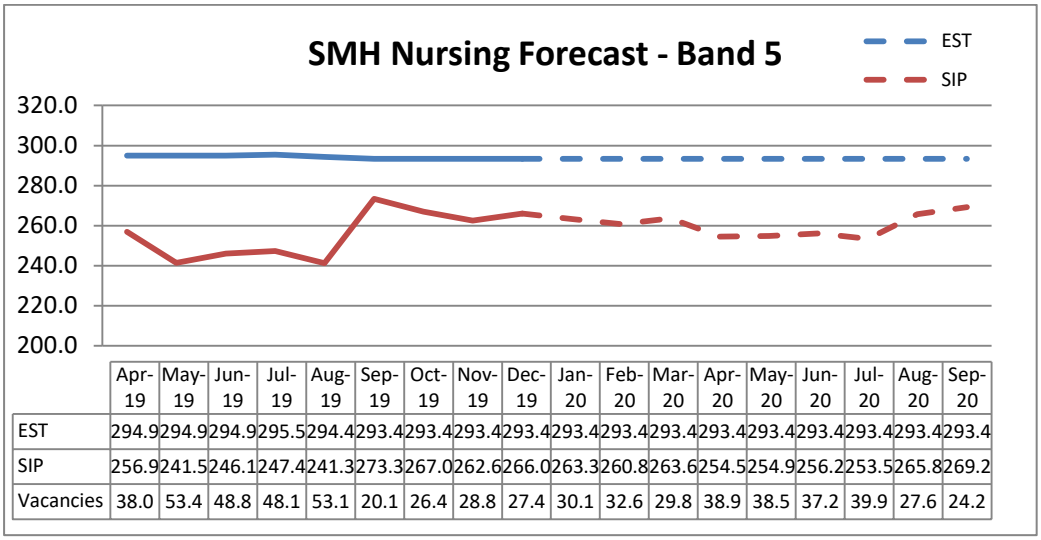
16.2 The Registered Nursing and Midwifery rolling 12 month turnover is **11.5%** within SMH and **12.5%** across the band 5 nursing and band 5/6 midwifery workforce. Retention remains a key focus with retention plans being developed in conjunction with the hospital HR team to reduce the turnover of staff and the reliance on temporary staffing.

16.3 Registered nursing and midwifery sickness absence levels have continued to rise across SMH MCS with the sickness rate for registered staff being 6.1% in December 2019 compared to 4.6% in June 2019. Absence Manager has been rolled out in SMH MCH

SMH Nursing Workforce Position

16.4 The majority of the vacancies within SMH MCS are within the Newborn Services nursing (Staff Nurse Band 5) workforce. **Graph 8** illustrates the nursing workforce position in SMH until September 2020. At the end of Dec 2019 there were **27.4wte (3.7%)** Band 5 Staff Nurse vacancies which is a reduction of **21.4wte** since June 2019. The band 5 vacancy position is expected to remain static during Q1-2.

Graph 8



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
EST	294.9	294.9	294.9	295.5	294.4	293.4	293.4	293.4	293.4	293.4	293.4	293.4	293.4	293.4	293.4	293.4	293.4	293.4
SIP	256.9	241.5	246.1	247.4	241.3	273.3	267.0	262.6	266.0	263.3	260.8	263.6	254.5	254.9	256.2	253.5	265.8	269.2
Vacancies	38.0	53.4	48.8	48.1	53.1	20.1	26.4	28.8	27.4	30.1	32.6	29.8	38.9	38.5	37.2	39.9	27.6	24.2

16.5 There are 13 Band 5 Staff Nurses currently in the pipeline appointed to work within neonatal services and gynaecology speciality before the end of March 2020. There have been 3 IR nurses employed in SMH over the last 12 months with a further 3 nurses recruited to work in theatres before the end of March 2020. Consideration is now being given to recruit IR nurses within gynaecology services.

16.6 The Registered Nurse rolling 12 month turnover is **11.3%** within SMH and **12.7%** 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.

SMH Safe Staffing - Nursing

16.7 Across SMH MCS wards and departments, **95%** of planned Registered Nursing shifts have been filled during the period of June to December 2019.

16.8 **Women's Health**: SNCT Census data has been collected across gynaecological services to support establishment reviews. On review of the census data it is apparent that the SNCT tool is not valid for these wards due to the case mix and high patient flow on both wards. A daily staffing huddle is completed by the senior nurses with each ward team to ensure staffing levels are safe to meet the acuity and activity on the ward each day.

16.9 **Newborn Services:** Nurse staffing for neonatal units is included in the recommendations from the Neonatal Toolkit (DH 2009) and forms part of the Neonatal Critical Care contract with NHSE. The guidance is based on mandated ratio of nurses:babies, dependent upon the acuity of the infant. Those infants requiring intensive care, for example, require a 1:1 ratio whereas babies requiring special care can be safely nursed as part of a ratio of 1:4. At MFT, the uplift element of the DH (2009) recommendations, 25%, has not been funded by NHSE and so the organisation has had a derogation against nurse staffing in place since 2013.

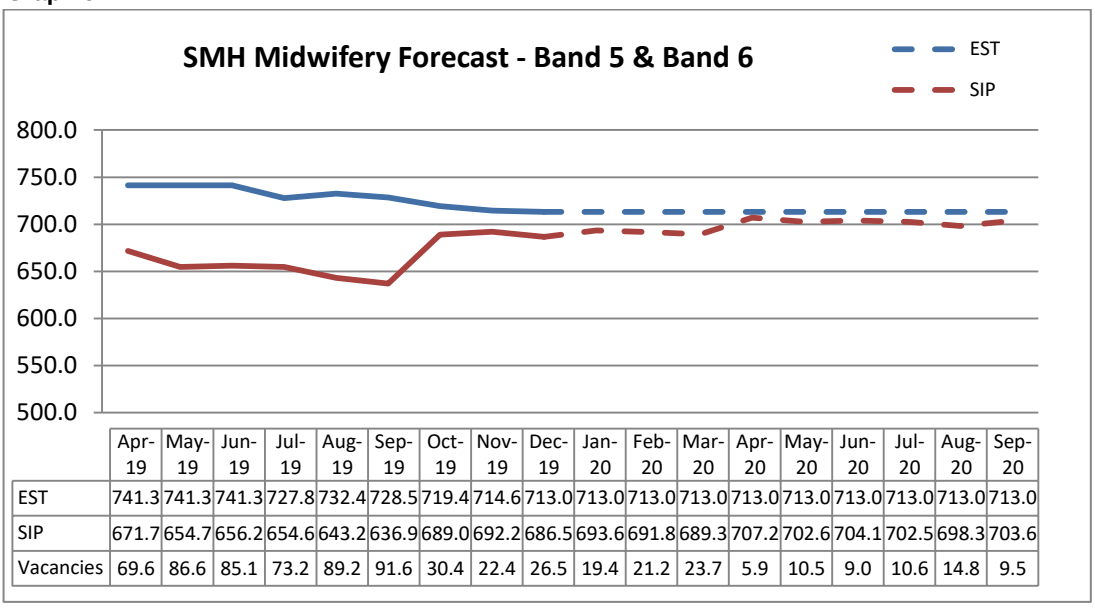
16.10 In order to ensure safe levels of nursing care are in place the service utilises an acuity tool which measures levels of dependency against nurse staffing requirements. This is assessed 3 times / day and nurse staffing is adjusted, where possible, accordingly. A proactive approach to delivering supportive rosters is taken whilst short term gaps in nurse staffing (arising from the unpredictable nature of activity or unexpected levels of sickness absence) are managed with the successful use of internal NHSP staff and / or redeploying staff employed to deliver 'quality' (i.e. non cot side) roles.

16.11 All units across the North West undertake an assessment of nurse staffing v activity twice each year. This exercise uses a mandated nurse staffing tool and is coordinated by the NW Neonatal Operational Delivery Network. The position is then reported annually in the NWNODN Activity, Capacity and Demand report. In the 2018/19 year the NICU @ ORC was reported to have a 2% shortfall against budgeted establishment whilst the Wythenshawe LNU was demonstrating a 10% shortfall. The focus for the 201/9/20 year has been to improve the Wythenshawe position.

SMH Midwifery Workforce Position

16.12 At the end of December 2019, there was a total of **26.5wte (3.7%**) band 5 and 6 Registered Midwifery vacancies across SMH MCS. This a reduction in the vacancies of 58.6wte since June 2019. **Graph 9** illustrates the band 5 and 6 Midwifery workforce position in SMH MCS until Sept 2020 when it is predicted the vacancy position will be **9.5wte (1.33%).**

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	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
EST	741.3	741.3	741.3	727.8	732.4	728.5	719.4	714.6	713.0	713.0	713.0	713.0	713.0	713.0	713.0	713.0	713.0	713.0
SIP	671.7	654.7	656.2	654.6	643.2	636.9	689.0	692.2	686.5	693.6	691.8	689.3	707.2	702.6	704.1	702.5	698.3	703.6
Vacancies	69.6	86.6	85.1	73.2	89.2	91.6	30.4	22.4	26.5	19.4	21.2	23.7	5.9	10.5	9.0	10.6	14.8	9.5

16.13 The Registered Midwife rolling 12 month turnover is **12.14%** within SMH and **12 .52%** across the band 5 nursing workforce This is an improvement in the turnover rate from June 2019 when turnover in the midwifery workforce was **14.35%** and **19.66%** in the band 5 and 6 midwifery workforce.

16.14 There are 6 Midwives in the recruitment pipeline due to start at SMH before the end of March 2020. The annual SMH recruitment open day will take place in May 2020. This is an opportunity for the MCS to showcase services and career opportunities in maternity, Newborn Services and women's health. The SMH senior team work closely with the local HEIs to ensure student nurses and midwives are prepared for with May recruitment event and have the opportunity to attend.

SMH Safe Staffing – Midwifery

16.15 The Birth-rate Plus (BR+) ratio at SMH at Oxford Road campus is **1:28**. This is a slight improvement to the ratio In June 2019 when the ratio was **1:29**. The BR+ ratio for SMH at Wythenshawe remains unchanged at **1:26**. Both results comply with the national recommendation of 1:28.

16.16 BR+ recommends 1:98 for community caseloads providing antenatal and postnatal care. The community midwifery caseloads have remained constant throughout the last 6 months with a ratio of **1:112** for the Oxford Road Campus and a ratio of **1:115** for Saint Mary's at Wythenshawe. It is acknowledged that more work needs to be done to improve the community caseload ratio and as such caseloads are being reviewed across Saint Mary's Hospital MCS to support the vision of one community midwifery service across the City of Manchester. This will provide a harmonised community midwifery service delivering safe and effective care to all women and their families.

16.17 The Delivery Unit Coordinator role has supernumerary status across the MCS to enable oversight of all birth activity. This is monitored on a local dashboard, which over the last 12 months has demonstrated 100% compliance. This role is further supported by a 24 hour midwifery allocated bleep holder who provides a helicopter view of the service and is also supernumerary. This role is being introduced to SMH at Wythenshawe in January 2020; initially the Bleep holder will be on duty from 07.30 to 20.00 hours with the night time being covered by the Delivery Suite Coordinator. There is ongoing work to implement the role overnight.

Recruitment

16.18 The senior nursing and midwifery team are working in partnership 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:

- The Director of Nursing and Midwifery and HR Director will develop a recruitment strategy promoting the 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

Retention

16.19 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.

- Develop a one day development programme for band 5 new starters 'Building capacity by Thriving/Surviving' in partnership with HEIs to support transition from student to midwife.
- Review and refresh band 6 leadership development programme.
- Skill mix reviews are being undertaken to explore opportunities of introducing the Advanced Clinical Practitioners and Nursing Associates into nursing areas.
- Introduced AEQUIP model offering clinical restorative supervision for band 6 midwives and students to provide access to professional midwifery advocates and pastoral professional support.
- Focus on health and well-being of staff following a critical incident.

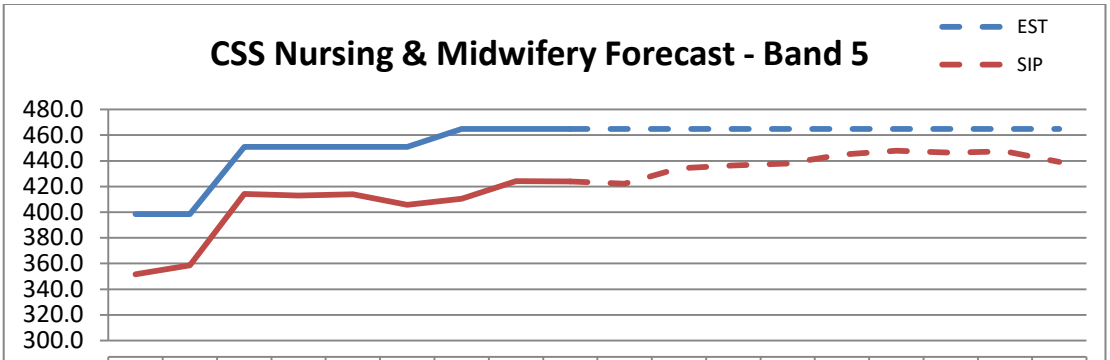
17. Clinical Support Services MCS (CSS)

CSS MCS Workforce Position

17.1 At the end of Dec 2019 there were a total of **48.7wte (6.83%)** qualified nursing vacancies across the CSS MCS. This is a decrease in overall nursing vacancies of **11wte** since June 2019. The hospital vacancy position will continue to improve during Q1-2 when it is predicted there will be **29.3wte (4.5%)** vacancies by September 2020.

17.2 The majority of the vacancies are within the Staff Nurse (band 5) workforce. At the end of December 2019 there were **40.9wte (8.7%)** staff nurse vacancies which is an increase of **4.4wte** vacancies since June 2019. **Graph 10** illustrates the CSS band 5 workforce position until Sept 2020. The vacancy position will continue to improve slightly in Q1-2 with 25.5wte vacancies projected for September 2020.

Graph 10



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
EST	398.5	398.5	450.8	450.8	450.8	450.8	464.8	464.8	464.8	464.8	464.8	464.8	464.8	464.8	464.8	464.8	464.8	464.8
SIP	351.7	358.7	414.3	413.0	414.0	405.8	410.5	424.1	423.9	422.2	434.2	436.3	437.8	444.8	447.8	446.5	447.4	439.3
Vacancies	46.8	39.8	36.5	37.8	36.8	45.0	54.3	40.7	40.9	42.6	30.6	28.5	27.0	20.0	17.0	18.3	17.4	25.5

17.3 There are currently 35 Band 5 Nurses going through the recruitment process, all of which are due to start before the end of Q1 2020. In addition, 30 international nurses are scheduled to start before the end of March 2020. The MCS has identified that without the IR recruitment programme the vacancy situation rate would be much higher at 19%. Workforce plans are being developed to agree recruitment requirements for 2020/21.

17.4 Within CSS the rolling 12 month turnover for all qualified nurses is 15% which is an increase from **13.9%** in June 2019. The 12 month rolling turnover for band 5 staff for the same period is **18.2%**

17.5 CSS sickness absence for registered nursing staff was **5.1%** in December 2019. The sickness rate has increased over the last 6 month period with registered nurse sickness ranging from **2.9%- 5.1%**. Absence Manager was introduced in CSS on the Oxford Road Campus in line with that already established at Wythenshawe.

Service Transformation

17.6 The Trust's strategic direction provides additional workforce challenges as it seeks to grow capacity in CSS. Critical Care capacity is essential to support reconfiguration of services across Manchester and increase surgical activity. The increase to critical care bed capacity over the next 6 months will require additional 21wte nursing staff.

Safe Staffing – CSS

17.7 Professional standards have and continue to be developed and the main references in terms of CSS nursing workforce are Guidelines for the Provision of Intensive Care Services (GPICS 2019) and Standards for Providing a 24 hour Interventional Radiology Service (2017).

The updated (second edition) GPICS standards were launched on 29th June 2019 following extensive consultation. Advice statements are made in GPICS in two ways - 1.Standards ***must*** be routine practice in UK Intensive Care Medicine (ICM) and - 2. Recommendations ***should*** be routine practice in UK ICM. These standards are used by professional and regulatory bodies to appraise services.

17.8 In terms of GPICS standards the units are compliant with all nurse staffing standards (ratios of nurses to patients per shift, coordinators and support nurses per shift, numbers of clinical education nurses and use of agency staff) All units with the exception of AICU currently meet the requirement that a minimum of 50% of registered nurses within Critical Care hold a post basic Critical Care qualification.

17.9 AICU was compliant but due to the recruitment of additional nurses to run all 17 beds this had diluted the number of staff with a critical care qualification to 39% at the time of the last report. This is highlighted on the Risk Register for the unit together with the plan for recovery. The number of staff currently with a Critical Care qualification stands at 42%. Plans are in place to recover this over the next 12 months (8 staff are currently undertaking the Critical Care course from AICU with a further 8 nominated for the next course commencing Sep 2020).

17.10 The provision of nurse staffing in RADU in relation to Guidelines for Providing a 24 hour Interventional Radiology Service is entirely compliant on the Oxford Road Campus and this is now being addressed at Wythenshawe Hospital where a voluntary out of hours arrangement will be replaced by a formal out of hours arrangement on conclusion of the consultation with staff Feb 2020.

Recruitment and Retention of Staff

17.11 The Interim Director of Nursing and Deputy Director of Nursing will oversee and deliver key actions to continue to work towards a reduction in the vacancy rate and turnover over the next 6 months including:

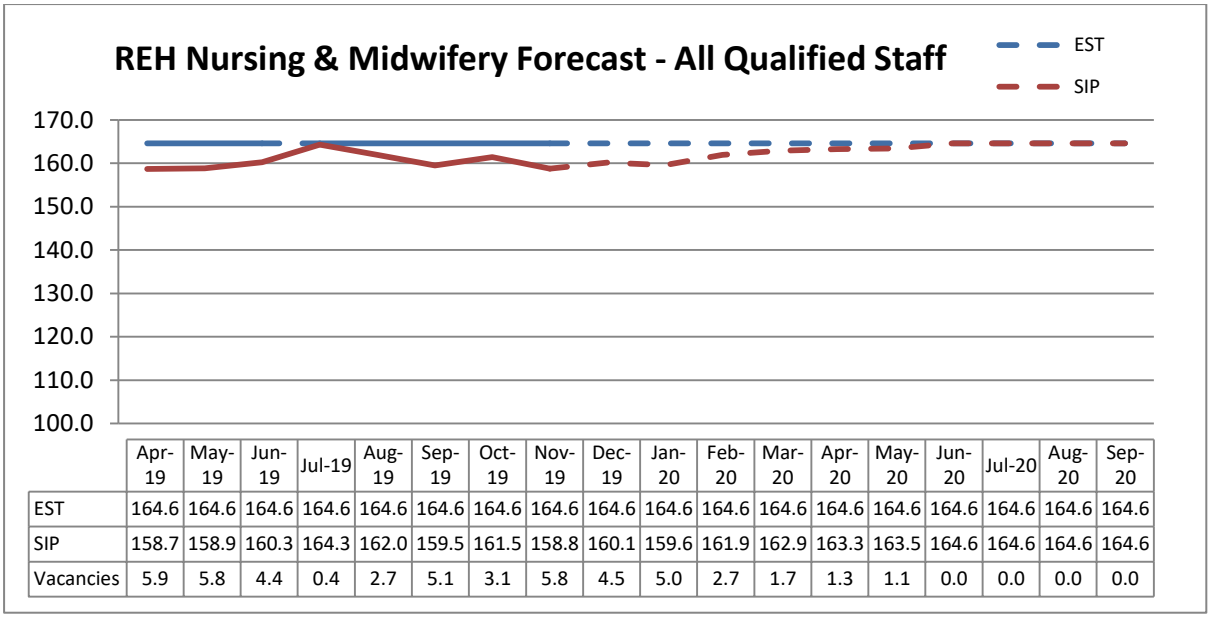
- All units to maintain an ongoing schedule of monthly recruitment for band 5 staff nurse posts to support workforce plans and expansion of services.
- Continue to ensure maximum engagement with staff to address staff satisfaction and well-being.
- All Matrons meet with students during placement to discuss their career aspirations.
- 'Keep in touch' process with new recruits following appointment until they are in post.
- Staff are able to transfer to other units/departments as soon as possible.
- Lead Nurses support all reasonable requests for rotation to other units/departments within CSS.

18. Manchester Royal Eye Hospital (MREH)

MREH Workforce Position

18.1 At the end of Dec 2019, there were a total of **8.4wte (5.1%)** qualified Nursing vacancies across MREH. This is an increase from the **4.3wte (2.6%)** reported in June 2019. It is predicted that the nursing vacancies will remain during Q1-2 and as such the Hospital will continue to recruit to turnover (**graph 11**).

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	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-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	164.6	164.6	164.6	164.6	164.6	164.6
SIP	158.7	158.9	160.3	164.3	162.0	159.5	161.5	158.8	160.1	159.6	161.9	162.9	163.3	163.5	164.6	164.6	164.6	164.6
Vacancies	5.9	5.8	4.4	0.4	2.7	5.1	3.1	5.8	4.5	5.0	2.7	1.7	1.3	1.1	0.0	0.0	0.0	0.0

18.2 The 12 month rolling turnover rate for nursing remains below the MFT average at 6.5% for all qualified staff and at 1.5% for band 5 staff.

18.3 Registered Nursing sickness absence levels have between 7.0% (June 2019) and 9.2% in December 2019. The introduction of Absence Manager in Q1 will support the hospital in ruducing sickness absence.

REH Safer staffing

18.4 Safer Nursing Care census data has been collected on ward 55 however the data has limited validity due to the high patient volume of short stay surgery patient mix. Planned and actual staffing data is submitted by ward 55 in MREH. The ward consistently achieves more than 85% planned Registered Nurse staffing during both day and night. The use of bank staff is low and there is a high fill rate for shifts 90% that require temporary staff. FFT score for ward 55 are consistently high, 98% and there are no nurse sensitive indictors flagging. Therefore no staffing red flags have been raised.

18.5 The establishment workforce models adopted across the clinical areas have been agreed with the senior nurses apply both professional judgement and benchmarking with similar tertiary ophthalmology services.

Recruitment and Retention

18.6 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.

19. University Dental Hospital (UDHM)

UDHM Workforce Position (Dental Nurses)

19.1 At the end of November 2019, there were a total of 3.5wte (4.21%) qualified Dental Nursing vacancies across the UDHM with the establishment currently at 83.21wte. This is mainly due to the introduction of new posts to support a changed staffing model at the Dental Sedation Suite on the main ORC which has provided the opportunity of development and career progression of the Nursing teams. It is predicted that these vacancies will be appointed to in Q4. Vacancies remain low in the UDHM and therefore the Hospital will continue to recruit to turnover.

UDHM Safe Staffing

19.2 The UDHM is working collaboratively with the Association of Dental Hospitals (ADH) undertaking a benchmarking exercise looking at Dental Nurse support in each of the 14 Dental Hospitals across the NHS. This piece of work is focussing on staffing ratios based on the number of dental chairs within each of the Hospitals (approximate guidance is one dental nurse per dental chair, however clinic layout and student numbers also influence staffing allocation) with a view to producing a dental specific safer staff guidance for Dental Nursing in the Hospital setting. This is a national piece of work led by the Dental Nurse Managers and Education Group.

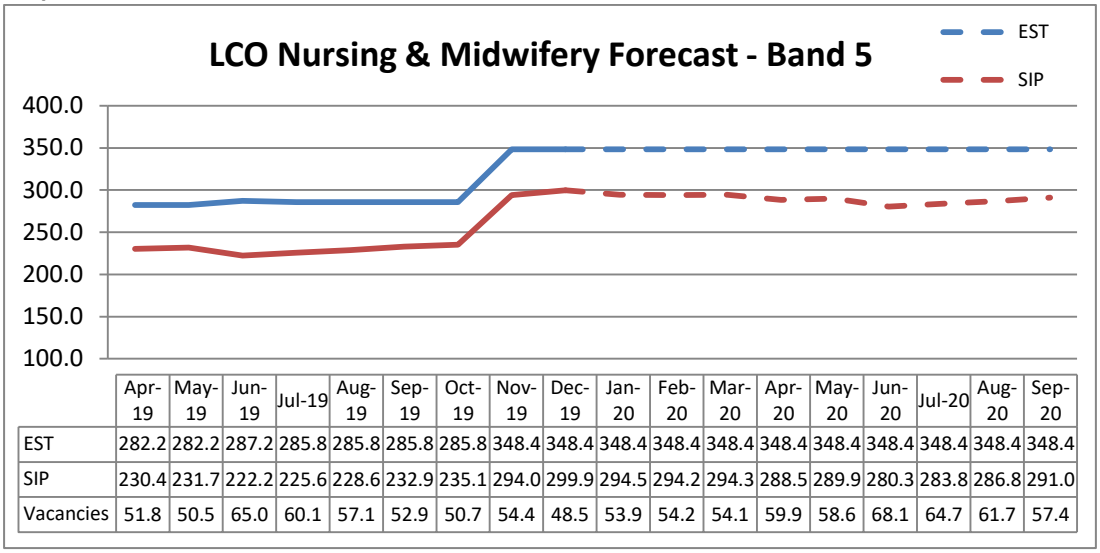
20. Manchester Local Care Organisation/Trafford Local Care Organisation (LCO)

LCO Workforce Position

20.1 At the end of Dec 2019 there was a total of 91wte (8.4%) Registered Nurse vacancies across the LCO. This is a reduction of 24.3wte in overall nursing vacancies since June 2019. The LCO nursing workforce establishment has increased since June 2019 following the merge with Trafford Community Services therefore the true vacancy position has improved and the vacancy rate reduced from 13.7% to 8.5% during the last 6 month period.

20.2 The majority of vacancies are within the Staff Nurse (band 5) workforce. At the end of Dec 2019 there were **48.5wte (13.9%)** staff Nurse (band 5) vacancies compared to **65wte (22.6%)** at the end of June 2019**. Graph 12** illustrates the workforce position across the MLCO until Sept 2020.

Graph 12



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
EST	282.2	282.2	287.2	285.8	285.8	285.8	285.8	348.4	348.4	348.4	348.4	348.4	348.4	348.4	348.4	348.4	348.4	348.4
SIP	230.4	231.7	222.2	225.6	228.6	232.9	235.1	294.0	299.9	294.5	294.2	294.3	288.5	289.9	280.3	283.8	286.8	291.0
Vacancies	51.8	50.5	65.0	60.1	57.1	52.9	50.7	54.4	48.5	53.9	54.2	54.1	59.9	58.6	68.1	64.7	61.7	57.4

20.3 There are **15** Band 5 Staff Nurses currently in the pipeline to start in the MLCO before the end of October 2019. In addition, In January 2019, 8 Nursing Associates from cohort 1 were recruited into the MLCO with a plan to recruit a further **12** when cohort 2 qualify in Apr 2020.

20.4 Across the LCO the rolling 12 month turnover for Nursing is **11.2%** with **14.3%** rolling turnover reported within the band 5 staff group.

20.5 Registered Nursing sickness absence levels have increased from 4.5% in June 2019 to 6.3% in December 2019. Programmes of work led by the Lead Nurses and HR Business Partners are in place to ensure that there are robust processes for monitoring and manging absence. This is supported by programmes of well-being and self-care both for physical and mental health.

LCO Safe Staffing

20.6 The LCO 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. In order to ensure safe staffing a daily situation report has been introduced to manage caseloads and workforce requirement temporarily deploying district nursing staff when necessary across the Neighbourhoods or Localities.

Recruitment and Retention of Staff

20.7 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.

20.8 In order to retain band 5 and 6 community nurses eleven staff have commenced Community Specialist Practitioner training in September 2019. Within Children's Community Health Services twelve staff have commenced on the Specialist Community Public Health Nursing Programme (Health Visiting and School Nursing)

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

- The development of a refreshed LCO Nursing Recruitment and Retention Strategy.
- Implementation of LCO 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.
- Expand the Advanced Clinical Practitioner Programme.
- Explore the development of AHP posts to support safer staffing and a blended skill mix/workforce within ITC and Continuing Health Care Units.

21. Allied Health Professions Workforce

21.1 There is currently no recognised national shortfall within generalist AHP therapists for adult services however speciality posts such as acute Occupational Therapists (OT), paediatric specialist OTs, Dietetic (DT) and Speech and Language Therapists (SLT) due to lack of paediatric training in pre-registration courses.

CSS MCS – AHP Workforce

21.2 At the end of December 2019 there were **28.9wte** (5.6%) registered AHP vacancies within CSS with the highest number of vacancies in adult specialist OT and Dietetics.

21.3 The rolling 12 month turnover rate for registered AHPs within CSS is **12.8 %** which has steadily improved over the last 12 months. Although turnover remains above the Trust target it is currently below the national AHP benchmark of 14.8%:

21.4 Sickness absence rates are below the trust target for this staff group. The sickness absence rate since April 2019 is between **3.1%** and **3.4%** (December 2019).

21.5 CSS have established an AHP Recruitment Task and Finish Group to review both recruitment and retention strategies to provide solutions to ensure that service demands can be met.

MREH AHP Workforce

21.6 The Orthoptic department is fully established with no vacancies and does not experience any issues recruiting high calibre orthoptists at all bands. As the HEIs offering Orthoptic degree programmes sit outside of the GM footprint and provide a national workforce for the UK and therefore we do not offer positions to those who attend on clinical placement or with a Manchester post code but to the best candidate through recruitment. AHPs are required to implement job planning by 2021 and this is a current work stream of high quality and safe staffing for Orthoptists with the intention to implement early at MREH. Nationally Orthoptics is recognised as one of the four vulnerable AHP professions.

MLCO/TLCO AHP Workforce

21.7 In MLCO/TLCO adult community services, AHPs work in multi-disciplinary, integrated teams. Current workforce reports do not specify the AHP vacancies per profession and band within these teams. Vacancies are reported under the generic AHP title only. Further work is being undertaken in order to obtain granular detail of AHP profession-specific vacancies to inform future reporting. There are **40.1wte** vacancies within the AHP workforce. With a number of these vacancies within the nutrition and dietetic service, and Learning Disability services and Speech and Language Therapy Services.

21.8 The AHP 12 month rolling turnover rate is **11.7%** for the MLCO and **3.64%** for the TLCO. Sickness absence rates are below the trust target for this staff group. The sickness absence rate is 3.03% across both the MLCO and TLCO.

MLCO/TLCO Workforce Transformation

21.9 The MLCO and TLCO are committed to transforming the AHP workforce to support the delivery of the MLCO and TLCO's key priorities across services to deliver better outcomes for the people of Manchester and Trafford.

21.10 The MLCO and TLCO will continue to expand the Advanced Clinical Practitioner workforce which is open to both nursing and AHP staff. The MLCO have supported 5 trainee Advanced Clinical Practitioners on the Clinical Masters apprenticeship programme at Salford University which commenced in September 2019. Two of these are AHPs. In addition, there are AHP Advanced Clinical Practitioners working in the Crisis Response Service in all localities. The TLCO are supporting an AHP to undertake the Advanced Clinical Practitioner on the Clinical Masters apprenticeship programme at Liverpool John Moore's University which is due to commence early 2020. In addition, an Assistant Practitioner working in Urgent Care Therapies has successfully obtained a place on the OT Apprenticeship course at Sheffield University, which the Trust has agreed to support.

21.11 The MLCO Palliative Care Service has had a recent investment of £5.4 million which has included the recruitment of a range of AHP posts citywide. The service has been completely re-designed to offer a multi-disciplinary approach in delivering end of life care. Therapists are actively involved in enhancing quality of life in the last 12 months of life as well as contributing to delivering a holistic approach to palliative care intervention.

21.12 As part of Trafford System's Living Well At Home Strategy, TLCO is currently working with its partners to re-design the IMC Pathway offer. This will include the IMC at home element, which will ensure that OT and Physiotherapy services are available at the point of discharge which is currently a gap within TLCO. Consideration will need to be given to any increase this may have on the number of adult therapy posts required.

21.13 The development of the national specification for Enhanced Health in Care Homes will include additional investment in AHP services. This builds on the previous two care home pilots in north and south Manchester which took place last year. AHPs will be integral to the development of this new care model.

AHP Workforce Developments

21.14 A number of Trust wide initiatives have been introduced to support the development of the AHP workforce and include:-

- A Learning Needs Analysis has been undertaken to identify competency and training gaps to facilitate a workforce development plan for future resilience. This will include training and support for AHP Advanced Clinical Practitioners (ACP), Clinical Academic careers, Leadership training and apprenticeships across all sites.
- An AHP Recruitment Task and Finish Group has been established to explore opportunities for improving recruitment and retention e.g. widening participation with work in local schools, NHSP Bank expansion, rolling recruitment, cross site recruitment days alongside existing strategies such as managed over-establishment, use of reserve pools and developmental/transitional posts in hard to fill specialties.
- HEI partnership working to support pre-registration curriculum design and delivery and to support career pathways & potential for interface/joint appointment.
- A non-registered AHP workforce review has been undertaken to facilitate career pathway and staff development. The AHP Division successfully secured funding from the Greater Manchester (GM) Workforce Board to scope demand for level 3 and level 5 AHP apprenticeships. The AHP Division are collaborating with the Universities of Bolton and Salford to develop programme. Provision of level 3 and 5 apprenticeships aim to meet the nationally recognised shortfall in the CPD opportunities available to the non-registered AHP workforce, provide a structured career pathway and widen access to professional training.

- AHP Associate roles at Band 4 are being considered as part of the above GM work stream.
- Job planning: In collaboration with the CSS Workforce Transformation Manager, job planning is currently being piloted with a small number of AHP teams with the aspiration to roll out across the Division in 2020. This will enable matching the workforce capacity to patient needs in order to increase productivity.

22. CSS MCC – Radiology and Sonography

22.1 Currently there are no national shortage of diagnostic radiographers or ultrasonographer however MFT like all other trusts in the region and nationally is recruiting from a limited workforce supply.

22.2 The Society of Radiographers undertake an annual workforce census which has clearly identified that significant vacancy numbers are being reported during a time when demand for imaging services is consistently increasing. It is widely acknowledged that as demand and complexity increases, more radiographers and sonographers will be required to deliver physical imaging procedures as well as delivering reporting, particularly given the coexistent shortage of Consultant Radiologists.

22.3 At the end of December 2019 there are **14.67wte (5.8%)** radiographer vacancies and **2.7wte (6.58%)** ultrasonographer vacancies. Turnover across the Imaging Division is below MFT target at 6.6%.

22.4 Most vacancies within the general radiography workforce are filled through recruitment of student radiographers. Student radiographers are interviewed early in their third year once vacancies are identified and conditionally offered a job pending successful qualification. Turnover of these staff is low as the staff go on to progress and subspecialise in CT, MR, Intervention etc. There have been 7 radiographers recruited through the IR recruitment programme for hard to fill vacancies. The division has a linked grade process in place for Band 5 radiographers to progress to Band 6 when appropriately skilled and experienced. This is an attractive proposition for newly qualified radiographers who may be considering a career with the organisation and supports retention.

22.5 Ultrasonographer vacancies have been partially filled however the process has frequently resorted to training posts which can present pressures elsewhere as they require backfill in areas which may be equally difficult to recruit to. The trust has also taken steps to accept 'Direct' Entry' ultrasonographers who have not trained initially as diagnostic radiographers but have accessed pure, post graduate level ultrasound training. This new training option will increase the potential number of candidates available for vacant posts. There is a recruitment and retention premium in place for ultrasonographers. This is payable at £2000 per annum (pro-rata for part time staff). This is reviewed in consideration of other trusts in the region to ensure that MFT remains competitive and the employer of choice for sonographers where possible.
Staff are eligible for the retention premium on completion of 1 years continuous service in a qualified post.

22.6 In order to further improve the recruitment and retention of staff Radiology has established a Directorate wide Education and Training Board to commence in 2020 promoting:

- Recruitment and retention of staff.
- Equality in access to available training funds.
- Inclusion of all bands of professional and non-professional staff groups
- Appropriate access to training in accordance with service need and development.
- Mandatory CPD for HCPC registered staff.
- In-house Training Schemes (Cannulation, Fluoroscopic Procedures etc.).

This is in addition to the CSS MCS Workforce Board which assumes a wider focus and considers a trust wide agenda in terms of workforce transformation and skill mix.

22.7 The division will continue to identify areas for skill mix, over and above those already established and this will include more delegation of medical roles to Clinical Expert Radiographers and more Radiographic roles to Assistant Practitioner and Apprentice roles.

Safe Staffing - Radiology and Sonography

22.8 Professional standards have and continue to be developed and the main references in terms of imaging safety standards for Radiographer are the Society of Radiographers Principles of 'Safe Staffing for Radiography Leaders' document and the standards as described by the Quality Standards in Imaging scheme (QSI). The Trust is currently working towards QSI accreditation of imaging services in 2020.

23. Summary

23.1 This paper outlines the continuing challenges in relation to nursing and midwifery and AHP staffing. Since September 2019 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. 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.

23.2 The Trust has seen an improved workforce position since April 2019 in comparison to the previous year however, it is acknowledged that this improvement has been achieved due to the increase in IR nurses (300 additional nurses) joining the Trust over the last 12 months. Whilst the improved position supports the hospitals/MCS to achieve their workforce plans there is recognition that more work is required to maximise domestic recruitment and specifically nurse retention.

23.3 WTWA and MRI have the highest vacancy rates with particular hot spots challenges within general medicine, medical assessment, care of the elderly and orthopaedic surgery. Areas with high vacancies are a priority for recruitment and retention. The opportunity to look to create new roles and ways of working has been presented by developing the role of the Nursing Associate in these areas.

23.4 The Trust has seen an overall increase of 0.6% in the registered nursing and midwifery sickness rate since June 2019. The registered nursing and midwifery sickness rate has increased across all hospitals/MCS and LCO with the exception of WTWA which have seen a reduction of 1% over the last 6 month period. The reduction of sickness absence remains a key focus for Hospitals/MCS and LCO supported by programmes of staff wellbeing. This is expected to improve following the introduction of Absence Manager across the Trust.

23.5 The Nursing and Midwifery turnover rate has reduced by 1% over the last 12 months with a reduction of 3% in band 5 staff nursing and midwifery turnover. It is recognised that the number of band 5 staff leaving the organisation is 38% of staff leaving within the first two years of qualifying however this is an improved position on the previous 12 months and a reduction of 7%.

23.6 The Trust works in partnership with NHS Professionals who manage the Trust Bank responding to the Trust temporary staffing demands. This mitigates concerns in relation to safe staffing of the clinical areas and meeting patient care needs. The number of wards achieving 80% planned registered staffing is 90%. There are 7 wards of which the registered nurse vacancies are greater than 25% which is an improvement from September 2019 when there were 16 wards. Measures are in place to maintain patient safety through effective staff redeployment following daily senior nurse review.

23.7 Where appropriate new roles such as the introduction of the Nursing Associate, AHP Assistants and ward pharmacy technicians will bridge a gap between registered and unregistered staff and create career opportunities.

23.8 Across the Trust each Hospital/MCS has established a workforce plan outlining plans to support recruitment and retention of staff. Progress on these work streams will be reported to the Hospitals/MCS Management Boards by the Directors of Nursing, Midwifery, HCP and HR. The Trust retention programmes are intended to support a sustainable workforce retaining the expertise and experience of nursing and midwifery staff and reducing the rate at which staff leave. Investment in these areas will reduce the reliance on the bank and agency and support financial sustainability.

23.9 The Trust was been invited to join the NHSI Nursing and Midwifery Retention programme which commenced in October 2019. The programme provides an opportunity for the trust to access NHSI resources and sharing good practice to support the development of retention schemes and improvement plans. An internal band 5 transfer scheme has been developed and a pilot ‘transfer window’ will be launched in February 2020.

23.10 The new Trust recruitment branding and careers site ‘All here For You’ was launched in January 2020. Launching a new employer brand for the Trust will create a clear and consistent recruitment message to potential candidates about career opportunities at MFT.

24. Conclusion

24.1 The Board of Directors are asking to receive this paper and note progress of the work undertaken to address the nursing, midwifery and AHP vacancy position across the Group.

Workforce and Quality Report - December 2019		Workforce Data - December 2019										Safer Staffing - December 2019						Friends & Family Test - December 2019		Nurse Sensitive Indicators - December 2019			
												Day		Night									
Hospital/MCS	Ward	Funded Establishment (WTE) December 2019		Skill Mix % December 2019		Staff in post (WTE) from ESR - December 2019				Variance Funded Establishment - Staff in Post (December 2019)		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Total staffing fill rate (%)RN only	Overall Care Hours Per Patient Day (CHPPD)	Percentage Recommended (Extremely Likely & Likely) %	Percentage Not Recommended (Unlikely & Extremely Unlikely) %	Falls (All)	Falls with Harm	VTE	Medication Errors
		Registered	Support Staff	% Registered	% Support Staff	Registered	Support Staff	Nursing Associate (Registered)	Total SIP	Registered	Support Staff												
Manchester Royal Infirmary	3	20.60	14.00	59.5%	40.5%	19.93	14.20	0.00	34.13	0.67	-0.20	85.0%	168.8%	85.2%	171.0%	85.1%	7.4	96.3%	0.0%	1	0	0	2
	4	31.50	19.79	61.4%	38.6%	21.13	17.07	1.00	39.20	9.37	2.72	74.9%	128.5%	79.5%	117.1%	76.8%	7.7	92.4%	1.5%	3	0	0	0
	7 (previously ward 5)	18.60	22.84	44.9%	55.1%	14.32	25.41	1.00	40.73	3.28	-2.57	89.2%	70.3%	100.0%	91.7%	93.4%	6.3	50.0%	50.0%	4	1	0	0
	8	20.10	19.74	50.5%	49.5%	17.00	14.59	2.00	33.59	1.10	5.15	70.0%	127.7%	61.3%	123.3%	66.8%	7.5	93.3%	0.0%	0	0	0	1
	14	21.63	15.72	57.9%	42.1%	17.00	11.80	0.00	28.80	4.63	3.92							Zero Responses	Zero Responses	0	0	0	0
	30	11.80	20.48	36.6%	63.4%	9.33	19.16	0.00	28.49	2.47	1.32	85.3%	132.0%	93.6%	103.2%	89.0%	8.6	94.7%	5.3%	1	0	0	1
	31	20.28	19.48	51.0%	49.0%	19.13	18.71	0.00	37.84	1.15	0.77	82.9%	96.0%	100.0%	135.3%	89.4%	6.9	100.0%	0.0%	9	1	0	1
	32	13.00	15.36	45.8%	54.2%	14.53	13.41	0.00	27.94	-1.53	1.95	88.1%	94.6%	100.0%	99.0%	92.6%	7.3	100.0%	0.0%	1	0	0	2

36	15.00	15.95	48.5%	51.5%	13.00	6.32	0.00	19.32	2.00	9.63	83.3%	136.6%	98.9%	135.8%	89.5%	4.1	0.0%	100.0%	10	0	0	1
37	15.72	17.00	48.0%	52.0%	4.00	9.52	1.00	14.52	10.72	7.48							96.8%	3.2%	4	0	0	2
44	59.98	14.80	80.2%	19.8%	54.27	11.75	0.00	66.01	5.71	3.05	79.4%	107.9%	90.6%	121.5%	84.3%	28.7	92.9%	0.0%	1	0	0	0
45	20.28	25.09	44.7%	55.3%	19.53	22.76	0.00	42.29	0.75	2.33	83.8%	78.9%	98.7%	106.4%	89.6%	6.5	78.6%	0.0%	8	1	0	0
46	19.28	32.21	37.4%	62.6%	17.83	31.11	1.00	49.93	0.45	1.10	75.3%	127.2%	71.0%	137.3%	73.5%	7.7	90.0%	10.0%	6	0	0	2
11&12	35.85	25.23	58.7%	41.3%	30.09	25.20	1.00	56.29	4.76	0.03	73.1%	82.3%	80.9%	108.3%	76.1%	5.8	85.7%	5.7%	4	2	0	4
9 & 10	37.00	29.19	55.9%	44.1%	37.69	20.53	1.00	59.23	-1.69	8.66	71.8%	87.9%	93.3%	126.1%	79.5%	6.0	60.0%	20.0%	3	1	0	2
Acute Cardiac Centre	26.99	11.70	69.8%	30.2%	21.00	8.00	0.00	29.00	5.99	3.70	92.9%	100.4%	80.6%	151.6%	87.6%	10.9	88.0%	8.0%	3	0	0	0
Acute Medical Unit	55.03	39.00	58.5%	41.5%	51.65	28.31	3.00	82.96	0.38	10.69	85.5%	97.5%	85.1%	107.7%	85.3%	8.2	88.9%	11.1%	10	2	0	11
AM1	21.96	17.24	56.0%	44.0%	21.23	15.64	0.00	36.87	0.73	1.60	91.3%	115.6%	100.0%	114.0%	94.6%	5.6	100.0%	0.0%	9	0	0	2
AM2	21.96	16.56	57.0%	43.0%	20.53	15.41	0.00	35.95	1.43	1.15	89.4%	85.9%	94.9%	129.9%	91.5%	5.5	76.5%	17.6%	5	1	0	4
AM3	17.53	21.00	45.5%	54.5%	18.21	18.19	1.00	37.40	-1.68	2.81	66.8%	112.6%	69.4%	105.5%	67.8%	5.8	50.0%	0.0%	5	1	0	2
AM4	20.00	18.00	52.6%	47.4%	16.92	14.36	1.00	32.28	2.08	3.64	75.4%	137.6%	73.4%	108.4%	74.6%	6.3	75.0%	0.0%	3	0	0	1
Elective Treatment Centre	13.61	15.59	46.6%	53.4%	12.03	14.56	0.00	26.59	1.58	1.03	85.5%	79.9%	95.9%	87.8%	89.5%	7.4	80.0%	10.0%	7	2	2	1
Emergency Surgical Unit	32.66	35.47	47.9%	52.1%	27.03	19.07	2.00	48.09	3.63	16.40	86.1%	100.2%	64.8%	97.7%	75.7%	7.8	88.9%	0.0%	7	0	1	19

	HNSU	20.11	19.22	51.1%	48.9%	15.68	12.07	1.00	28.75	3.43	7.15	81.0%	124.6%	73.9%	145.5%	78.0%	8.4	96.4%	1.8%	2	0	0	2
	Manchester Ward	14.00	21.16	39.8%	60.2%	11.03	19.28	0.00	30.31	2.97	1.88	95.9%	79.8%	100.0%	101.1%	97.7%	5.7	100.0%	0.0%	2	1	0	1
	MVC	18.39	16.59	52.6%	47.4%	15.61	12.96	1.00	29.57	1.78	3.63	73.2%	127.7%	70.9%	121.0%	72.3%	7.0	90.9%	0.0%	4	0	0	1
	MRI ED	84.02	21.81	79.4%	20.6%	75.25	16.17	0.00	91.42	8.77	5.64							96.5%	1.8%	2	0	0	4
	MRI Theatres	150.97	60.88	71.3%	28.7%	147.80	44.67	0.00	192.47	3.17	16.21							Zero Responses	Zero Responses	0	0	0	2
	OMU/ACC	26.86	14.92	64.3%	35.7%	18.60	13.13	0.00	31.73	8.26	1.79	92.9%	100.4%	80.6%	151.6%	87.6%	10.9	75.0%	0.0%	3	0	0	2
	Ophthalmology Day Case	12.71	3.84	76.8%	23.2%	13.03	3.80	0.00	16.83	-0.32	0.04							98.6%	0.0%	0	0	0	0
Eye & Dental Hospital	54 & 55	17.12	10.40	62.2%	37.8%	16.64	7.59	1.00	25.23	-0.52	2.81	81.8%	112.2%	100.0%	96.6%	87.3%	12.6	98.7%	0.0%	1	0	0	8
	75	36.27	13.66	72.6%	27.4%	31.98	12.43	0.00	44.41	4.29	1.23	77.8%	51.7%	88.2%	73.1%	82.3%	7.5	52.9%	11.8%	0	0	0	9
	77	35.69	17.11	67.6%	32.4%	37.51	6.17	2.00	45.68	-3.82	10.94	76.6%	146.9%	81.5%	67.7%	78.8%	9.0	66.7%	33.3%	0	0	0	6
	78	41.57	27.32	60.3%	39.7%	42.23	15.04	1.92	59.19	-2.58	12.28	79.3%	100.0%	82.5%	94.3%	80.7%	9.0	68.6%	21.6%	2	0	0	21
	83	18.44	22.97	44.5%	55.5%	29.13	11.60	1.00	41.73	-11.69	11.37	91.1%	71.5%	88.6%	81.2%	90.1%	15.3	100.0%	0.0%	0	0	0	6
	84	54.09	21.88	71.2%	28.8%	55.16	14.04	1.92	71.12	-2.99	7.84	72.2%	105.4%	67.7%	125.8%	70.1%	9.4	62.5%	12.5%	1	1	0	4
	85	34.49	11.41	75.1%	24.9%	37.80	4.40	2.00	44.20	-5.31	7.01	82.3%	152.0%	81.0%	103.2%	81.7%	7.2	78.9%	10.5%	1	0	0	5

	76 (ETC)	29.24	17.04	63.2%	36.8%	30.97	8.64	0.40	40.01	-2.13	8.40	70.8%	62.1%	79.7%	113.6%	72.4%	18.3	98.3%	0.0%	0	0	1	3
	81 (Burns Unit)	22.18	7.59	74.5%	25.5%	24.21	3.77	0.00	27.98	-2.03	3.82	76.6%	45.5%	75.0%	64.8%	75.9%	11.0	Zero Responses	Zero Responses	0	0	0	3
	84 (BMTU)	32.90	9.44	77.7%	22.3%	31.41	6.03	1.00	38.43	0.49	3.41	100.0%	107.6%	100.0%	100.0%	100.0%	23.2	100.0%	0.0%	0	0	0	6
	Galaxy House	13.00	12.52	50.9%	49.1%	15.40	11.60	0.00	27.00	-2.40	0.92	83.5%	94.5%	86.1%	103.5%	84.1%	10.4	Zero Responses	Zero Responses	0	0	0	0
	PICU	166.73	8.48	95.2%	4.8%	147.48	13.57	0.00	161.05	19.25	-5.09	75.9%	75.2%	83.7%	91.3%	79.6%	24.7	95.7%	0.0%	0	0	0	29
	Starlight Unit	51.89	20.57	71.6%	28.4%	52.23	13.84	0.00	66.07	-0.34	6.73	100.0%	87.2%	93.5%	125.8%	97.3%	10.6	100.0%	0.0%	1	1	0	1
	PED	48.13	6.75	87.7%	12.3%	53.01	7.07	0.00	60.08	-4.88	-0.32							97.7%	2.3%	0	0	0	7
	Trafford Childrens resource Centre	6.80	5.04	57.4%	42.6%	6.00	3.40	0.00	9.40	0.80	1.64							0.0%	100.0%	0	0	0	0
	Children's Theatres	103.05	24.33	80.9%	19.1%	92.61	15.44	0.00	108.05	10.44	8.89							Zero Responses	Zero Responses	0	0	0	2
CSS	Acute ICU	99.67	7.00	93.4%	6.6%	89.03	4.99	0.00	94.01	10.64	2.01	100.0%		100.0%		100.0%	27.7	Zero Responses	Zero Responses	0	0	1	2
	CTCCU	177.07	17.08	91.2%	8.8%	159.46	12.52	0.00	171.98	17.61	4.56	100.0%	52.7%	100.0%	72.6%	100.0%	41.7	100.0%	0.0%	1	0	0	2
	CSITU	75.97	10.28	88.1%	11.9%	61.12	10.53	0.00	71.66	14.85	-0.25	86.9%	96.6%	89.2%	90.9%	88.0%	27.0	100.0%	0.0%	0	0	0	1
	Urgent Care Centre	27.95	2.80	90.9%	9.1%	26.24	2.80	0.00	29.04	1.71	0.00	100.0%	67.3%	100.0%	100.0%	100.0%	102.9	Zero Responses	Zero Responses	1	0	0	0

	HDU & ITU (Crit Care Nursing)	247.31	27.36	90.0%	10.0%	243.35	16.59	0.00	259.93	3.96	10.77	100.0%	100.0%	100.0%	100.0%	100.0%	25.5	100.0%	0.0%	2	1	0	14
Saint Mary's Hospital	47	15.65	9.60	62.0%	38.0%	17.85	7.27	0.00	25.12	-2.20	2.33							Zero Responses	Zero Responses	0	0	0	0
												89.2%	79.9%	98.9%	58.1%	91.9%	8.9	96.8%	0.8%	1	0	0	2
	62	35.31	15.60	69.4%	30.6%	31.15	9.85	0.00	41.00	4.16	5.75	87.1%	92.9%	90.3%	119.8%	88.0%	12.0	96.7%	0.0%	0	0	0	0
	65	14.35	7.60	65.4%	34.6%	15.87	1.00	0.00	16.87	-1.52	6.60	87.6%	96.2%	87.4%	87.1%	87.5%	6.5	100.0%	0.0%	0	0	0	3
	66	18.46	15.20	54.8%	45.2%	19.20	15.00	0.00	34.20	-0.74	0.20	94.8%	86.6%	96.0%	91.9%	95.1%	7.2	100.0%	0.0%	0	0	0	1
	64 - Delivery unit	57.61	13.60	80.9%	19.1%	59.93	7.53	0.00	67.47	-2.32	6.07	86.8%	88.6%	87.3%	77.5%	87.0%	28.2	100.0%	0.0%	0	0	0	7
	Birth Centre	11.97	4.32	73.5%	26.5%	11.99	4.32	0.00	16.31	-0.02	0.00							100.0%	0.0%	0	0	0	0
	Neonatal Unit	42.84	10.43	80.4%	19.6%	29.69	7.37	0.00	37.07	13.15	3.06	100.0%	71.9%	100.0%	53.6%	100.0%	110.8	100.0%	0.0%	0	0	0	6
	NICU	268.03	29.70	90.0%	10.0%	240.24	13.97	1.00	255.21	26.79	15.73	100.0%	52.9%	100.0%	50.0%	100.0%	14.2	87.5%	0.0%	0	0	0	20
	Team 1 Delivery Suite	56.23	18.21	75.5%	24.5%	59.00	21.81	0.00	80.80	-2.77	-3.60	100.0%	98.8%	100.0%	92.3%	100.0%	13.6	100.0%	0.0%	0	0	0	0
	Team 2 Ward C2	8.98	13.93	39.2%	60.8%	9.32	13.91	0.00	23.23	-0.34	0.02	100.0%	58.7%	94.3%	90.3%	97.7%	7.7	98.4%	0.0%	0	0	0	0
	Team 3 Ward C3	6.75	2.24	75.1%	24.9%	8.92	1.44	0.00	10.36	-2.17	0.80	100.0%	54.2%	97.5%	79.6%	99.1%	8.0	100.0%	0.0%	0	0	0	1

	Ward F16	30.82	13.04	70.3%	29.7%	25.52	12.24	0.00	37.76	5.30	0.80	91.3%	101.6%	100.0%	103.3%	93.0%	12.3	96.8%	0.0%	7	2	0	1
	St. Mary's Theatres	65.96	24.97	72.5%	27.5%	58.37	19.69	0.00	78.07	7.59	5.28							Zero Responses	Zero Responses	0	0	0	0
LCO	Buccleuch Lodge	13.00	13.50	49.1%	50.9%	12.44	13.60	0.00	26.04	0.56	-0.10							100.0%	0.0%	1	1	0	0
	Dermot Murphy Close	18.64	35.94	34.2%	65.8%	19.49	31.28	0.00	50.77	-0.85	4.66							Zero Responses	Zero Responses	1	0	0	0
WTWA	2	14.24	33.81	29.6%	70.4%	13.95	16.11	1.00	31.05	-0.71	17.70	79.5%	78.3%	68.1%	86.0%	75.7%	8.8	0.0%	100.0%	3	0	0	3
	4	31.50	19.79	61.4%	38.6%	21.13	17.07	1.00	39.20	9.37	2.72	76.7%	118.1%	98.9%	201.7%	84.3%	6.7	91.7%	8.3%	6	1	0	6
	6	19.89	23.86	45.5%	54.5%	16.63	14.36	0.00	30.99	3.26	9.50	79.6%	106.3%	97.7%	141.0%	86.6%	6.1	81.8%	18.2%	5	0	0	3
	Acute CCU	26.19	4.89	84.3%	15.7%	28.19	4.79	0.00	32.98	-2.00	0.10	76.7%	64.3%	90.6%	100.0%	81.9%	14.4	Zero Responses	Zero Responses	0	0	0	2
	AMU - Wythenshawe	56.48	46.68	54.7%	45.3%	50.59	30.13	1.00	81.72	4.89	16.55	99.9%	84.7%	92.4%	87.3%	96.7%	8.2	98.0%	0.7%	13	4	7	19
	AMU - Trafford	18.91	19.60	49.1%	50.9%	15.92	10.96	1.00	27.88	1.99	8.64	78.7%	73.7%	100.0%	140.6%	83.3%	9.2	66.7%	33.3%	4	0	1	1
	Burns Unit	43.98	12.00	78.6%	21.4%	42.33	9.92	0.80	53.05	0.85	2.08	81.6%	85.8%	98.4%	96.8%	87.7%	17.4	100.0%	0.0%	0	0	0	3
	Doyle Ward	19.17	13.56	58.6%	41.4%	18.13	12.75	0.00	30.88	1.04	0.81	83.3%	108.0%	76.2%	109.8%	80.2%	7.0	100.0%	0.0%	3	0	1	2
	Jim Quick Ward	18.17	6.28	74.3%	25.7%	19.29	4.33	0.00	23.63	-1.12	1.95	100.0%	92.8%	100.0%	100.0%	100.0%	8.1	100.0%	0.0%	0	0	0	1
	Manchester Orthopaedic Centre	31.87	21.85	59.3%	40.7%	27.05	21.89	1.00	49.94	3.82	-0.04	70.7%	70.6%	77.5%	93.3%	72.3%	31.1	98.1%	0.6%	0	0	0	6

Pearce Ward	25.50	8.57	74.8%	25.2%	22.55	4.76	0.00	27.31	2.95	3.81	83.7%	88.0%	93.5%	71.0%	87.1%	6.2	100.0%	0.0%	0	0	0	2
POU	16.60	11.27	59.6%	40.4%	17.40	8.92	0.00	26.32	-0.80	2.35	92.8%	94.6%	100.0%	111.1%	95.2%	6.6	100.0%	0.0%	2	1	0	0
Ward 1 Stroke Unit	14.38	15.02	48.9%	51.1%	13.71	8.60	1.00	23.31	-0.33	6.42	88.7%	123.8%	100.0%	148.6%	92.6%	8.4	71.4%	28.6%	0	0	0	2
Ward 3 INRU	31.31	48.45	39.3%	60.7%	21.96	38.11	0.00	60.07	9.35	10.34	68.0%	87.5%	72.8%	86.7%	69.9%	8.6	Zero Responses	Zero Responses	4	0	0	1
Ward A1	17.17	15.80	52.1%	47.9%	18.55	14.33	1.00	33.88	-2.38	1.47	89.6%	88.2%	97.1%	95.2%	92.9%	6.5	95.0%	0.0%	4	1	1	2
Ward A2 (Surg Mgt)	10.37	5.86	63.9%	36.1%	11.09	4.48	0.00	15.57	-0.72	1.38	85.0%	66.7%	97.3%	119.0%	85.9%	38.5	100.0%	0.0%	0	0	0	1
Ward A3	19.77	20.63	48.9%	51.1%	17.51	15.07	0.00	32.57	2.26	5.56	71.5%	99.4%	93.2%	119.4%	79.2%	7.0	94.1%	2.0%	4	1	0	4
Ward A4	21.40	11.72	64.6%	35.4%	13.52	10.41	0.00	23.93	7.88	1.31	67.6%	111.6%	92.5%	98.4%	76.9%	4.9	95.5%	2.3%	1	0	0	9
Ward A5	20.54	20.55	50.0%	50.0%	17.76	19.25	0.00	37.01	2.78	1.30	79.8%	108.6%	100.0%	159.1%	87.2%	6.9	100.0%	0.0%	4	1	0	1
Ward A6	23.34	13.92	62.6%	37.4%	19.01	12.53	0.92	32.47	3.41	1.39	85.0%	90.6%	83.5%	98.4%	84.4%	7.9	100.0%	0.0%	0	0	1	3
Ward A7	17.64	14.59	54.7%	45.3%	13.88	18.60	0.00	32.48	3.76	-4.01	84.5%	63.5%	95.2%	88.9%	89.0%	4.8	94.7%	0.0%	19	1	0	5
Ward A9	15.95	18.34	46.5%	53.5%	16.61	13.80	1.00	31.41	-1.66	4.54	94.3%	94.9%	96.8%	122.6%	95.4%	4.9	97.6%	0.0%	10	0	1	1
Ward F1 (B&P)	18.09	13.34	57.6%	42.4%	18.96	12.08	0.00	31.04	-0.87	1.26	90.7%	92.9%	96.5%	104.3%	93.1%	9.2	94.6%	2.7%	2	0	0	0
Ward F12 (former A10)	17.00	17.34	49.5%	50.5%	17.35	16.15	0.00	33.49	-0.35	1.19	99.2%	89.5%	93.0%	130.7%	96.5%	5.0	Zero Responses	Zero Responses	16	1	0	2

Ward F14	17.10	14.46	54.2%	45.8%	15.15	13.21	0.00	28.36	1.95	1.25	83.0%	83.2%	94.6%	142.5%	88.1%	5.0	100.0%	0.0%	13	3	0	1
Ward F15	22.33	15.50	59.0%	41.0%	18.90	14.53	1.00	34.43	2.43	0.97	70.4%	87.3%	74.6%	200.8%	71.9%	7.2	100.0%	0.0%	1	0	0	1
Ward F2 Lung Surgery	21.76	8.26	72.5%	27.5%	20.20	5.65	0.00	25.85	1.56	2.61	77.5%	72.5%	73.1%	136.3%	76.1%	6.7	92.3%	7.7%	3	0	0	0
Ward F2/F5	50.44	19.99	71.6%	28.4%	48.63	16.04	0.00	64.67	1.81	3.95	100.0%	91.7%	96.1%	132.0%	98.4%	7.4	99.0%	0.0%	1	0	0	3
Ward F3	17.94	16.39	52.3%	47.7%	17.00	12.41	0.00	29.41	0.94	3.98	67.3%	76.5%	77.5%	105.5%	71.3%	6.0	100.0%	0.0%	6	1	0	2
Ward F4	21.80	29.15	42.8%	57.2%	20.72	24.92	0.00	45.64	1.08	4.23	68.5%	82.5%	94.0%	125.1%	77.8%	6.5	95.1%	2.4%	4	1	0	2
Ward F6	32.34	14.44	69.1%	30.9%	34.94	12.40	0.00	47.34	-2.60	2.04	100.0%	92.8%	98.5%	138.8%	99.5%	6.1	100.0%	0.0%	2	0	0	3
Ward F7	23.77	26.68	47.1%	52.9%	17.07	19.52	0.00	36.59	6.70	7.16	72.1%	102.0%	88.7%	122.0%	78.8%	6.3	100.0%	0.0%	2	0	0	1
Ward F9	17.68	8.13	68.5%	31.5%	17.76	6.64	1.00	25.40	-1.08	1.49	88.3%	130.5%	89.0%	268.1%	88.6%	8.0	96.6%	3.4%	8	6	0	0
F11/PITU	14.29	9.30	60.6%	39.4%	13.91	7.31	0.00	21.21	0.38	1.99	85.3%	76.0%	100.0%	136.1%	88.7%	15.1	100.0%	0.0%	0	0	2	1
Cardiothoracic Theatres	46.99	16.80	73.7%	26.3%	41.44	10.63	0.00	52.07	5.55	6.17							Zero Responses	Zero Responses	0	0	0	0
F Block Theatres	58.47	15.92	78.6%	21.4%	48.30	11.31	0.00	59.61	10.17	4.61							Zero Responses	Zero Responses	0	0	0	0
Acute Theatres	76.63	19.58	79.6%	20.4%	68.39	15.61	0.00	84.00	8.24	3.97							Zero Responses	Zero Responses	0	0	0	1

AMRU	7.08	4.64	60.4%	39.6%	12.28	8.64	0.00	20.92	-5.20	-4.00							88.9%	5.6%	0	0	0	0
Catheter Lab	29.81	3.80	88.7%	11.3%	28.19	4.00	0.00	32.19	1.62	-0.20							Zero Responses	Zero Responses	0	0	0	0
C.D.U. Dept.	12.20	4.10	74.8%	25.2%	9.64	3.64	0.00	13.28	2.56	0.46							96.5%	0.0%	0	0	0	2
LTVS	23.58	13.33	63.9%	36.1%	21.29	10.97	0.00	32.27	2.29	2.36							Zero Responses	Zero Responses	0	0	0	0
Opal House	19.13	34.49	35.7%	64.3%	16.12	29.21	2.00	47.33	1.01	5.28	92.5%	103.6%	93.6%	101.1%	93.0%	5.8	Zero Responses	Zero Responses	9	0	0	0
TDC Theatre	34.51	12.82	72.9%	27.1%	34.00	13.12	0.00	47.12	0.51	-0.30							100.0%	0.0%	0	0	0	0
ED @ Wythenshawe (inc Paeds)	109.95	42.52	72.1%	27.9%	104.07	27.47	0.00	131.53	5.88	15.05							100.0%	0.0%	1	0	0	13
Trafford Theatres	69.33	26.87	72.1%	27.9%	59.09	21.77	0.00	80.87	10.24	5.10							Zero Responses	Zero Responses	0	0	0	0
Wilson Ward	18.00	15.24	54.2%	45.8%	19.64	14.83	1.00	35.47	-2.64	0.41	78.1%	150.4%	71.5%	127.7%	75.1%	6.6	100.0%	0.0%	3	0	1	2

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Peter Blythin, Group Executive Director of Workforce and Corporate Business.
Paper prepared by:	Peter Blythin, Group Executive Director of Workforce and Corporate Business. Helen Farrington, Group Director of Organisational Design and Development
Date of paper:	March 2020
Subject:	2019 NHS Staff Survey Results for MFT
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	The NHS Staff Survey results are the primary method by which MFT can measure how well the Trust supports the well-being of its workforce and enables each member of staff to reach their full potential. This is essential to maintaining improved organisational performance.
Recommendations:	The Board of Directors is asked to consider the survey results and approve the action plan.
Contact:	Name: Peter Blythin, Group Executive Director of Workforce and Corporate Business Tel: 0161 276 5850

MFT Staff Survey Results 2019 and Action Plan

1.0 Background and Context

1.1 This paper provides an overview of the 2019 national staff survey results. The purpose is to provide the Board of Directors with detail of the Group level results, plus a summary of the results for Hospitals / Managed Clinical Services (MCS), Local Care Organisations (LCO), Research & Innovation (R & I) and corporate teams.

1.2 The NHS staff survey is the Trust's primary method by which organisational culture is measured. This includes how 'well led' staff are and whether they feel sufficiently supported to enable them to fulfil their potential. This can be best described as 'staff experience'.

1.3 The culture MFT seeks to create is described in the MFT Leadership and Culture Strategy. The overall aim of the MFT Leadership and Culture Strategy is to develop a compassionate, inclusive and high quality care culture that is underpinned by exemplary leadership and which ensures the best outcomes for people.

1.4 The 2019 NHS staff survey results are based on staff in post and organisational structures as at 1st September 2019. The 2019 survey is the second to be reported nationally for Manchester University NHS Foundation Trust (MFT) given it formed at the point of merger in 2017.

1.5 MFT received two reports: a national one issued by the Survey Co-ordination Centre (SCC) that is published and available for public scrutiny and provides some benchmark data, together with a private report issued by Quality Health. The latter provides a more detailed report but does not provide national benchmark data. Both reports are referred to in this paper.

1.6 The previously-used 32 key findings were replaced by 10 key themes in 2018, which are reported using a 10-point scale. 'Team working' has been added in 2019, making 11 key themes in total. These themes cover around two-thirds of the questions included in the survey. The remaining questions are reported separately.

2.0 Response rate

2.1 There were 6978 completed surveys giving a response rate of 33% (-2% on 2018). The median response rate for the MFT benchmark group 'combined acute and community trusts' was 46% (41% in 2018).

2.2 220 (33%) Sodexo ROI staff also responded to the survey but are not included in the SCC report for MFT. This is almost a 50 % increase on last year (17%). A separate locally developed report will be considered by the Sodexo team and the results are therefore not included in this report.

3.0 National reporting of the staff survey results

3.1 The staff survey results for each NHS Trust and participating organisations are published by the SCC and the results are reported under 11 key themes. These themes cover 54 of the questions included in the survey. Responses to the remaining questions are reported separately. A 10 point scale is used for the scoring of key themes, to one decimal point.

3.2 Each NHS Trust is assigned an appropriate benchmarking group. For MFT this is 'combined acute and community Trusts'.

3.3 Benchmarking data is provided in the reports provided by the SCC, showing the 'best', 'worse' and 'average' scores for each key theme.

3.4 Five years of historical data is provided by the SCC, however data for MFT only goes back to 2017 when the Trust was formed.

3.5 National reporting for 2019 includes results by Group / Hospital / MCS / LCO and Corporate / R&I, at 'Key Theme-level', with question-level reporting also provided at Group Level. The national report also includes benchmarked data for individual questions at Group level.

3.6 In addition to the core survey questions that all participating organisation use, MFT includes additional optional questions covering the MFT Values and Leadership and Career Development. These are excluded from national reporting.

4.0 Group Results: Summary – overall staff engagement

4.1 As in previous years, the overall staff engagement score is based on three factors: recommendation of the organisation as a place to work/receive treatment (advocacy) staff motivation at work (motivation); and contribution towards improvements at work (involvement).

4.2 Nationally, the overall staff engagement score has remained static at 7.0, unchanged since 2015, but with small improvements in both the motivation and advocacy dimensions of engagement.

4.3 For MFT, the reported Group staff engagement score has remained at 7.1 with the actual score being 0.02 lower than 2018. This could be viewed as a disappointing result but the data should be considered against the fact the survey was conducted in the second year of a major merger of two organisations.

4.4 The chart below compares the 2018 and 2019 staff engagement scores across the factors of advocacy, motivation and involvement at MFT. There have been no statistically significant changes in scores, or in the overall staff engagement score.

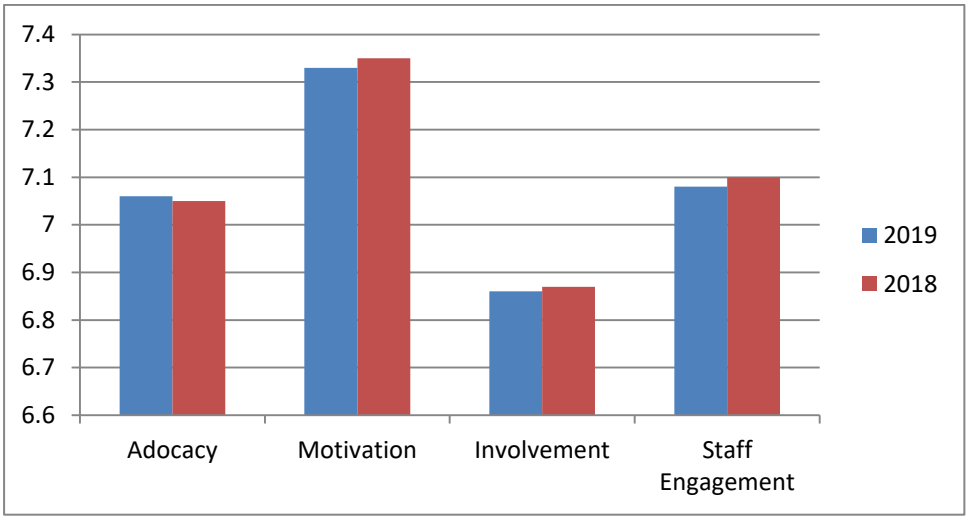


Chart 1: Staff engagement MFT Group 2018-2019

4.5 *Regional Benchmarking- Greater Manchester Acute Trusts*

The table below shows how MFT compares to other acute hospital trusts in Greater Manchester for the overall staff engagement score.

Trust	2017	2018	2019
Bolton	7.1	7.3	7.3
Wrightington, Wigan and Leigh	7.4	7.0	7.3
East Cheshire	7.1	7.2	7.2
MFT	**7.0**	**7.1**	**7.1**
Salford Royal	7.0	7.1	7.1
Tameside and Glossop Hospitals	7.2	7.1	7.0
Pennine Acute Hospitals	6.8	6.8	7.0
Stockport	6.8	6.9	6.9

Table 1: Benchmarking – Acute Greater Manchester hospital trusts

5.0 Group Results Summary – key themes and individual questions, including optional questions

5.1 Group Results - Key Themes

5.1.1 There are 11 key themes in the staff survey. Questions not covered by these themes are reported individually. The table below shows the key themes results for 2019, compared with our sector average and with the equivalent scores for 2018.

Theme	2019 MFT	2018 MFT	2019 Sector
Equality, Diversity and Inclusion	9.1	9.1	9.2
Health and Wellbeing	6.0	6.0	6.0
Immediate Managers	6.9	6.8	6.9
Morale	6.2	6.2	6.2
Quality of Appraisals	5.5	5.3	5.5
Quality of Care	7.4	7.5	7.5
Safe Environment – Bullying & Harassment	8.2	8.3	8.2
Safe Environment - Violence	9.6	9.6	9.5
Safety Culture	6.8	6.8	6.8
Staff Engagement	7.1	7.1	7.1
Team working	6.6	6.7	6.7

Table 3: Group Key Themes' scores 2018-19

Favourable difference since 2018 and /or against benchmark average
Within 0.1% of absolute average of benchmark group

5.1.2 The SCC report offers two statistically significant changes to the MFT key theme scores in the 2019 survey:

- a statistically significant improvement for *Quality of Appraisal.*
- a statistically significant decline for *Safe Environment – Violence* (although, due to rounding and sample size, this score is summarily reported as unchanged).

5.1.3 The SCC does not report on the statistical significance of differences between the Trust and sector key theme scores. However, MFT is within 0.1 of the sector average score for all 11 key themes.

5.1.4 Nationally, six key theme scores remained the same and five improved*: immediate managers, morale, quality of appraisal, quality of care and safety culture*.

5.1.5 At benchmark sector-level, three key theme scores remained unchanged and eight key themes improved: *immediate managers, quality of appraisal, safety culture, equality, diversity and inclusion, health and wellbeing, safe environment (bullying and harassment), team working and staff engagement*. All improvements were by 0.1.

5.1.6 Appendix 1 is a summary table provided by the SCC of MFT scores across the 11 key themes against the benchmark sector average, and the best and worst sector scores.

6.0 Hospital / MCS / LCO / Corporate summary

6.1 Reports at Hospitals / MCSs, and for the LCO, corporate departments and R & I, are provided by the SCC for key themes only. The table below shows the overall **staff engagement score** for each Hospital / MCS and for the LCO, corporate departments and R & I:

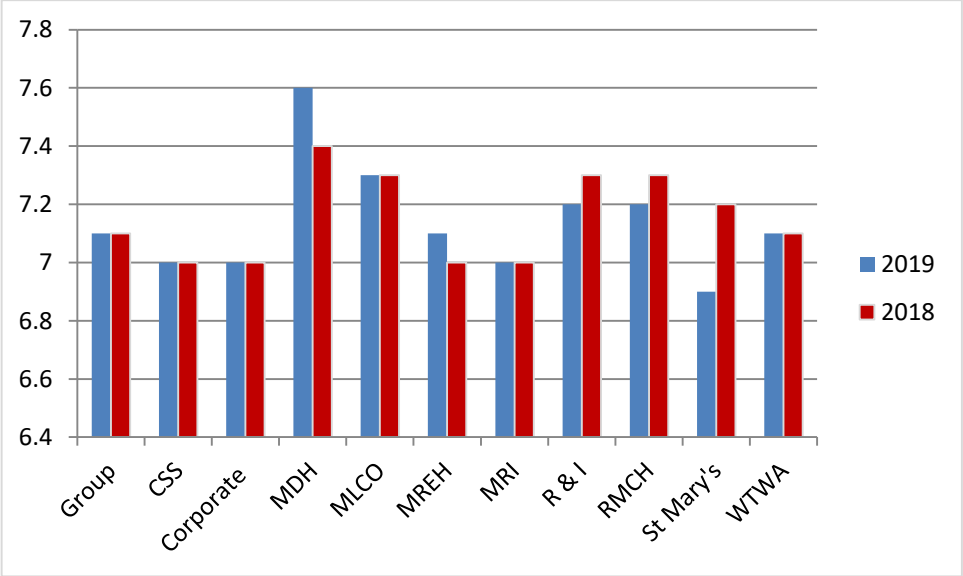


Table 3: Overall staff engagement score**s** by Hospital/MCS/Corporate area 2018-19

6.2 Appendix 2 shows the results for each key theme by Hospital / MCS and for the LCO, Corporate and R & I.

7.0 Survey free text comments

7.1 Staff are given the opportunity to add unattributed free text comments when they complete the survey. As yet, these comments are not available to MFT. When they are, a thematic analysis will be undertaken to identify key areas of concern, opportunities for improvement and to acknowledge concerns.

8.0 Next Steps and Key Actions for 2020/21

8.1 The detail provided by the NHS staff survey will be used to inform actions required to improve the experience of staff working at MFT. This will include consideration of how best to build on the positive feedback provided by staff. The priority areas for improvement will focus on the key themes where the Trust has either deteriorated or where it is below the benchmark group as outlined in this report.

8.2 At a Group Level, priority areas and actions will be progressed and monitored through the Staff Engagement Task & Finish Group, the membership of which includes Hospital / MCS / LCO and representatives from staff side.

8.3 Specific focus will be given to delivery of the MFT Leadership and Culture and Equality and Diversity Strategies both of which are aimed at making improvements to the working life of our staff.

8.4 In tandem with the Group level work each Hospital /MCS will include specific actions in the annual plans to satisfy local circumstances. Corporate areas and the LCO will undertake similar activities.

8.5 Feedback on staff experience and staff engagement will continue to be measured though the 'Staff Friends and Family Test', the Trust 'Pulse Checks', and, the 'Culture of Care' surveys. Performance will reported and monitored through the Accountability Oversight Framework (AOF) and to the Board of Directors through the monthly Board Assurance Reports.

8.6 A comprehensive report on the survey results together with a detailed action plan will be submitted to the HR Scrutiny Committee in Quarter 1 (20120/21).

9.0 Recommendations

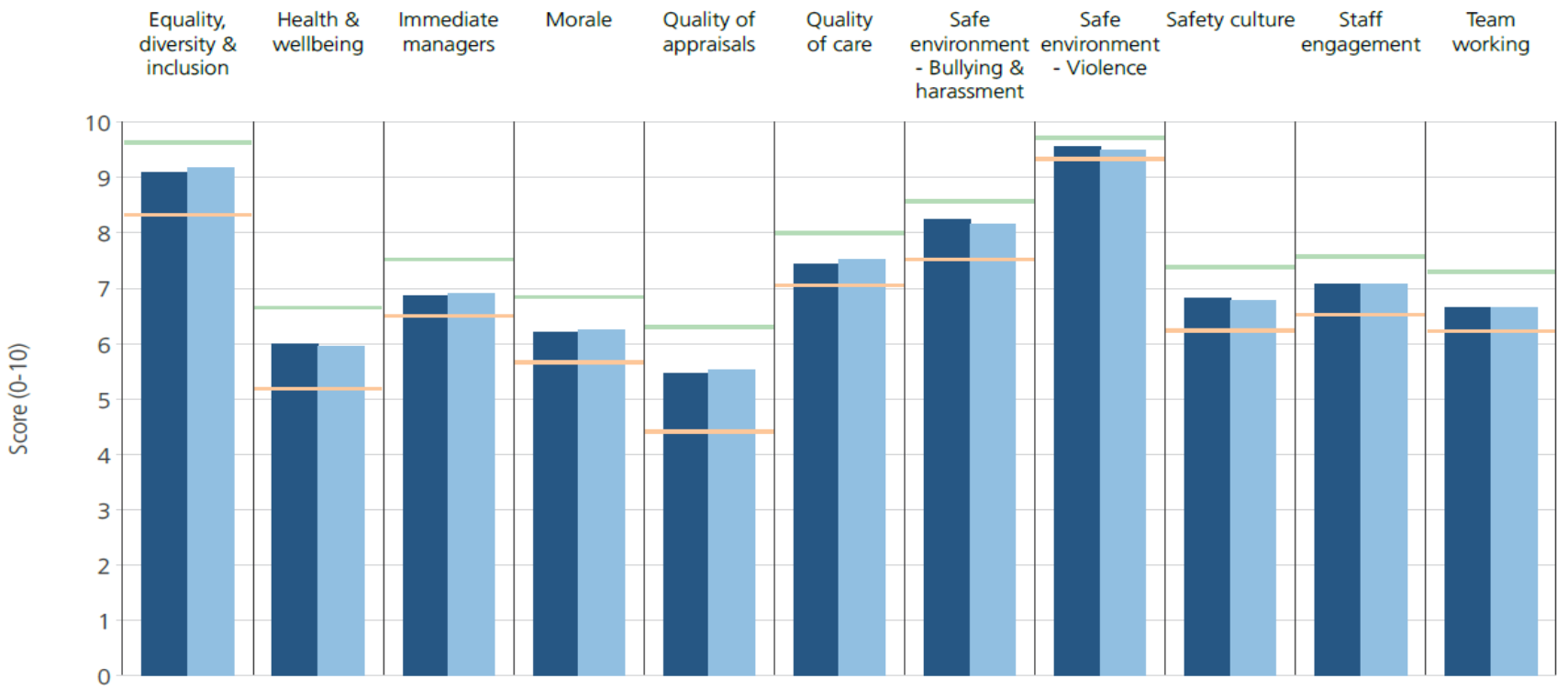
9.1 The Board of Directors is requested to note the strengths, improvements and areas for development captured within the latest 2019 Staff Survey and the priority areas for action in 2020/21 as set out in section 8 of the report.

Appendix 1: Group Staff Survey Results by Key Theme, including sector comparison

Survey Coordination Centre

2019 NHS Staff Survey Results > Theme results > Overview

NHS England



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.6	6.7	7.5	6.8	6.3	8.0	8.6	9.7	7.4	7.6	7.3
Your org	9.1	6.0	6.9	6.2	5.5	7.4	8.2	9.6	6.8	7.1	6.6
Average	9.2	6.0	6.9	6.2	5.5	7.5	8.2	9.5	6.8	7.1	6.7
Worst	8.3	5.2	6.5	5.7	4.4	7.1	7.5	9.3	6.2	6.5	6.2
Responses	6,795	6,859	6,893	6,768	5,860	5,904	6,809	6,788	6,818	6,952	6,839

Appendix 2: 2019 Staff Survey Results for Key Themes, by Hospital/MCS/Corporate area

	Equality, Diversity and inclusion	Health and Wellbeing	Immediate managers	Morale	Quality of Appraisal	Quality of Care	Safe environment - Bullying and harassment	Safe environment - Violence	Safety culture	Staff engagement	Team-working
Group	9.1	6.0	6.9	6.2	5.5	7.4	8.2	9.6	6.8	7.1	6.6
CSS	9.2	6.0	6.7	6.2	5.5	7.4	8.4	9.6	6.8	7.0	6.5
Corporate	9.3	6.3	6.9	6.2	5.4	6.9	8.9	9.9	6.6	7.0	6.6
MDH	9.2	6.5	7.5	7.0	6.7	8.1	8.4	9.8	7.3	7.6	7.4
MLCO	9.3	6.2	7.2	6.6	5.6	7.7	8.5	9.8	7.0	7.3	7.4
MREH	9.0	5.7	6.6	6.1	5.6	7.9	7.5	9.8	7.1	7.1	6.3
MRI	8.7	5.7	6.6	6.0	5.4	7.4	7.6	9.2	6.6	7.0	6.4
R & I	9.3	6.5	7.3	6.2	5.8	7.7	9.2	9.9	7.0	7.2	7.2
RMCH	9.3	6.1	6.9	6.4	5.5	7.3	8.1	9.6	7.0	7.2	6.8
St Mary's	9.3	5.8	6.6	6.1	5.2	7.1	8.5	9.8	7.1	6.9	6.7
WTWA	8.9	6.0	6.9	6.3	5.4	7.7	8.0	9.4	6.8	7.1	6.5
Sector	9.2	6.0	6.9	6.2	5.5	7.5	8.2	9.5	6.8	7.1	6.7

	0.3+ higher than Group
	Up to 0.2 higher than Group
	Up to 0.2 lower than Group
	0.3+ lower than Group

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Miss T S Onon, Joint Group Medical Director
Paper prepared by:	Mrs Sarah Corcoran, Group Director of Clinical Governance
Date of paper:	January 2020
Subject:	Proposed changes to Group risk management arrangements.
Purpose of Report:	Indicate which by ✓ • Information to Note • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Patient safety and clinical quality.
Recommendations:	The Board of Directors is asked to consider approving the recommendations set out in section 4
Contact:	Name: Sarah Corcoran, Group Director of Clinical Governance Tel: 0161 276 8764

1. **Background:**

In 2017 when the two legacy Trusts merged both organisations used the same governance process for the management of risk, all risks above a certain level were considered at an organisation wide risk meeting, chaired by an Executive Director. During the planning stages of the merger a decision was made not to change the arrangements substantially in order to ensure stability during the early stages of significant organisational change.

In July 2019 the Group Risk Management Committee discussed the need for a change in the governance process. It was agreed that two years into the merger a need for modification existed and readiness for change should be evaluated.

It has been recognised that as a group of hospitals, managed clinical services and the Manchester and Trafford Local Care Organisations, risk oversight now needs a different approach and that one committee cannot continue to receive detailed reports on every risk at every meeting. The approach no longer supports the process as it is now undertaken. Hospitals / MCS and the M/TLCO have firmly embedded senior leadership teams and more mature governance structures. These teams and structures are now supporting a more mature and cohesive approach to the management of risk which requires a different approach at Group level.

In summary, the Group model supports the local management of risk and the Group Risk Management Committee can now, 24 months in to the new structure, refocus on oversight of the risk management *process* rather than every risk at ≥15.

2. **Assurance on Supporting Governance Structure and Reporting Arrangements**

In order to ensure that safe systems and good governance processes were in place to support the change the Group Risk Management Committee commissioned an audit of the process in all Hospitals/MCS and the MLCO.

The purpose of the audit, undertaken by KPMG, was to set out the risk management processes within each hospital/MCS alongside any recommendations for improvement. The Group can then use this information to decide whether any further elements of the risk management process can be devolved to hospitals/MCSs to allow the Group Risk Management Committee to focus discussion on the most significant risks as needed and scheduled

The audit considered:

- the design and operating effectiveness of the risk management arrangements within each hospital/MCS as well as their processes for reporting and escalating risks up to Group level. This included:
- policies, procedures and template documents in use within each hospital/MCS;
- the process for identifying, recording and scoring risks;
- how departmental and divisional-level risks feed up to the hospital/MCS level risk registers and the process for moderating which risks are accepted on to hospital/MCS level risk registers;
- The governance structure within each hospital/MCS for the management and oversight of risk;
- The process within each hospital/MCS for the compilation of the bi-monthly Hospital Risk Profile Reports which go to the Operational Risk Management Group (ORMG);

- How thematic reports which are produced for the ORMG are used by each hospital/MCS to identify any gaps in currently identified risks and how these reports are used by the ORMG to escalate any common risks across a number of areas of the Group; and
- How each hospital/MCS reports and escalates risk up to Group level and the process for moderating which risks are accepted onto the Group-level risk register.

Each hospital MCS/MLCO was given a maturity rating and all of these were given as mature or developing from basic to mature as new processes embed.

The Group as a whole was given significant assurance with 2 medium actions and 5 minor. All of these were accepted as recommendations and are being acted upon. The medium recommendations related to the documentation of the reporting schedule and rand the establishment of the Risk Management Committee in RMCH.

In summary the audit supported the readiness for change.

To follow up it is proposed that KPMG will undertake a desktop exercise on the new process and observe the next Group Risk Oversight Committee in March.

3. Testing

The Group Risk Management Committee received a presentation on the new approach and tested the revised agenda on 20 January 2020, the committee recommends the new approach, revised Terms of Reference[1], revised Risk Management Strategy[2] and reporting schedule[3] to the Board of Directors for approval.

4. Recommended changes for consideration:

- Change the title of the committee to Group Risk *Oversight* Committee
- Continue to present <u>all</u> risks at ≥15 in the form of a Risk Register – but add to this detail on the oversight arrangements
- Present detailed reports on all <u>new</u> risks – and agree schedule for detailed reporting
- Present detailed reports on all <u>risks requiring consideration for downgrade</u> with assurance on mitigation
- Present detailed reports on risks for which there is a <u>low appetite</u> these would generally be patient safety/patient experience related. However, some of these, such as records management where the solution is in the long term and the risk is well managed at another Group Committee may need to report less often
- Present detailed reports on risks <u>scheduled</u> for reporting throughout the year – i.e. risks such as finance, performance, strategy and cyber security which are reported on in detail at high level Group committees may be scheduled for an annual report across the year unless there is a requirement for an exception report. An exception report would be made to escalate any significant change such as a sudden deterioration in position. These risks would generally fall into the category of those for which there is a <u>medium to high appetite</u>

[1] Appendix 1
[2] Appendix 2
[3] Appendix 3

- Hospitals / MCS / MLCO would manage their own local risks and provide a detailed report on request

5. Recommendations

The Board of Directors is asked to:

- Approve the recommendations set out at section 4
- Approve the revised Terms of Reference
- Approve the revised Trust Risk Management Strategy

Appendix 1

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

Group Risk Oversight Committee
Terms of Reference

1. CONSTITUTION

1.1. The Board of Directors has established a Committee of the Board to be known as the Risk Oversight Committee (the Committee).

2. MEMBERSHIP

Chief Executive Officer (Chair)
Joint Group Medical Director(s)
Group Chief Nurse
Group Chief Finance Officer
Group Executive Director of Workforce and Corporate Business
Group Chief Operating Officer
Group Executive Director of Strategy
Hospital/MCS Chief Executives
Group Director of Clinical Governance
Group Associate Director of Clinical Governance
Group Director of Corporate Services/Trust Board Secretary
Corporate Directors as required

In attendance - Internal Audit Representative

3. ATTENDANCE AT MEETINGS

3.1. Non-Executives of the Trust may attend this Committee and will be provided with copy papers in advance of each meeting.

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

3.3. A quorum shall consist of eight members including a minimum of one Executive Director and one Hospital/MCS Director.

4. FREQUENCY OF MEETINGS

4.1. Every two months and at other times as may be necessary.

5. OVERVIEW

5.1. The Committee will review and report on the overall risk profile of the organisation and ensure that effective assurance mechanisms are in place.

5.2. The Committee will approve the process for the management of risk, communicated through the Group Risk Management Strategy, and set the tone and appetite for risk across the Group.

6. SCOPE AND DUTIES

6.1. To provide an assurance to the Board of Directors that risks of all types are identified, and controlled to an acceptable level, and to advise the Board on significant risks (those with a residual score of 15 or above).

6.2. To receive the Trust Risk Register from the Risk Management Department and any significant risks identified through other reports and ensure the Board Assurance Framework is updated with reference to these risks, any gaps in control and gaps in assurance.

6.3. The GROC will review reports on the following:

- New risks at level ≥15 – single report detailing management and oversight arrangements
- ~~Group wide risks~~
- Scheduled risk reports for Hospital/MCS/MLCO/Corporate risks
- Risks escalated for review/support by Hospitals/MCS where further mitigation is outside of the control of the Hospital/MCS (for example a national tariff issue)
- Level ≥15 risks in Hospital/MCS with an AOF score of 6
- The GROC may also identify risks that require more detailed scrutiny arising from the Group Board Assurance Report, Group Board Assurance Framework, regulatory issues, national reports, patient/service user feedback and public interest issues

6.4. To provide a forum for consultation between all professions on methods for assessing risks of all types in a consistent fashion and to propose levels of acceptability for Board of Directors' approval.

6.5. To provide the Board of Directors with the Group Risk Management Strategy for its approval.

6.6. To raise awareness and understanding of risk management at all levels and among all professions in the Trust.

6.7. Based upon the reporting and assurance framework, advise the Board of Directors on risk considerations relevant to the agreement of strategic objectives and investment priorities.

6.8. To agree and oversee the methodology for treating risks for use by operational management and to propose the relationship between this and the business planning process.

6.9. To ensure that there is an effective mechanism for reporting significant risks to the Board or senior management in a timely fashion (outside the usual reporting mechanism).

6.10. To ensure that there are effective mechanisms for reporting risks to the appropriate bodies both internally, for example:

- Pharmacy
- Occupational Health
- Medical equipment

Externally, for example:

- Care Quality Commission
- NHS Improvement
- NHS North West
- Medicines Healthcare products Regulatory Agency MHRA
- Health and Safety Executive HSE

6.11. To investigate and propose longer term risk indicators and report on progress against them to the Board of Directors.

6.12. To ensure an effective mechanism for escalating issues from Trust Groups to the appropriate Committee of the Board of Directors and the Board Assurance Framework.

6.13. To provide the Board of Directors with an assurance that the risk is well managed. This should be through quarterly reporting which demonstrates:

- The risk management reporting route includes all aspects of risk arising out of Trust activities
- Risk management training reflects the needs of all professions and that content and delivery is effective
- Risk assessments, risk registers and risk planning include clinical issues

6.14. To ensure that systems are in place which improve all practice appropriately as a consequence of risk assessment, incidents, complaints or claims.

6.15. To provide an assurance to the Audit Committee that the risk management structure contributes to a system of internal control, by reporting on:

- The methods for ensuring the full range of risks is encompassed
- Accountability for aspects of risk management and internal control
- Any high level risk associated with progress on completing baseline self-assessments of local and national standards, and generating subsequent action plans

6.16. To ensure an effective mechanism for reporting risk issues to all levels of management and staff.

6.17. To receive a report of the Group Operational Risk Management Group.

6.18. To receive the minutes of the Trust Strategic Health and Safety Committee.

7. DOCUMENT REVIEW

7.1. The Committee will be responsible for the review and submission of the following documents:

7.1.1. The Group Risk Management Strategy

8. RELATIONSHIPS AND REPORTING

8.1. The Committee report shall be considered at the next Board of Directors' meeting.

8.2. The Committee report shall be considered at the next Trust Audit Committee.

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

8.4. The Committee will work closely with both the Audit Committee and other Board sub-committees to provide assurance to the Board of Directors that there are effective systems of internal control.

9. AUTHORITY

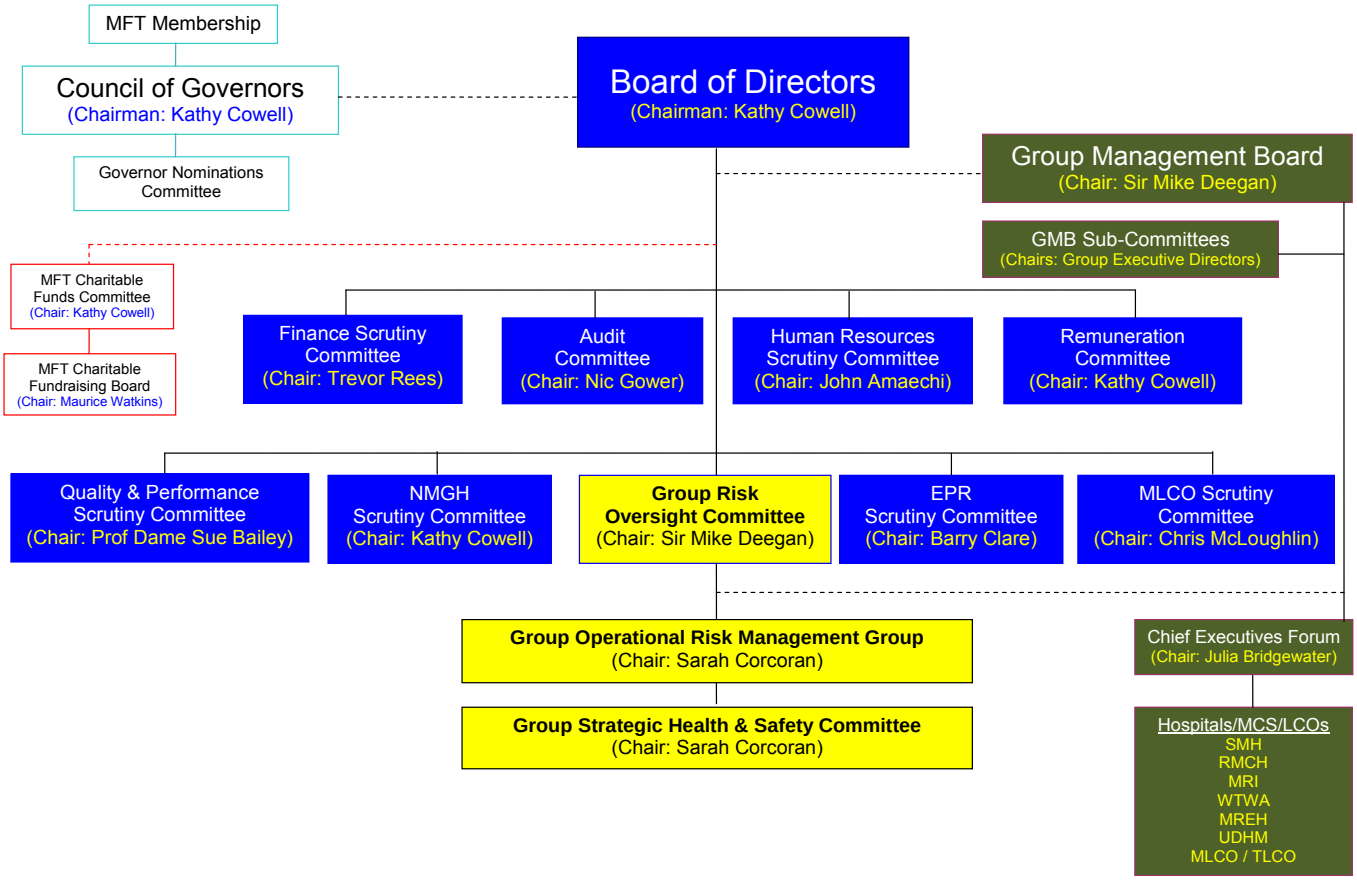
9.1. The Committee is empowered to examine and investigate any activity within the Trust pursuant to the above scope and duties.

10. KEY PERFORMANCE INDICATORS

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

10.1.1. 75% attendance of all listed members or nominated deputy
10.1.2. Presentation of the Group Risk Management Strategy
10.1.3. Presentation of risk management detail in the Annual Report
10.1.4. Contribution to the Annual Governance Statement
10.1.5. Documented discussion at each meeting of risk referral
10.1.6. Annual report for the Health and Safety Committee

11. REPORTING STRUCTURE CHART



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Date of Next Review: January 2021

Appendix 2

DOCUMENT CONTROL PAGE		
Title	Title: Version: Reference Number:	Risk Management Strategy and Policy 2
Supersedes	Supersedes:	Version 1
Minor Amendment	Date: Notified to: Summary of amendments:	Date:
Author	Originated / Modified by: Designation:	Ann Parker-Clements Associate Director Clinical Governance
Ratification	Ratified by: Date of Ratification:	Group Risk Management Committee
Application	All staff	
Circulation	Issue Date: Circulated by: Dissemination and Implementation:	
Review	Review Date: Responsibility of:	October 2021
Date placed on the Intranet:		Please enter your EqIA Registration Number here:

Contents

1. Statement of Intent

1.1. Manchester University NHS Foundation Trust (MFT) intends to provide the best possible care for the people that we serve and to strive for zero avoidable harm. We will do this through an open and transparent culture of learning, research and continuous improvement. This is clearly detailed in the Trust's principal objectives[4]

1.2. The Group Board of Directors (hereafter referred to as 'the Board') acknowledges that:

a. As a large, complex organisation delivering a range of highly specialised services and the way in which MFT provides these services, carries with it unavoidable and inherent risk

b. The identification and recognition of these risks – together with the systematic proactive management, mitigation, acceptance (if appropriate within its strategy) and (where possible) elimination of these risks – is essential for the efficient and effective delivery of safe and high quality services

c. Effective risk management is not an end in itself, but an integral part of Manchester University Hospitals NHS Foundation Trust quality, governance and performance management processes

d. All staff have a role in considering risk and helping to ensure it does not prevent the delivery of safe and high quality service; and that

e. The Board with the support of its committees has a key role
   - in ensuring a robust risk management system is maintained and effectively resourced
   - in encouraging a culture whereby risk management is embedded across the Trust, and
   - through its plans, set out its appetite and priorities in respect of the mitigation of risk when delivering a safe and high quality service
   - in supporting staff to work collaboratively with colleagues, service users and carers to support the provision of high quality safe services

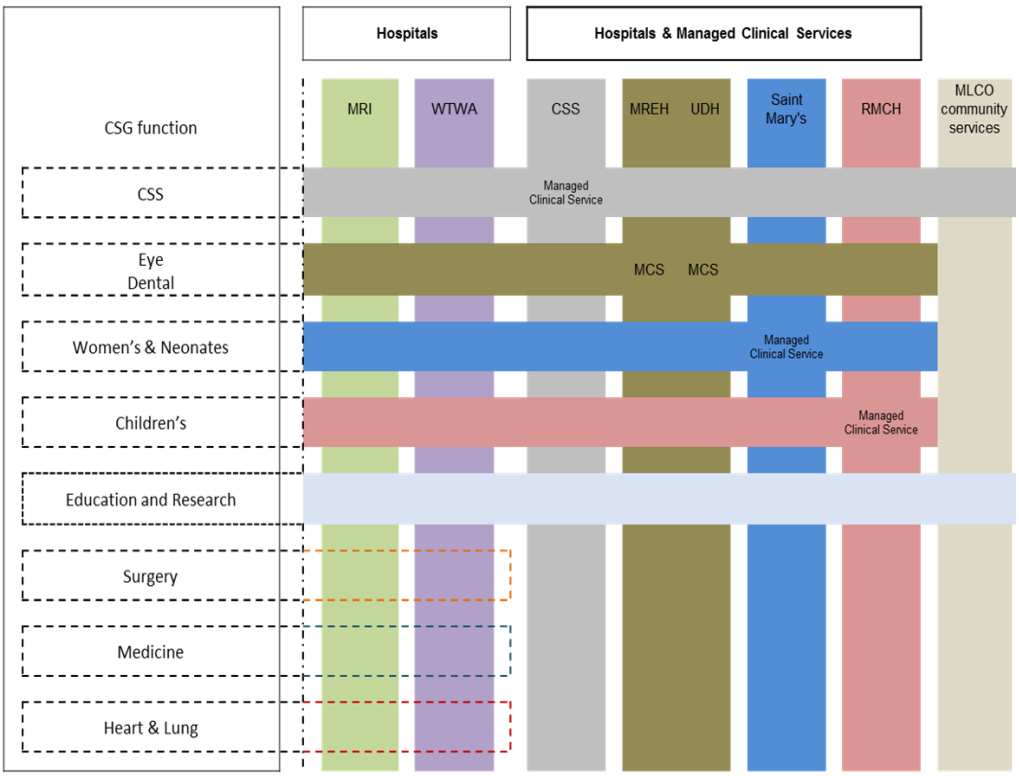
1.3. This Strategy covers a two year period from October 2019 to September 2021 and outlines the approach for continued development of a risk management system. For a comprehensive list of risk management definitions refer to *Appendix A: Glossary of Terms*

2. Purpose

2.1. MFT is a new organisation which came into being on 01 October 2017. The scale and complexity of the organisation is recognised and the organisational form is set out below in Figure 1 to provide a visual representation of reporting structures

Figure 1: Organisational Matrix

[4] https://mft.nhs.uk/the-trust/



2.2. This Strategy outlines the Trust's safety and risk management system. The principles and procedures described within this Strategy are applicable to all types of risk. The Strategy sets out the management structure and responsibilities, and supports the delivery of the operational policies in place within the organisation. The aim of the Strategy is to embed risk management into the day to day practice and management of the Trust. It covers all aspects of risk including clinical, workforce, environmental, corporate and financial risk

2.3. The Trust has in place a unified Strategy for managing all risks. This forms an integral part of the **Board Assurance Framework** (BAF) and Business Planning process. The BAF brings together in one place all of the relevant information on the risks to the Board's strategic objectives. All risks scored at 15-25 will be aligned to the Board Assurance Framework via association with the Trust Strategic Objectives and as such, the Board will be aware of any risks that impact the strategic direction of the Trust

2.4. The Trust monitors its structures and processes for managing risk through detailed Key Performance Indicators which are set out in Section 9

2.5. The Trust is obliged to deliver services according to national and local requirements that dictate the level and quality of services[5]. Key drivers include regulatory requirements set out by the Care Quality Commission (CQC), Department of Health, NHS England, Health and Safety Executive, and NHS Improvement. In addition, the Trust must meet its statutory duties, comply with standing financial instructions and ensure that healthcare professionals within the Trust adhere to the standards of their regulatory bodies. Risk management must be an integral part of the business planning process

3. Purpose – Strategic objectives

[5] NHS Outcomes Framework https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework/current
Health and Social Care Act 2012 https://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
CQC Fundamental Standards http://www.cqc.org/uk/what-we-do/how-we-do-our-job/fundamental-standards

3.1. The vision of the Manchester University NHS Foundation Trust is to improve the health and quality of life for our diverse population by building an organisation that:

- Excels in quality, safety, patient experience, research, innovation and teaching
- Attracts, develops and retains great people, and
- Is recognised internationally as a leading healthcare provider

3.2. This vision will be delivered through the following strategic objectives:

- To improve patient safety, clinical quality and outcomes
- To improve the experience of patients, carers and their families
- To develop our workforce enabling each member of staff to reach their full potential
- To develop single services which build on the best from all our hospitals
- To develop our research portfolio and deliver cutting edge care to patients
- 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 achieve financial sustainability

3.3. The principal aims of the Risk Strategy are:

- to foster a culture of risk awareness and responsibility
- to provide systematic approach to risk identification, management and mitigation
- to ensure effective communication of risk at all levels of the organisation

This Strategy is intended for use by all staff engaged in the business of the Trust

4. Risk appetite and accepted risk

4.1. The Board accepts that there is an element of risk in every activity that is undertaken and the Trust's appetite for accepting or taking a particular risk will depend on a range of factors, including the effects of the risks on the Trust's strategic goals and initiatives, should the risk materialise

4.2. The Board recognises the complexity of decision-making in providing services and the inherent risks associated with those decisions. It is also acknowledged that there is no absolute risk-free formula for establishing whether the Board considers that an activity is or is not an acceptable risk to take. Each case requires the exercise of judgement and the *Risk Appetite* guidance below will be used to inform decision-making in connection with risk

4.3. The Board's appetite for risk-taking and tolerances should be mapped against the Strategic Objectives using the levels set out in Table 1 below. The appetite for tolerating/accepting or taking a risk is separate to and not dependent on, the overall risk rate score. Table 1 provides guidance on the levels of risk appetite to be selected. These are examples and there may be occasions when the appetite may alter if the risk of alternative options is higher. The risk assessor should consider this as part of the overall assessment of each specific risk

Table 1: Levels of risk appetite

Appetite Level	Guidance	Example
Low	Prepared to accept only the very lowest levels of	Patient

	risk, with the preference being for ultra-safe options, or willing to accept some low risks, while maintaining an overall preference for safe delivery options despite the probability of these having mostly restricted potential for reward/return	Safety
Moderate	Tending always towards exposure to only modest levels of risk in order to achieve acceptable, but possibly unambitious outcomes	Workforce planning
High	Prepared to consider/eager to seek all options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risks in order to secure successful outcomes and meaningful reward/return	Business development

4.4. It may be necessary to accept a risk, for example, if no further mitigation is possible or if there is an appetite for taking a risk because of the perceived benefits of doing so. The decision as to whether a risk can be accepted should be made based on the appetite for acceptance and agreed according to the risk Authority, which is detailed in Section 5. All risks of ≥15 that are accepted must be reviewed and reported to the Group Risk Oversight Committee every 12 months or additionally in the event of any changes to the risk level or controls.

5. Authority within the Trust to act according to the level of risk

5.1. Not all risks can be avoided and there will be a level of identified risk in some areas that is agreed as acceptable/tolerated. The decision to accept the level of risk will be based on any effect it may have on service provision, financial capacity and the extent to which it can be minimised. Ongoing review and monitoring using the Trust's governance committee structure will ensure that risks and their management plans remain relevant. Detailed below is the level of authority to act on and accept a risk according to the current risk score

5.2. ***Very low and low risks (Green/Yellow)*** (Score 1-9) – are dealt with by responsible managers at different levels within the services and are reported through the Trust governance structure. All managers have the authority for the effective management of very low/low risks within teams, services or departments. Managers have the authority to assess and manage risks and directly manage risks graded low and very low reporting through their local electronic risk register and their line management structure

5.3. ***Medium risks (Amber)*** (Score 10-12) – require approval of any remedial action by the Hospital site/Managed Clinical Services (MCS). Hospital/MCS/MLCO clinical and service directors have the authority to assess and manage the risks, and are accountable for the implementation of remedial action

5.4. ***High risks (Red)*** (Score 15 or above) – the relevant Group Executive Director has the authority to nominate a lead individual to manage each of these risks, reporting progress to them and the Group Risk Oversight Committee as outlined below:

- The responsibility for the day to day management of suitable[6] high level risks is delegated to the Hospital and MCS teams. The Hospitals/MCS will report on the management of these to the Group Risk Oversight Committee (GROC) on an annual basis
- Each Hospital site/MCS will also report annually on their overall management of risk, risk profile and progress with mitigation of risks

[6] Those risks applicable to one Hospital/MCS/MLCO only with the potential to be mitigated locally

- In addition to the GROC reporting, the Group operates an Accountability Oversight Framework. This framework is a fundamental component of the risk identification methodology and will act as an assurance source for the Group Board. This framework will support the assessment of decision making rights and thus inform the level of support or intervention on risk identification and management
- The Board has the ultimate authority for ensuring risks at this level are managed effectively and efficiently, and that controls are put in place are robust
- The Risk Register will be presented in its entirety but detailed reports will not be required at each meeting. Detailed reports of risks will be scheduled based on the following criteria:
    - Annual reports – Hospital site/MCS risks[3], accepted risks, those with oversight by an existing Scrutiny Committee and any risks with an agreed long term plan for mitigation
    - As identified/required reports – any new/emerging risks and any risks requiring consideration for downgrade as required
    - Regular – all other risks will have an agreed reporting schedule
- The GROC will approve the process for the management of risk, communicated through the Risk Management Strategy, and set the tone and appetite for risk across the Group
- The GROC will review the analysis of the organisational risk profile including ratio of high, moderate, low level risks, types of risk and emergent themes

6. Risk management organisational governance structure

6.1. The management of risk is to be embedded in day to day activities at all levels and responsibility for the management of risk is devolved throughout the Trust. The committee and governance structure in place to support this is outlined below

The Group Board of Directors

6.2. The Board ensures systems are established to identify any risks that the Trust is exposed to and ensure that procedures are in place to monitor and control these risks to acceptable levels. The Trust will ensure that any new Board member (including Non-Executives) is inducted as to the risk management system: this will particularly emphasise the structure and processes for risk management and personal responsibilities at all levels

6.3. The Board takes responsibility for establishing the strategic context for risk management and will ensure that all stakeholders are adequately involved in the Trust's Risk Management Strategy. The Board also ensures effective means of communication in order that stakeholders are informed of the risks the Trust is exposed to, and the measures taken to reduce these to an acceptable level. For example by sharing of the Group level risk register with commissioners, regulatory bodies as required and requested

6.4. The Board is responsible for receiving, considering and acting, where necessary, on reports from the Group Risk Oversight Committee

6.5. The Board has ultimate responsibility for overseeing the process of identification of principal risks for the organisation, the incorporation and prioritisation of these risks within the Board Assurance Framework and the attention to risks in all planning activity

6.6. The Board is supported in their duties as detailed above by the Group committees with a responsibility for risk within the Trust which are outlined below:

- Group Risk Oversight Committee
- Audit Committee
- Quality and Performance Scrutiny Committee

- Finance Scrutiny Committee
- Human Resources Scrutiny Committee
- Group Management Board

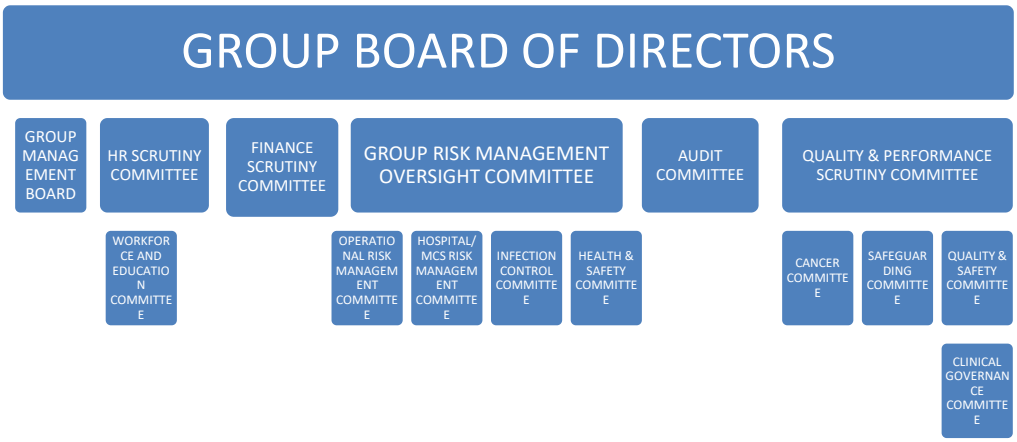
6.7. The Terms of Reference for the Group committees with responsibility for risk are updated annually and available from the relevant committee Chair

6.8. The Group committees are supported in delivery of their responsibilities by the following Group level committees/groups

- Quality and Safety Committee
- Safeguarding Committee
- Infection Control Committee
- Health and Safety Committee
- Operational Risk Management Group
- Workforce and Education Committee
- Group level Specialist Committees such as Cancer, Transfusion, Radiation Protection

The Group supporting committee structure is depicted in Figure 2, below

Figure 2: Group supporting committee structure



6.9. In addition, Hospital/MCS/MLCO and Clinical Standards Groups have committees in place to support the objectives of the Group level committees. The structures are established across the organisation to provide:

- Forums for different professions to discuss risk issues by sharing experiences with those outside their workplace
- Common approaches to identifying, quantifying and reducing risks
- Appropriate fora for risks of specific types to be considered
- A route for escalating issues to the appropriate level
- A process for providing feedback
- Advice to the Board regarding significant risks and an assurance to the Board that structures and processes exist to reduce risk to an acceptable level

Group Risk Oversight Committee (GROC)

6.10. The Group Risk Oversight Committee will review and report on the overall risk profile of the organisation ensuring that effective assurance mechanisms are in place

6.11. The Group Risk Oversight Committee provides an assurance to the Board that risks of all types are identified and controlled to an acceptable level, and advises the Board on significant risks; that is those risks with a current risk score of 15 or above

6.12. The Group Risk Oversight Committee receives the High Level Risk Register which includes all strategic risks scored at level 15 or above and receives detailed reports on the management of these risks from the risk lead as per schedule outlined in 5.4

6.13. The Group Risk Oversight Committee will request supplementary reports on any (but not necessarily all) risks present on the Trust Risk Register. The GROC will review reports on the following:

- New risks at level ≥15 – single report detailing management and oversight of arrangements
- Group wide risks with score of ≥15 that are not accepted and *that are not subject to scrutiny at Finance, Human Resources or Quality and Performance Scrutiny Committees*
- *Accepted risks level* ≥15 should be reviewed annually or in the event of any change in accepted risk level
- Level ≥15 risks in Hospital/MCS/MLCO with an AOF score of 6
- Risks escalated for review/support by Hospitals/MCS where further mitigation is outside of the control of the Hospital/MCS/MLCO (for example a national tariff issue)
- The GROC may also identify risks that require more detailed scrutiny arising from the Group Board Assurance Report, Group Board Assurance Framework, regulatory issues, national reports, patient/service user feedback and public interest issues

6.14. The GROC will receive a 'closure/downgrade' assurance report on any risk reduced to <15 by a Hospital/MCS/MLCO

6.15. Group wide risks that are rated as ≤12 will be managed at the appropriate forum – for example an informatics risk that is rated at 9 but applicable to most or all sites may be referred for oversight to the Informatics Strategy Board. These risks will have a corporate lead and oversight of their management will be undertaken by the Operational Risk Management Group

Audit Committee

6.16. The Audit Committee has primary responsibility for monitoring the integrity of the financial statements, assisting the Board in its oversight of risk management and the effectiveness of internal control, oversight of compliance with corporate governance standards and matters relating to the external and internal audit functions

6.17. The Audit Committee provides the Board with an independent and objective review of financial and corporate governance, assurance processes, and risk management across the whole of the Group activities (clinical and non-clinical) both generally and in support of the annual governance statement

6.18. The scope of the Audit Committee includes financial (including statements, standing orders, standing financial instructions and standards of business conduct), the annual report, internal control and risk management, whistleblowing, corporate governance, and internal and external audit

Quality and Performance Scrutiny Committee

6.19. The Quality and Performance Scrutiny Committee is responsible for seeking assurance on an exception or as required basis on the work of MFT on Quality (Patient Safety, Clinical Quality and Patient Experience) and Performance (all key performance measures including workforce)

6.20. The committee will identify areas that require more detailed scrutiny arising from internal metrics including the Group Board Assurance Report, national reports, patient/service user feedback and public interest issues

Finance Scrutiny Committee

6.21. The Finance Scrutiny Committee is responsible for seeking assurance on an exception or as required basis on the work of MFT on financial control and performance

6.22. The committee will identify areas that require more detailed scrutiny arising from internal metrics including the Group Board Assurance Report, national reports, patient/service user feedback and public interest issues

Human Resources Scrutiny Committee

6.23. The Human Resources Scrutiny Committee is responsible for seeking assurance on an exception or as required basis on the work of MFT on management of Human Resources

6.24. The committee will identify areas that require more detailed scrutiny arising from internal metrics including the Group Board Assurance Report, national reports, patient/service user feedback and public interest issues

7. Duties and responsibilities of key individuals

Group Executive and Non-Executive Directors

7.1. The **Group Chief Executive** is the Accountable Officer with overall responsibility for risk management. As such, they must take assurance from the systems and processes for risk management and ensure that these meet statutory and Department of Health requirements. They chair the Group Risk Oversight Committee and sign the Annual Governance Statement

7.2. The Group Chief Executive has delegated the responsibility for risk management as detailed below

7.3. The **Group Medical Director(s)** report to the Board on the activity and work undertaken in relation to clinical effectiveness and on all aspects of clinical quality and patient safety including communicating directly to the Group Risk Oversight Committee as required. They oversee the submission of the quality and safety component of external regulatory requirements

7.4. The **Group Medical Director (1)** is also the Trust's Caldicott Guardian. The Caldicott Guardian has responsibility for safeguarding the confidentiality of patient information

7.5. The **Group Chief Nurse** is the Director of Infection Prevention and Control (DIPC). The DIPC is responsible for the provision of oversight and assurance on infection prevention (including cleanliness) to the Board

7.6. The **Group Chief Finance Officer** holds overall fiscal responsibility in the Trust and is responsible for ensuring a sound system of internal financial control, establishing effective financial systems and providing adequate financial information. S/he is the key contact for the auditors and responsible for providing assurances to the Audit Committee

7.7. The **Group Deputy Chief Executive (2)** is the Group Senior Information Risk Owner (SIRO). The SIRO is accountable for information risks within the organisation. S/he is responsible for overseeing implementation and performance assessment of Information Governance

7.8. All **Executive Directors** will oversee progress against the Board Assurance Framework for their areas of responsibility

7.9. The **Board of Directors** has a collective responsibility to ensure that the risk management processes provide adequate and appropriate information, and assurances relating to risks against the Trust's objectives

7.10. **Non-Executive Directors** must satisfy themselves that financial information is accurate and that financial controls and systems of risk management, including clinical governance, are robust and defensible. Membership of the Trust Audit Committee is an integral part of this assurance process

Others with specific responsibilities

7.11. The **Group Director of Clinical Governance** oversees the implementation of the Clinical Effectiveness (Risk and Governance) Strategy across the Trust. S/he will ensure that corporate support on Clinical Effectiveness (Risk and Governance) is provided to the Hospital/MCS/MLCO and Clinical Standards Groups (CSG) in order that they can continuously improve the quality of their clinical services. Members of the Hospital/MCS/MLCO will participate in the strategic development of risk management in the Trust through representation on the Group Risk Oversight Committee

7.12. The **Director of Corporate Services/Board Secretary** will facilitate the population and update of the Board Assurance Framework

7.13. The **Associate Director of Clinical Governance** will oversee the day to day implementation of the Risk Management Strategy. As the responsibility for managing risks is devolved to all levels of management across the Trust, it is the responsibility of the Associate Director of Clinical Governance to assist through provision of leadership, support and professional advice. S/he is responsible for reviewing Serious Untoward Incidents and for overseeing processes required to support meeting external deadlines including reporting via the Strategic Executive Information System (STEIS) and forwarding of completed reports to the relevant external organisations as required under the 'Serious Incident Framework 2015'

7.14. The **Group Health and Safety Adviser(s)** oversee the implementation of the Trust's Health and Safety Strategy and provide specialist health and safety management, advice and training in order to achieve high standards of health and safety management throughout the Trust in line with the Trust's Health and Safety policies. S/he will report all 'Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR 1995)[7] incidents to the Health and Safety Executive

Hospital Site and Managed Clinical Service Group responsibilities

7.15. Hospital/MCS/MLCO Chief Executives (CEO) are required to implement the Risk Management policies and to put systems and processes in place to manage risk

7.16. Hospital sites/MCS are expected to participate in the strategic development of risk management in the Trust through representation on the Group Risk Oversight Committee. This ensures that the Trust's Strategy, policies, procedures, structure

[7] Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995
http://www.hse.gov.uk.riddor/

and decision making on risk management take into account the services provided by each Hospital site and Managed Clinical Service

7.17. Hospital/MCS/MLCO CEOs also ensure that the Risk Management Strategy is implemented within their Hospital site and Managed Clinical Service business planning and performance monitoring processes

Others

7.18. **All managers** are responsible for ensuring that risks in their area are identified, monitored and controlled according to the principles in this Strategy. This ensure a consistent approach to support improved delivery of services

7.19. Each service should have a designated lead for Risk Management. In the absence of a designated lead, this role falls to the manager on an area. The responsible manager must ensure that:

- the training needs of the risk lead have been assessed
- adequate resource is available for the risk lead
- the responsibilities defined below are fulfilled and included within their performance review

7.20. Managers are responsible for conducting risk assessments, agreeing any action plans to reduce/mitigate risk and for incorporating such plans into the business planning process for their area. Managers must be involved in regular monitoring of progress against such plans

7.21. Managers must also manage risk by responding to adverse events of all types (refer to Incident Reporting and Investigation Policy [including Serious Incidents])

7.22. All managers have health and safety responsibilities for their staff and areas

7.23. Managers must allow time for risk issues to be included in Hospital site/MCS and CSG meetings to:

- ensure a full understanding of the profile of risk
- provide assurance of risks being minimised
- ensure appropriate escalation of risk issues

7.24. Managers must ensure they are up to date with all Risk Management policies and documentation

7.25. Department and ward managers are responsible for ensuring that staff in the workplace have an understanding of risk management issues, adhere to Risk Management policies and procedures, receive and provide feedback regarding incidents and risks, and adopt changes to practice accordingly

7.26. Managers have a direct responsibility for the health, safety and welfare of staff and for ensuring a safe environment for the delivery of care. Managers must apply the Trust's Health and Safety policies, and ensure that risks of this type are included within risk assessment, risk registers and action planning

All staff

7.27. All staff, including those on temporary or fixed term contracts, placements or secondments, and contractors, must keep themselves and others safe. All staff have a duty of care to provide safe services and do no harm. They have a responsibility for managing incidents and risks within their area of responsibility

7.28. The Group will provide an environment which enables all staff to feel comfortable with managing and reporting risk issues

7.29. All staff must commit to being made aware of their responsibilities and of the risk management process through:

- induction into the Trust or into a new role
- discipline or department specific training
- management and supervisory training
- mandatory update training
- awareness raising or *ad-hoc* events

7.30. All staff should contribute to the identification of risk either as part of risk assessment or in reporting any risks, hazards, adverse events or complaints. All staff should then comply with any action requiring them to reduce risks which have been identified

Individual job descriptions for employees reflect risk management responsibilities and risk issues, and are a part of Personal Development Review (PDR) or appraisal as relevant

8. Risk processes

Risk assessments

8.1. A risk assessment is the systematic identification, assessment and evaluation of anything that can interfere with the delivery of the highest standard of service and working environment within the Trust

8.2. All risk assessments will include an analysis of severity of the potential risk and the likelihood of it occurring in order to ascertain the current risk score and also the target risk scores; which is what the score will decrease to following implementation of planned actions to add new control and mitigation measures. This will assist in the assessment and communication of risk throughout the organisation with a 'common currency' being used. *See Appendix B*

8.3. A risk assessment will identify the current standards and controls in place to manage the risk. The risk assessment will also demonstrate the requirement for further control measures that can be taken to decrease the level of risk. It is important to note that not all risk can be eliminated and there will sometimes by ongoing risk. All risk that can be minimised and managed locally must be

8.4. Risks must be systematically monitored and reviewed. Risks are constantly changing and therefore effective control of risk in Hospital sites/MCS/CSGs can only be achieved with up to date information on the risks, the controls in place and the provision of evidence that the controls are managing the risk to acceptable levels. All risks on the register will have a review date to assist with this process

8.5. Risks are collated to form a **Risk Register**. The Risk Register will assist Hospital sites/MCS/CSGs in the evaluation and management of risk. This is intended to improve the standard of service provided and the working environment. Hospital/MCS/MLCO/CSG structures can differ but all risks must be communicated via the Risk Register. Each Hospital/MCS/MLCO/CSG will need to ensure that there are sustainable structures in place to identify hazards, risks, and monitor and evaluate action plans

8.6. Some risks will be identified as strategic in nature, those affecting the Trust as a whole or having a significant impact on wider Trust objectives. These will need to be reviewed at the Group Risk Oversight Committee

Risk Registers

8.7. The Risk Register is a log of risks that threaten a service's success in achieving its declared aims and objectives. It is a dynamic living document, which is populated through the risk assessment and evaluation process. This enables risk to be quantified and ranked. It is the key mechanism for the communication of risk throughout the organisation. It is fundamental to Board Assurance and will act as an audit trail for the management of significant risks

8.8. The Trust's principal Risk Register, the 'Corporate Risk Register' which contains all risks with a current score of 15 to 25, will be reviewed and reported to the Group Risk Oversight Committee on a two-monthly basis via the Board Assurance Framework and individual risk reports against each risk

8.9. High risks (15 to 25) must be reported and managed at Hospital/MCS/MLCO/CSG level. Resource must be allocated to implement actions to reduce the risk score as soon as is practicable. A Hospital/MCS/MLCO Director must be identified to manage high level risks with the respective Hospital site/Managed Clinical Service or Corporate Services. High level risks with a risk score ≥15 may need to be referred as a detailed report to the Group Risk Oversight Committee and may be part of the Board Assurance Framework

8.10. The Corporate Risk Register and Board Assurance Framework will be reported to the Board via the Group Risk Oversight Committee to ensure that the identified principal risks are integrated into appropriate strategic objectives and that appropriate corporate processes such as business planning have informed the Board Assurance Framework

Incident reporting

8.11. An adverse incident is where an event occurs that has the potential to, or has, caused actual harm to any person or damage to or loss of any property or assets of the Trust or any individual, and may damage the reputation of the Trust

8.12. The Trust will promote a culture of being open where all staff feel comfortable to raise awareness of issues of risk. This is particularly important where staff are aware of anything which has or could have gone wrong, adverse incidents and near misses. The Trust recognises that these incidents may rarely be attributed to an individual and that only by reporting such events can their underlying causes be addressed. Reporting of these incidents is, therefore, to be encouraged and accepted as any other part of standard practice of every member of staff. The aim is to learn lessons from our experiences and ensure that practice is altered to improve the way services are delivered and the environment in which they are provided

8.13. For complete details of the incident reporting and investigation process, please refer to Incident Reporting and Investigation Policy (including Serious Incidents[8])

Training

8.14. A training needs assessment for all staff, the Board and senior managers has been undertaken. All staff will attend annual risk awareness training either by completion of the Trust mandatory training or by delivery at a Board of Directors' seminar. (This may be delivered at the Trust Audit Committee for Non-Executive Directors.) Non-attendance is managed in line with the Trust Mandatory Training Policy

[8] Incident Reporting and Investigation Policy

8.15. Additional training in risk management processes will be managed by the Risk Management Department in conjunction with the Hospital/MCS/MLCO/CSG leads

8.16. For complete details of the risk management training process, please refer to the Corporate and Clinical Mandatory Training Policy[9]

9. Key Performance Indicators

9.1. The following key performance indicators will be used to measure the effectiveness of the Risk Management Strategy:

- There is regular representation of each Hospital/MCS/MLCO/CSG at the Group Risk Oversight Committee
- There is a regular (at least alternate months) meeting at Hospital/MCS/MLCO level which considers risk management issues
- Individual services and departments hold regular meetings (at least monthly) to consider risk management issues
- Clinical Effectiveness/risk leads have been established to cover all areas of each Hospital/MCS/MLCO
- All departments conduct risk assessments (covering all types of risk)
- Risk assessments, where appropriate, are recorded on Risk Registers at Department, Directorate and Hospital/MCS/MLCO level
- Actions are implemented as a consequence of risk assessments and service planning takes account of these
- Good practice and lessons learned are shared across the Trust through Group and Hospital/MCS/MLCO communications

10. Equality, Diversity and Human Rights Impact Assessment

10.1. The Trust Risk Management Strategy has been assessed by the author using the Trust's Equality, Diversity and Human Rights Impact Assessment

10.2. The initial Equality, Diversity and Human Rights Impact Assessment score fell into low priority[10]

11. Duty of candour and raising concerns

11.1. The Trust is committed to promoting a culture of openness and transparency across all areas of its activities and has a number of policies and procedures underpinning this[11]

12. Consultation, approval and ratification process

12.1. Communication with stakeholders

The key stakeholders are:

- Manchester Health and Care Commissioners
- Greater Manchester Health and Social Care
- Care Quality Commission
- NHS England
- NHS Improvement
- North Western Deanery

[9] Induction and Mandatory Training Policy
[10] Equality Act 2010 http://www.legislation.gov.uk/ukpga/2010/15/pdfs/ukpga_20100015_en.pdf
[11] Duty of Candour Policy
Whistleblowing/Raising Concerns Policy

12.2. Strategy approval process

The Strategy is circulated for consultation to the Governance and Risk Steering Group, the Integration Oversight Group and the Interim Board of Directors

When all comments are received, these are retained for governance purposes; amendments are made as deemed appropriate by the author

12.3. Ratification process

The Trust Risk Management Strategy will be ratified by the Board. The ratification of the Risk Management Strategy must be documented in the Board minutes

13. Dissemination and implementation

13.1. Dissemination

The ratified Strategy will be available on the Trust Intranet under the Policies section and this will be communicated through various channels

The Strategy will be sent electronically to all key stakeholders. Refer to Section 13.1

13.2. Implementation

Progress on implementation of this Strategy will be reported to the Group Risk Oversight Committee

The ratification and availability of the Risk Management Strategy will be reported to the Board

14. Review and monitoring compliance

14.1. Process for monitoring compliance and its effectiveness

The Group Risk Oversight Committee is responsible for monitoring compliance with the Risk Management Strategy and the effectiveness of risk mitigation systems at Hospital/MCS/MLCO and Corporate level

14.2. Overview of monitoring process

Management of risk locally		
Standard	Via	Monitoring frequency
Each Hospital/MCS/MLCO has identified and added risks to their risk register and reviewed these during the year	Risk Register monitoring	Every two months (each meeting)
Risks are appropriately escalated according to score	Formal monitoring report	Every two years
Ensuring a continual, systematic approach to risk assessments is followed		
Standard	Via	Monitoring frequency
Risks are being reviewed within designated timescales and scores adjusted to reflect any additional controls implemented	Risk Register monitoring	Every two months (each meeting)

Additional assurance on the effectiveness of risk management systems and processes within the Trust will be undertaken. This will be reported to the Audit Committee	By internal audit	On an annual basis

Any shortfalls identified will have an action plan put in place to address, which will have timescales included for re-audit/monitoring

15. Appendices

Appendix A: Glossary of Risk Management terms

Appendix B: Risk Management measure of severity of consequences. Likelihood and scoring risk matrix

Appendix C: Flowchart for the process of the management of risk registers

Appendix D: Supporting documents and statements

Appendix A: Glossary of management terms

Hazard	Anything with the potential to cause harm
Risk	The chance that something will happen that will impact on the Trust's achievement of its aims and objectives. This is measured by the likelihood (frequency or probability of the event occurring) by the severity (impact or magnitude of the effect of the event should it occur). This includes anything that may impact on objectives such as safe care, financial balance, etc. This Strategy addresses all risks faced by the Trust, including but not limited to, the areas of: Health and Safety; Patient Safety; Financial Risks; Estate and Utilities Risks; Infection Control; Medical Devices; Recruitment and Retention etc.
Reasonably practicable	What can reasonably be done to identify, remove or reduce a risk
Business planning	A tool which assists achievement of objectives – components include setting and reviewing objectives, target setting and monitoring, performance measurement and review
Common currency	A standard quantitative value of risk (both in terms of severity and likelihood) that spans the organisation enabling the comparing and contrasting of all risks in a systematic manner
Compliance risk	The risk of failing to meet standards, laws and regulations
Continuity plan	Arrangements in place to minimise the impact of something going wrong or the unexpected happening to maintain standards of service to the public and the delivery of programmes
Control	Any action, procedure or process undertaken to either contain the impact of a risk to an acceptable level, decrease the likelihood of occurrence or to increase the probability of a desired outcome
Impact	The effect or result of a particular occurrence actually happening (and evaluated as such)
Internal control	An organisation's ongoing processes for identifying and managing all significant risks to achievement of objectives and review of the effectiveness of the systems of control for financial reporting and accountability
Current risk score	The grade of the current risk quantification (takes in to consideration those controls already in place)
Target risk	The grade of the risk quantification once additional actions/controls have been put in place
Risk appetite	The appetite for tolerating/accepting or taking a risk
Accepted risk	A risk that is accepted at its current level as no further mitigation is possible or a risk that is considered worth accepting due to the potential benefits that may ensue
Risk assessment	The process and approach used to prioritise and determine the likelihood of risks occurring and their potential impact on the achievement of objectives
Risk register	A tool used to collate and record risks, enabling them to be measured and prioritised
Trust risk register	A risk register that contains all the Trust-wide risks with risk scores of 15 or greater
Risk frameworks	A statement on the procedures and processes used for reaching decisions on risks
Risk identification	The process for finding and specifying key risks in terms of achievement of objectives
Risk management	Risk management means having in place systematic processes for evaluating and addressing the impact of risks in a cost effective way and having staff with the appropriate skills to identify and assess the potential for risks to arise

For any advice or information required on anything within this policy, please do not hesitate to contact the Associate Director of Clinical Governance

Appendix B: Risk Management measure of severity and consequences, likelihood and scoring risk matrix[12]

The following Matrix to be used following merger of both organisations when assessing

1. Risks (the impact will be the potential impact if the risk were to occur)
2. Incidents (based on something that has actually happened, therefore based on the potential for and actual harm as a result of the incident)

Score	1	2	3	4	5
Descriptor	**No Harm/Insignificant**	**Low/Minor**	**Moderate**	**Severe Harm/Major**	**Death/Catastrophic**
Risk of Patient/Staff/Public harm	Minimal injury requiring no/minimal intervention or treatment	Minor injury or illness	Moderate injury requiring professional intervention	Major injury with long-term/permanent incapacity or disability	Risk of death or an event which would impact on a large number of patients/ staff/public
Patient Safety Incidents potential harm (Severity) and actual physical/ psychological harm	Impact Prevented – any patient safety incident that had the potential to cause harm but was prevented resulting in no harm to people receiving NHS funded care	Patient experienced minor injury or illness as a result of the incident, patient requiring extra monitoring or minor intervention e.g. bruising, skin tear, psychological harm due to a delayed surgery	Patient Safety Incident that resulted in moderate increase in treatment and which caused significant but not permanent harm to one or more persons receiving NHS funded care e.g. broken wrist, ankle or unexpected return to theatre Hospital acquired PE or DVT (avoidable) including within 3 months' of admission	Major injury leading to long-term or permanent incapacity or disability requiring extensive rehabilitation Mismanagement of patient care with long term effects Serious sexual assault of a patient	Incident leading to death
Control of Infection Healthcare Acquired Infection (HCAI)	Non-compliance of infection control policy	Non-compliance with isolation of patients with: Hospital acquired colonisation or infection affecting one or more patients, staff or public or bay closure Diarrhoea due to possible	Outbreak of Noro-like virus NLV in one ward within a directorate MRSA/VRE/CPE Bacteraemia with eventual recovery Hospital acquired infection	HCAI with associated morbidity Pseudo-membranous colitis with associated morbidity Closure of two or more wards due to Noro-like virus NLV within a directorate	Loss of multiple services in critical areas due to infection MRSA or CPE bacteraemia as cause of death Hospital acquired infection detailed under Part 1 of

[12] Australian/New Zealand Risk Management Standards, *AS/NZA 4360:1999*
http://www.wales.nhs.uk/ihc/documents/A.4.1.4_Australia_and_New_Zealand_Methodology_AS_NZ%204360_1999.pdf

Score	1	2	3	4	5
Descriptor	**No Harm/Insignificant**	**Low/Minor**	**Moderate**	**Severe Harm/Major**	**Death/Catastrophic**
		infection	affecting a whole ward		cause of death Death due to pseudo-membranous colitis related to *Clostridium difficile* infection
Impact on staff	No time off work	Staff first aid/minor treatment requiring time off work for 1-7 days	RIDDOR reportable event >7 days off work (or on light duties) as a result of the accident or specified injury e.g. fractures (other than fingers, thumbs and toes)	Permanent/long term incapacity >6 months e.g. amputations Loss of or reduction in sight	Incident leading to unexpected death
Needlestick injury	Cleans sharps injury	Used sharps injury/body fluid splash to eyes/mouth	RIDDOR Used sharps injury or body fluid splash from patient with known blood borne virus	RIDDOR Seroconversion following sharp injury/body splash	
Patient experience	Unsatisfactory patient experience which is able to be resolved locally	Unsatisfactory patient experience – minimal risk to patient safety in the short term	Mismanagement of patient care – short term effects Impacting on a small number of patients but could significantly impact on patient safety if unresolved Mixed sex accommodation	Mismanagement of patient care – long term effects, unsatisfactory patient outcome or experience Mixed sex accommodation for >24 hours	Totally unacceptable patient experience which impacts on a large number of patients
Quality, complaints and audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (Stage 1 – green) Local resolution Minor implications for patient safety if unresolved Reduced performance rating	Treatment or service has significantly reduced effectiveness Formal complaint (Stage 2 – amber) complaint Local resolution Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Formal complaint (red) Multiple complaints/ independent review Critical report	Totally unacceptable level or quality of treatment/ service Inquest/Ombudsman inquiry Gross failure of patient safety if findings not acted on Large scale cervical screening errors

Score	1	2	3	4	5
Descriptor	**No Harm/Insignificant**	**Low/Minor**	**Moderate**	**Severe Harm/Major**	**Death/Catastrophic**
Human Resources, OD&T, staffing and competence			Late delivery of key objective due to lack of staff (recruitment, retention or sickness) Low staff morale Poor staff attendance mandatory training	Uncertain delivery of key objective due to lack of staff/loss of key staff Very low staff morale No staff attending mandatory training	Non-delivery of key objective due to staff shortage/loss of key staff
Staffing levels	Low staffing level impacting on the quality of service delivery for 1 shift	Low staffing level impacting on the quality of service delivery 1-2 days	Low staffing level impacting on the quality of service delivery >2 days or only one trained nurse on duty for a shift		
Service/business interruption	Loss/interruption Minor loss of non-critical service	Loss/interruption in a number of non-critical areas	Service loss in critical area	Extended loss of essential service in 1 or more areas	Loss of multiple services in critical areas
Statutory duty/inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Multiple breaches in statutory duty Enforcement action Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Very low performance rating or deteriorating in performance rating Severely critical report
Adverse publicity/ reputation of organisation	Rumours: Minimal Impact Local Press <1	Regular Concern Local Media 1 to <7 days	Moderate loss of confidence National Media <3 days	Major loss of confidence National Media >3 days	International adverse publicity Severe loss of confidence Public inquiry
Financial impact	Minimal impact	<300,000 – 0.5% of turnover of the Trust	>300,000 – 0.5% to 1% of Trust turnover	>600,000 – 1% to 2% of Trust turnover	>1.2 million – over 2% of Trust turnover
Objectives/projects	Insignificant cost increase/ schedule slippage. Barely noticeable reduction in scope or quality	<5% over budget/ schedule slippage. Minor reduction in quality/ scope	5-10% over budget/ schedule slippage. Reduction in scope or quality requiring client approval	10-25% over budget/ schedule slippage. Key objectives not met	>25% over budget/ schedule slippage. Key objectives not met

Score	1	2	3	4	5
Descriptor	**No Harm/Insignificant**	**Low/Minor**	**Moderate**	**Severe Harm/Major**	**Death/Catastrophic**
Litigation – claim	Risk of claim remote	Claim less than £10,000	Claim(s) between £10,000 and £100,000	Claim(s) between £100,000 and £1 million	Claim(s) >£1 million
Target/standard impact	Minimal impact on Trust targets or standards	Local risk of non-achievement of Trust targets or standards Single failure to meet internal standards	HOSPITAL SITE/MANAGED CLINICAL SERVICE/MLCO GROUP risk of non-achievement of Trust targets or standards Repeated failure to meet internal standards	HOSPITAL SITE/MANAGED CLINICAL SERVICE/MLCO GROUP risk of non-achievement of one or more Trust targets or standards – risk posed to overall Trust compliance	Trust failure to meet national standards
Non-physical or physical assault	Non-physical or physical assault which causes negligible offence or harm	Non-physical or physical assault that causes minor offence or harm	Non-physical or physical assault that causes significant offence or harm	Physical assault that causes major harm or non-physical assault which causes major offence and may be criminal (racially or religiously aggravated)	Physical assault that results in death
Fire incidents	False alarm	Minor fire, no injury or loss of service	Fire: minor injury or minor loss of services	Fire: major injuries or significant loss of services	Death as a result of fire incident

Level	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency of event	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability of event	<1%	1-5%	6-20%	21-50%	>50%
	May only occur in exceptional circumstances	Could occur at sometime	Will occur at sometime	Probably will occur	Expected to occur

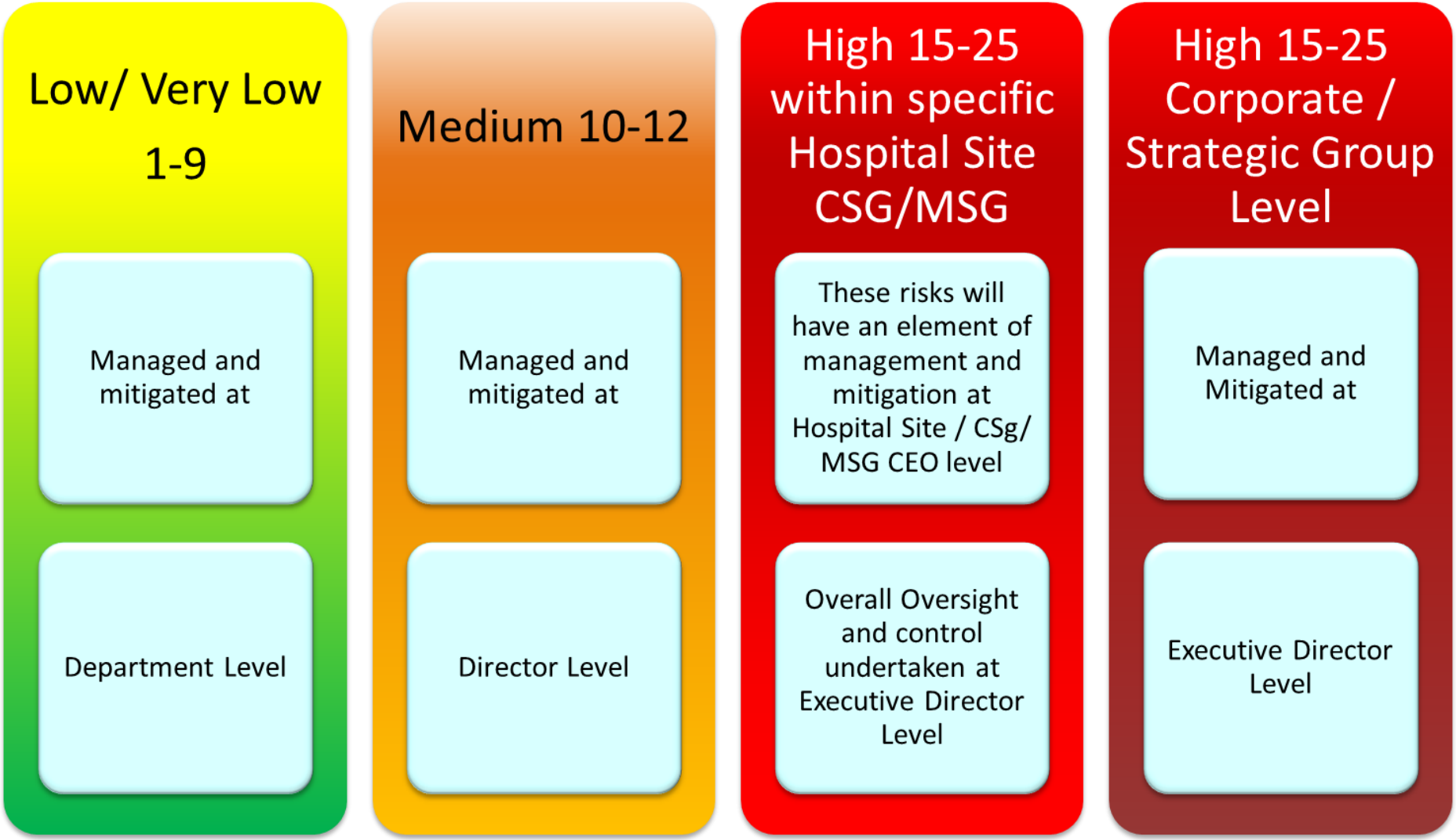
The final step in quantification is to combine the measures of severity and likelihood in a Risk Matrix, refer to Table 3

Table 3: Risk Matrix

	Likelihood

Severity	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 Low**	**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**

Appendix C: Flowchart for the process of the management of Risk Registers



Appendix D: Supporting documents and statements

Associated Trust documents

By definition, risk management is generative and integrates into every activity that the Trust undertakes and its objectives. Consequently, every procedural document may have some association with risk and risk management therefore it would be impractical to list all Trust documents. The key supporting Trust documents are listed below:

- Incident Reporting and Investigation Policy
- Duty of Candour Policy
- Safety Alerts Policy
- The Induction and Mandatory Training Policy

Supporting Statements

This Risk Management Strategy should be read in conjunction with the following statements:

SAFEGUARDING IS EVERYBODY'S BUSINESS

All Manchester University NHS Foundation Trust employees have a statutory duty to safeguard and promote the welfare of children and vulnerable adults, including:

- being alert to the possibility of child/vulnerable adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child/vulnerable adult
- knowing how to deal with a disclosure or allegation of child/adult abuse
- undertaking training as appropriate for their role and keeping themselves updated
- being aware of and following the local policies and procedures they need to follow if they have a child/vulnerable adult concern
- ensuring appropriate advice and support is accessed either from managers, Safeguarding Ambassadors or the Trust's Safeguarding team
- participating in multi-agency working to safeguard the child or vulnerable adult (if appropriate to your role)
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Manchester University NHS Foundation Trust policy and procedures and professional guidelines; roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise

EQUALITY AND HUMAN RIGHTS

Manchester University NHS Foundation Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the protected characteristics of age, disability, gender, race, religion or belief, sexual orientation and transgender. The Equality Act also requires regard to socio-economic factors including pregnancy/maternity and marriage/civil partnership. The Trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The Trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices. Manchester University NHS Foundation Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act. Manchester University NHS Foundation Trust is committed to carrying out its functions and service delivery in line with Human Rights based approach and the FREDA principles of Fairness, Respect, Equality, Dignity and Autonomy. Being safe requires an open, transparent culture where both successes and shortcomings are shared equally and openly. This helps us to all work together to protect our patients, members and employees, and enhance their health and wellbeing.

Group Risk Oversight Committee – Example Reporting Schedule
02 March 2020

Risk	Exec Lead	Director Lead	Oversight Committee	20.1.20	2.3.20	6.5.20	6.7.20	2.9.20	2.11.20	Notes
New Risks - *Every meeting*	NA	NA	NA	✓	✓	✓	✓	✓	✓	
Downgraded Risks - *Every meeting*	NA	NA	NA	✓	✓	✓	✓	✓	✓	
Risks escalated for discussion - *Every meeting*	NA	NA	NA	✓	✓	✓	✓	✓	✓	
MFT/001493 – RTT *Bi-annua*l - Oversight arrangements in place and monitored via AOF	JCB	CEs	Chief Executives Forum			✓			✓	
MFT/0001707 – Timely access to Emergency Services *Bi-annual* - Oversight arrangements in place	JCB	CEs	Chief Executives Forum			✓			✓	
MFT/001701 – Timely access to diagnostic services *Bi-annual* - Oversight arrangements in place	JCB	CEs	Chief Executives Forum			✓			✓	
MFT/001708 – Timely access to cancer services 62 day standard *Bi-annual* - Oversight arrangements in place	JCB	CEs	Chief Executives Forum			✓			✓	
MFT/002212 – Cancer pathway breaches *Bi-annual* - Oversight arrangements in place	JCB	CEs	Chief Executives Forum			✓			✓	
MFT/000992 – Control total *Bi-annual* - Oversight arrangements in place and monitored via AOF	AR	DFs	Finance Scrutiny Committee	✓			✓			
MFT/000236 – NWAS NWTS *Annual report or escalation as required* - Local to Saint Mary's	JCB	KC	Saint Mary's Hospital Quality and Safety Committee		✓					

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	The Group Executive Director of Workforce & Corporate Business
Paper prepared by:	Alwyn Hughes, Director of Corporate Services / Trust Secretary
Date of paper:	March 2020
Subject:	Board Assurance Framework (March 2020)
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Assurance • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	In the absence of robust and comprehensive BAF, the opportunities for supporting and enhancing organisational governance by using a body of good practice outcomes and evidence will be diluted.
Recommendations:	The Board of Directors is asked to accept the latest BAF (March 2020) aligned to the MFT Strategic Aims for 2019/20.
Contact:	Name: Alwyn Hughes, Director of Corporate Services / Trust Secretary Tel: 0161 276 4841

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

THE BOARD ASSURANCE FRAMEWORK (March 2020)

1. Introduction

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 strategic aims are reviewed and reported on at the Group Risk Management (Oversight) Committee and across other corporate Executive committees, where necessary, 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 BAF is received and noted at least twice a year by the full Board of Directors. The BAF for 2019/20 is attached (**APPENDIX A**) with the 2020/21 BAF to be presented to the Board of Directors at the next meeting in May 2020.

2. MFT Strategic Aims (2019/20)

Key Risks associated with the following Strategic Aims will be regularly reviewed at MFT Board Scrutiny Committees and the Group Audit Committee (as required):

- *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. Recommendation

The Board of Directors is asked to accept the latest BAF (March 2020) aligned to the MFT Strategic Aims for 2019/20.

APPENDIX A

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

THE BOARD ASSURANCE FRAMEWORK

(March 2020)

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

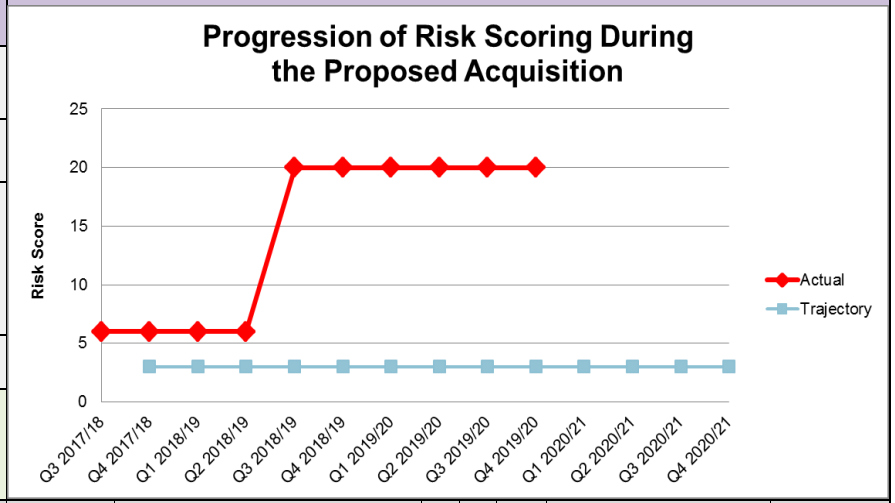
RISK CONSEQUENCES (What might happen if the risk materialises?):

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, significant unplanned shifts in clinical activity might occur.**
6. **Support contingent on demonstrating multi-agency commitment and delivery of a wider set of objectives.**

Associated Committees:
MFT TRANSACTION MANAGEMENT BOARD
NMGH SCRUTINY COMMITTEE
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 Strengthened transaction governance processes, with more effective leadership from NHS E/I, and on-going senior level discussions at national and local level on access to financial support. A.2 Comprehensive Due Diligence work undertaken and aggregated through Exec-led Finance Star Chamber sessions. Financial requirements to address Due Diligence challenges differentiated between management agreement and acquisition contexts, and communicated to NHS E/I. A3 Early establishment of an expanded and strengthened leadership team at NMGH to increase MFT knowledge and understanding of NMGH challenges, to create stability and give staff confidence about the future, and to start developing appropriate control and influence. A.4 Negotiation of Management Agreement to ensure a fair balance between the responsibilities transferring to MFT and the support being provided by other parties. A5 Development of a "North Manchester Implementation Plan" to capture and communicate the Trust's planned approach to managing NMGH, including the role of the Managed Clinical Services, the Day One plans of Corporate teams, and the Partnership Working Arrangements with PAHT/SRFT. A6 Development of the North Manchester Proposition, inclusion of NMGH in the national HIP2 programme for investment in health infrastructure, and submission of an appropriate Strategic Outline Case for the redevelopment of the NMGH site.	B.1 Discussions on financial support inconclusive to date. B.2 Negotiation of management agreement is on-going, with limited time left to conclude. B.3 PAHT Board still not fully appointed to and re-established. B.4 Continued rapid progress of HIP2 capital planning work not guaranteed.	C.1 Due Diligence reports reviewed by Board Committees and signed off by Board. C2 New NMGH leadership team established. C.3 North Manchester Implementation Plan approved by North Manchester Scrutiny Committee. C.4 NMGH SOC submitted, seed funding released, and MFT advised to continue (and accelerate) capital planning processes.	D.1 Performance of NMGH against financial targets and constitutional standards remains very weak. D.2 Management agreement and associated financial arrangements need to be finalised. D.3 PAHT Board and associated Committees need to be established. D.4 NHS E/I and DHSC feedback on SOC for redevelopment of the NMGH site.	20 (5x4)	Continue discussions with NHS E/I and local Commissioners about a financial plan to enable the safe transfer of NMGH to MFT. Maintain pressure to complete negotiation of Management Agreement. Maintain rapid design development process for next phase of HIP Capital Programme work.	CEO, Chief Finance Officer, Executive Director of HR and Corporate Business	April 2020	MFT Board of Directors	Weekly meetings of NHS E/I-led Transaction Delivery Group with support from specialist external advisers Capital Planning activities all in place, targeting first level of design development by end March.	**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 integration benefit delivery.**

Associated Committee:

MFT TRANSACTION MANAGEMENT BOARD

NORTH MANCHESTER SCRUTINY COMMITTEE

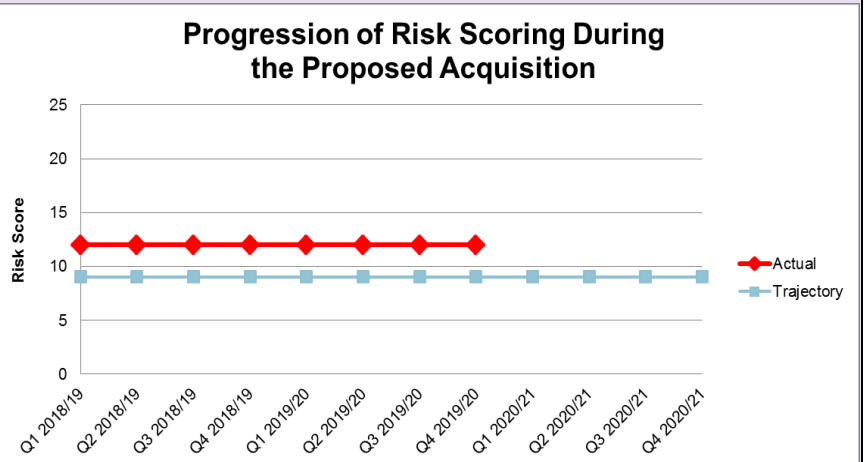
GROUP MANAGEMENT BOARD

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?"*	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 management agreement/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 Early establishment of an expanded and strengthened leadership team at NMGH to reduce the input required from Group Executive and Corporate Directors. A.4 Clearly defined clinical and corporate disaggregation processes being implemented to enable senior MFT staff to understand the services being acquired. A.5 Pennine Transaction Operational Group (PTOG) established jointly with SRFT to ensure MFT COO is aware of current and forthcoming operational changes at NMGH site. A.7 Integration Steering Group provides oversight for integration activity. A.8 MFT Transaction Management Board oversees delivery of the Programme.	B.1. PAHT Board and associated committees still not fully appointed to and re-established.	C.1 GM Transformation Funding in place to enable the infrastructure required to deliver the transaction. C.2 Revised NMGH Leadership Team in place to provide a focus for decision-making in respect of NMGH C.3. MFT internal governance arrangements working effectively including the sustained input of the SHS Team to support core leadership teams. C.4 North Manchester Implementation Plan approved by North Manchester Scrutiny Committee.	D.1 Performance of NMGH against financial targets and constitutional standards remains very weak. D.2 Management agreement and associated financial arrangements need to be finalised.	**12 (4x3)**	Work of the MFT Transaction Management Board to continue alongside focussed discussion at EDT. Maintain pressure to complete negotiation of Management Agreement.	Executive Director of HR and Corporate Business	April 2020	MFT Board of Directors	North Manchester Implementation Plan being considered by BoD for ratification.	**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?):

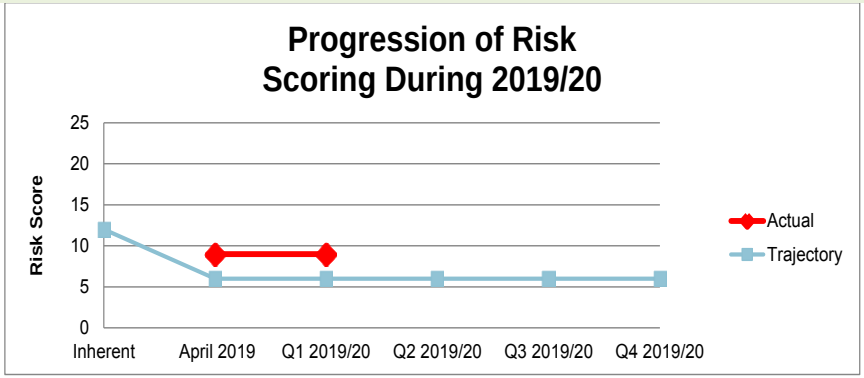
1. **Increase in serious harm to patients**
2. **Poor safety culture (including leadership) undermines Trust performance**
3. **Failure to eradicate 'Never Events'**
4. **Reputational damage because of safety concerns**
5. **Poor staff experience**
6. **Regulatory consequence**

Associated Committee:
QUALITY AND SAFETY COMMITTEE

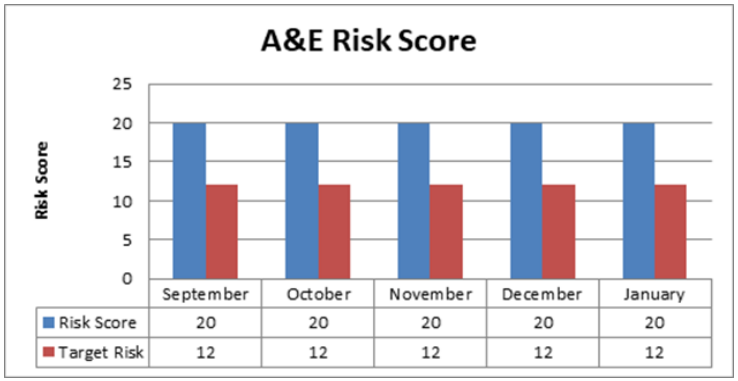
Operational Lead:
DIRECTOR OF CLINICAL GOVERNANCE

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.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 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. Patient Safety/Clinical Governance Team to be strengthened 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 (still awaiting further guidance on Serious Incident Framework before completion) Plan in place to revise investigation procedures 4. Identification of Trust Patient Safety Specialist as per National Guidance (Associate Director of Clinical Governance) 5. Inclusion of patient safety in mandatory training under discussion as part of the mandatory training review 6. Circulated the new National Patient Safety Strategy and aligned with MFT Q&S Strategy	**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 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 Performance, Quality and Safety Committees. A.4 Annual Capacity and Demand planning and contracting. A.5 Manchester Urgent Care and Transformation Board, supported by Operational Delivery Group. A.6 National Teams (ECIST) working onsite at Wythenshawe and MRI A.7 Bi-Weekly calls led by Wythenshawe Hospital Executive and system partners. A.8 Daily Executive Reporting – EDT. A.9 Stranded patient monitoring and escalation calls to the LCO A.10 Weekly Urgent Care meeting with COO/ Hospital Directors. A.11 Daily OPEL, Sitrep system reporting – Escalation Status	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) and system MADE events. 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 MRI/ PED estate plans managed through Estates and Facilities. C.6 Performance against quality standards: no 12-hour trolley waits, Ambulance Turnaround time. C.7 Updates on progress against Hospital / MCS capacity plans via OTOG. C.8 Mutual aid between sites to maintain safety. C.10 CUR assessment completed daily by ward teams. C.11 Clinical Standards Groups focus on ensuring patients receive high quality experience and outcomes. C.12 Major Trauma Ward for polytrauma patients.	A.7, C.3 Gaps in Care Home Market/ Community social care provision. A.9 Trusted Assessor for OOA patients. B.1 Gaps in overnight workforce. D.3 External surge demand management.	20 (5x4)	A.7, C.3 Additional community and Care Home capacity to reduce stranded patients and DTOC. B.1 Recruitment to consultant 24/7 shift patterns. D.3 Working with ODG to support the roll out of online GP appointments/ consultation from September. D.3 Reduce number of unregistered patients booking into A&E. D.3 Urgent Treatment Centres at MRI and Wythenshawe C.2 Shared learning from ECIST. C.2 Implementation of IDT at MRI to support timely discharge.	Julia Bridgewater	September 2020	Quality & Performance Scrutiny Committee	C.12 Major Trauma ward opened in MRI 5/12/19. A.9 GM commissioned North East Commissioning Group review of Urgent Care pathways. A.9. C.2 ECIST support for Stranded patient discharges. MADE event and learning shared with Hospitals. D.3 Manchester project to introduce UTC at Wythenshawe and MRI in progress. A.4 Urgent Care demand has increased by 4% across MFT compared to18/19. A.10 Weekly COO tracking with Hospitals of A&E, DTOC, Stranded and Mental Health performance. C.2 MRI IDT fully recruited to in January, mobilisation date to be agreed.	**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 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

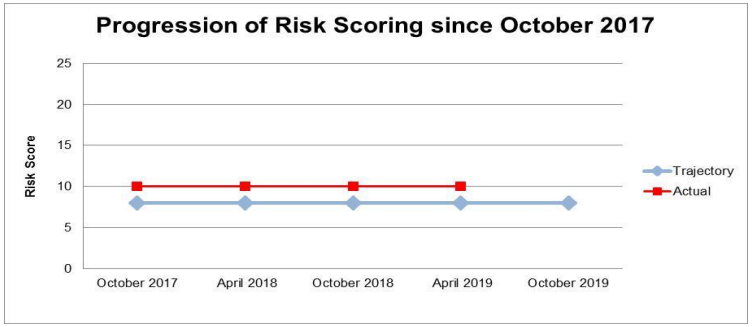
Associated Committee:
QUALITY & SAFETY COMMITTEE
OPERATIONS & TRANSFORMATION GROUP

Operational Lead:
HOSPITAL / MCS CHIEF EXECUTIVES

Material Additional Supporting Commentary (as required):

Indicator	Target Risk	Actual Score Sept 19	Actual Score Oct 19	Actual Score Nov 19	Actual Score Dec 19	Actual Score Jan 20
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 Quality, Safety and Performance Committees. A.4 Annual contracting, capacity and demand. A5 Hospital Transformation Programmes and opportunity packs to identify benchmark standards for LoS, Theatres, Outpatients. A.6 GM and Trust Access Policy. A7. Trust Cancer Excellence Programme. A8. Weekly Group COO Task and Finish RTT Group, commissioners in attendance. A.8 Hospital replication of AOF process, and supporting operational management and oversight structures A.9 Information services providing operational reporting. A10 Local PTL, Booking Scheduling and validation.	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.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 Increasing Primary care demand management. B.10 Workforce availability, vacancies to deliver activity B.11 Consistent application of Outpatient standards.	C.1 Reporting to the Executive Board and Committees C.2 Monthly AOF Group Executive oversight of Hospitals C.3 Group COO lead for Cancer Committee, RTT Task Force. C.4 Hospital Activity, capacity and annual plans. C.5 Internal/external audit of data quality. C.7 Monthly forecasting, planning and escalation for diagnostics. C.9 updates on progress against Hospital / MCS capacity plans via OTOG. C11. Clinical Standards Groups focus on ensuring patients receive high quality experience and outcomes, standardised across MFT locations C12. Annual Review and NHSI sign off Trust Access Policy.	D.1 Trust ERS performance oversight, and training. D.2 GM Capacity and demand for risk specialities. D.3 Standardised administration and booking processes	16 (4x4)	A8 RTT Taskforce to remain in place throughout 2020. D.1, D2 Performance Team oversight of ERS performance, training, compliance. D.3 Annual review of Patient Access policy in Q4, with implementation from April 2020. B.6 Introduce electronic competency training for A&C Staff booking, validating and managing waiting lists. D.2 GM ongoing review of high risk/ high demand specialities.	Julia Bridgewater	September 2020	Quality & Performance Scrutiny Committee	A8. Implemented Clinicom 4.4. Oversight of safety at weekly COO led Task and Finish Group. A10. Additional validators of RTT pathways across ORC. Waiting list trajectory has performed better than plan for most of the year. A7. Cancer Excellence Programme in place, some progress noted and finding presented to Q&PSC in February. Diagnostic demand remains a risk. **6 elements of the programme include;** • NHSI and Best Practice: • Best Practice and Innovation. • Capacity & demand planning. • Operational delivery. • - Professional development & Resilience. • Data C.7 Diagnostics have met the national standard for a number months. Marginal increase in the number of total breaches in December and January out with the target.	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: 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):	

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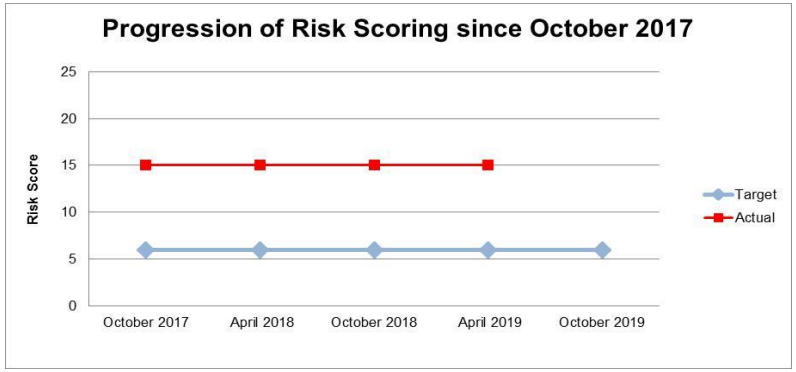
15 (5x3)	A1. Safeguarding Governance Structures in place. A2. Safeguarding policies and procedures. A3. Trust Safeguarding Teams actively support staff. A4.Directors of Nursing/Midwifery/Healthcare Professionals accountable for safeguarding within each hospital/MCS/ LCO. A5. Named Doctors and Named Nurses provide professional support and advice to staff. A6. Senior representation at all levels of the safeguarding Partnership Arrangements 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 in place. A9. Learning Disability flag to alert Matron review. A10 Reports provided to statutory meetings if Trust staff are unable to attend.	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 yet compliant with the changes to Statutory Intercollegiate Guidance, which requires increased numbers of staff to receive level 3 adult	C1. Annual Safeguarding Report to Board of Directors. C2. Hospital/Managed Clinical Service/LCO annual Safeguarding Work Programme, monitored by Safeguarding Team. C3. Annual Hospital/MCS/ LCO safeguarding assurance processes, observed by NED, to assess compliance with CQC and statutory 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 safeguarding adults Annual Assurance statement and supporting evidence. C7. Trust incident reporting system data C8. Regulatory inspection process C9. Training compliance data C10. Annual safeguarding	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. Hospitals/MCS/LCO to deliver agreed trajectories B5. 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	Assistant Chief Nurse (Safeguarding)	March 2020	Safeguarding Committee	A11.Work is underway to implement the Child Protection Information Sharing System (CP-IS) within SMH maternity services with full implementation expected by the end of Q1 2020/21 B1. Increased provision of DoLS training implemented. B1. DoLS audits undertaken in 2019 and actions delivered to improve quality and compliance with DoLS criteria. MCA/DoLS re-audit underway throughout Q4 of 2019/20. The results will be presented to the Group Safeguarding Committee. 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 continue. 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 continues to be delivered. Work commenced to review delivery options through Mandatory Training Scrutiny Committee. B4. Increased level 3 adult safeguarding training capacity continues to be provided with further increase implemented from September 2019. B5. Assessment of LD Specialist Nurse requirements completed, case developed and submitted to Chief Finance Officer. 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. Updates provided to Safeguarding Committee. B6 A Manchester-wide LD/Autism strategy is being produced and will be shared at the Group Safeguarding Committee as part of the ratification processes during Q1 of 2020/21	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):	

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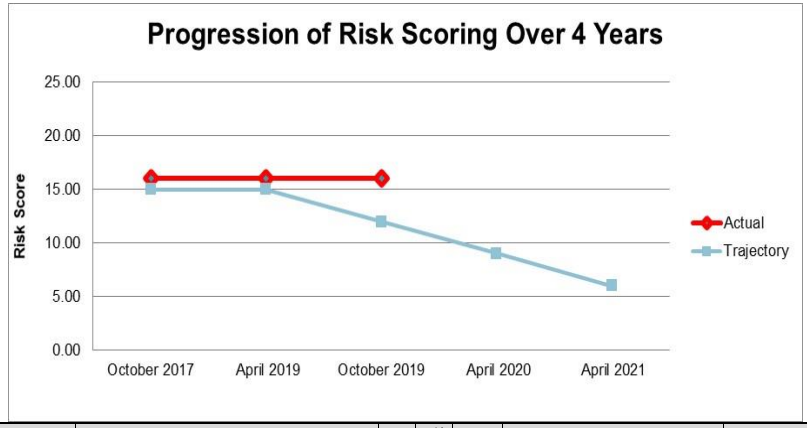
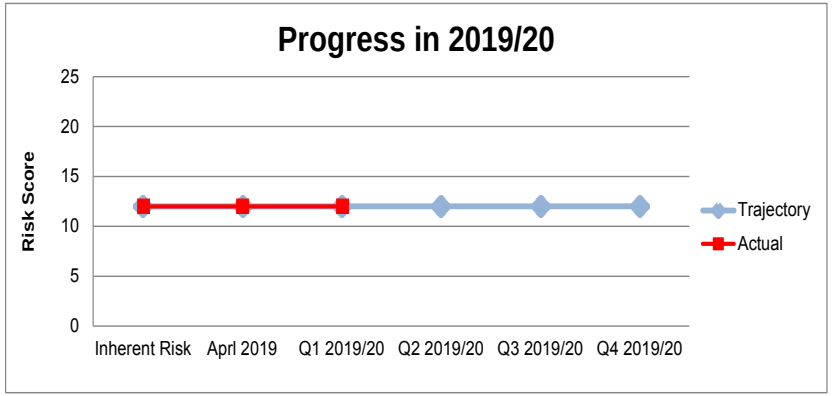
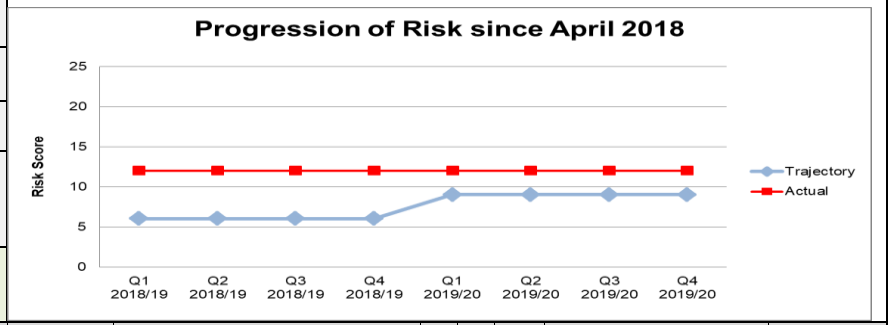
15 (3x5)	A.1 Detailed business continuity plans to mitigate the impact of any failure A.2 Multiple redundancy and layered systems to prevent the escalation of an issue (eg fire alarms; fire doors and sprinkler system; HV backup generation). A.3 Agreed maintenance regimes to ensure the infrastructure 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	Assurance task complete Remedial actions will run for a prolonged period (circa 24 months)	CEO Forum	Survey and remediation work ongoing Schematics being updated on an as needed basis External audits undertaken in August 2019 Fire compliance risk now being shared at a Hospital level 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):	

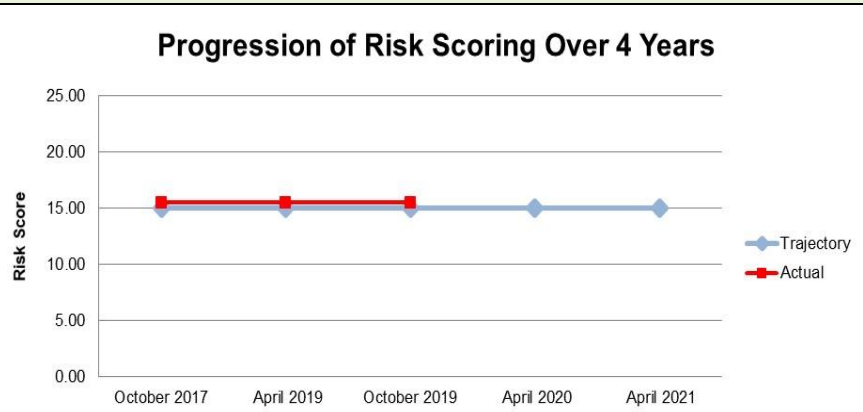
Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are 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. B.4 Movement of case-notes between clinical services, where the case-note is already in support at one clinical setting.	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). C.3 Gorton Library has maintained a consistent pulling rate of 95% for case-notes tracked to Gorton.	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. D.1 It has been established that the notes now missing are already out supporting Clinical care so need to address how to improve the movement of notes in clinical settings.	Director of Digital Delivery	April 2021	Group Informatics Strategy Board (Performance Metrics are reported to Group Information Governance 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. • Patient Records Group Terms of Reference approved and level of attendees under review. • Gorton's pulling rate for case-notes has been assured at 95% and managed service requests are cleared. • Informatics are supporting MRI's current transformation project in raising awareness with administration staff of their role within case-note flow.	**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**	Enabling Strategy: **QUALITY AND SAFETY STRATEGY;** **NURSING, MIDWIFERY & AHP STRATEGY** **Group Executive Lead:** **CHIEF NURSE**	
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**	**Associated Committee:** **NMAHP PROFESSIONAL BOARD** **HR SCRUTINY COMMITTEE** Operational Lead: **CORPORATE DIRECTOR OF NURSING** Material Additional Supporting Commentary (as required):	

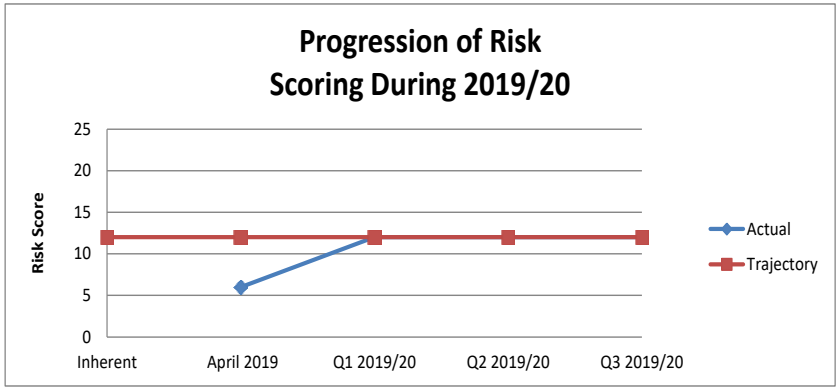
Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are 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. 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 A14 Trust have joined NHSI Retention	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 C11 Safer Nursing Care Tool (SNCT) introduced to support annual 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	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. The second cohort of 70 Nursing Associates will graduate in June 2020. There are 170 trainee Nursing Associates in training at MFT the Trust plan to continue to recruit	**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 A15. 7DS action plan A16. Locum and agency dashboards A17. Guardian of Safe working (GOSW)	B1. Consistency in approach of Hospitals/MCS to management of temporary medical staffing B2. Consistency in approach to use of Medical Agency suppliers across group B3. Key medical workforce processes (job planning, leave etc)require alignment across Group) B4. Medical Workforce systems not fully rolled out across Group B5. Medical workforce dashboards not fully in place and information not shared between systems B6. No electronic means of recording the 7DS standards. B7. 7DS Joint Assurance Group needs review to ensure meeting needs of new MDT Structure B8. Guardian of Safe Working (GOSW) post vacant	C1. NHSI weekly agency report C2. NHSE Monitoring reports C3. Percentage of consultant job plans on electronic system C4. Reducing agency/locum spend C5. Reduction in medical vacancies/unfilled shifts C6. Medical Workforce AOF Metrics C7. Audits of 7DS standards by Hospital/MCS C8. GOSW reports C9. Hospital/MCS Review meetings – risk/mitigation plans	D1. Medical Workforce dashboards need refinement and to be aligned to Hospital/ MCS and KPIS D2. GOSW reports do not cover non training posts	**12 (3X4)**	B1. Develop and expand MFT Medical Bank B1. Further develop and expand Internal recruitment programme B2. Introduce single Group wide Medical Agency Tier and Cascade process B3. Roll out new MFT job plan policy and leave policy B4. Develop job plan training guide for clinical leaders B4. Provide regular reports on job plan status to Hospitals/MCS B4. Complete the roll out of the Allocate Medical Workforce systems (job planning, e-rota) and embed into culture B4. Submit application to NHSI as part of their Capital Technology Bids process to accelerate MFT workforce systems strategy B5. (and D1) Develop and roll out new dashboards for Medical temporary staffing B6. Review potential to include 7DS standards 2 and 8 in existing MFT IT systems in advance of full EPR deployment B7. Review the Terms of the 7DS Joint Assurance Board B8. Recruit new GOSW and ensure improved engagement with all stakeholders D2. Develop GOSW reports to include non training 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 nearing completion for medical bank which will be concluded in March 2020. MFT Tier 5 GMC sponsorship progressing well which has improved international recruitment B2. Complete. B3. New MFT Job Planning Policy approved in January 2020. B4. Job plan training guide to support roll out being developed. Monthly reports sent to hospitals/MCS on job plan status Project team now in place for roll out of Allocate Medical Workforce systems B5. Complete B6. 7DS standard included in Patientrack scoped and formal testing to commence in MRI B8. Complete B9. New GOSW appointed and engagement plan progressing well D1. Updated dashboards rolled out across Hospital/MCS D2. GOSW reports updated and full link to vacancies will be available when Allocate rotas fully rolled out	**9 (3X3)**

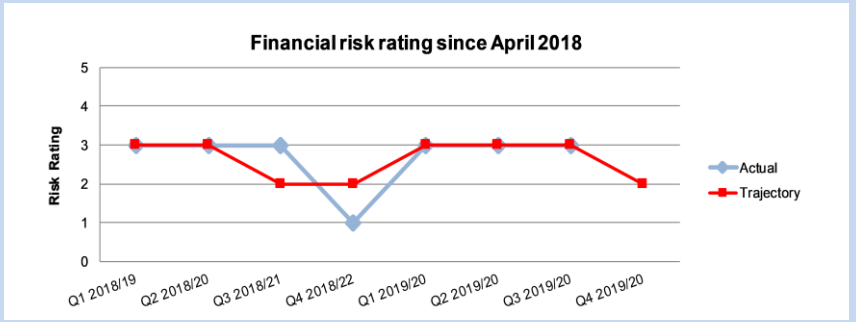
2	Strategic Aim: To improve patient safety, clinical quality and outcomes	
PRINCIPAL RISK (What is the cause of the risk?): If there are malicious attacks to IT system(s), vulnerabilities could compromise or disable access to systems and or data.	Enabling Strategy: **MFT GROUP INFORMATICS STRATEGY** 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.	

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"*
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)**

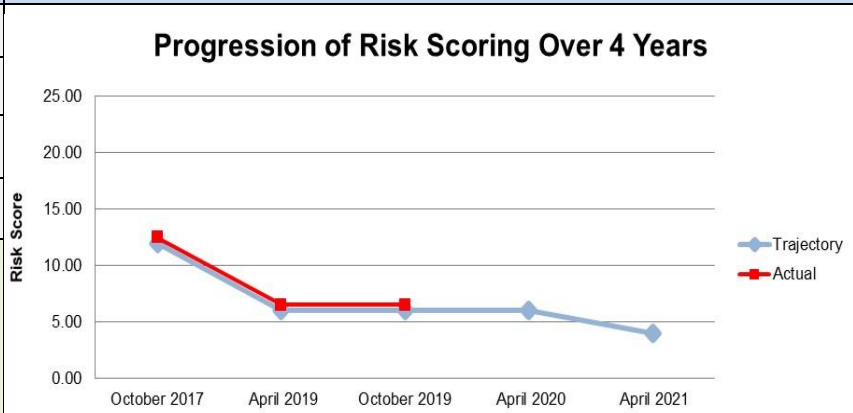
3	**Strategic Aim: To improve the experience of patients, carers and their families**	
PRINCIPAL RISK (What is the cause of the risk?): If the care provided to patients is not responsive to their individual needs and the environment is unsuitable, this could impact negatively on patient experience, outcomes and reputation	Enabling Strategy: **QUALITY AND SAFETY STRATEGY; NURSING, MIDWIFERY & AHP STRATEGY** Group Executive Lead: 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):	

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. Corporate and hospital/MCS/ LCO 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/LCOs. A7. Accountability Oversight Framework (AOF) monitoring. A8. Improving Quality Programme (IQP). A9. What Matters to Me (WMTM) Patient Experience programme A10. Clinical accreditation	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 in all areas. B4. Lack of Patient Experience Involvement Strategy. B5 Lack of food handling training to comply with the EHO recommendatio ns	C1. Internal quality assurance processes (Clinical Accreditation programme, Quality Reviews, Senior Leadership Walkrounds, Unannounced CQC action walkrounds) 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	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 patient experience scores across the Trust D3 Limited evidence that all staff involved in food handling processes comply with relevant level of food	**12** **4X3**	B1. Patient Experience Matron to support areas where WMTM is not yet embedded B2. Patient Experience 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/LCOs to develop and deliver nutrition and hydration implementation plans B3. Establish escalation processes where patients' nutrition and hydration needs are not being adequately met B4. Development of Patient Experience & Involvement Strategy B5 Develop and implement the appropriate food handling training programmes to satisfy the regulatory requirements of the EHO D1. Deliver Patient Environment of Care work programme	Chief Nurse's Team	March 2021	Quality and Performance Scrutiny Committee	B1/B2. Patient Experience Matron in post and working with Hospital/MCS teams to embed WMTM and IQP. IQP Cohorts 1 to 4 delivered, with review underway prior to further cohorts. B1. Always Events^{R} Programme Manager in post and programme commenced on Ward 84, RMCH in January 2020. B3. Hospital/MCS/LCO/E&F nutrition and hydration updates are agenda'd at Patient Environment of Care and Quality and Patient Experience Forum B.4 Patient Experience & Involvement Strategy 2020-2023 developed following Engagement Event with stakeholders D1 Patient Environment of Care work programme progressing as planned through ORC and WTWA meetings. D2 Hospital/MCS/LCO action plan exception reports monitored at AOF meetings. B5 Food task and finish group with E&F and nursing to comply with the regulatory requirements established. Food Safety in the Clinical Environment Policy developed. Patient food fridge monitoring booklet drafted. Food safety training sub-group established to enable compliance	**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. 2020/21 has a similar level of required efficiency improvement.**	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 Provider Sustainability Funding in 2019/20 would significantly jeopardise the ability to invest in and sustain improvements for patients. The risk in 2020/21 is similar, in that a breach of the Financial Trajectory will mean loss of the agreed PDC funding of £23.1m.**	Associated Committee: **FINANCE SCRUTINY COMMITTEE**	
	Operational Leads: **HOSPITAL FINANCE DIRECTORS**	
	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 2019/20 Control totals at Hospital/MCS level have been agreed at Finance Scrutiny Committee (FSC) A.2 Hospitals'/MCS' 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.3 Escalation of recovery and delivery actions was agreed through the November Group Management Board meeting, with each Hospital/MCS leadership team developing specific additional delivery commitments and supporting actions to mitigate the run-rate performance through the fourth quarter of 2019/20 A.3 Weekly reporting on key indicator measures of implementation of these actions, established from the beginning of January A.4 Follow up discussions will continue to be held regularly 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.5 Progress of each Hospital/MCS was reviewed at January Group Management Board and will continue to be scrutinised and challenged at Board Finance Scrutiny Committee A.6 Hospital/MCS teams are developing plans to manage the 20/21 challenge. These are being reviewed on a week by week basis with CFO and COO to ensure they are of sufficient scale to meet the challenge and that they are supported by detailed implementation plans. These will be reviewed at the March 2020 Finance Scrutiny Committee 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		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		**16 (4x4)**

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 was established for Milestone Approvals. • EPR Governance Framework defined and approved by Trust Board EPR Task & Finish Committee. • EPR Scrutiny Committee Terms of Reference defined. • EPR Implementation & Benefits Realisation	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	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. • EPR Governance Framework defined and approved by EPR Task & Finish Committee. • EPR Scrutiny Committee Terms of Reference defined. • EPR Implementation & Benefits Realisation Programme Board Terms of Reference defined and inaugural meeting held in Feb	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

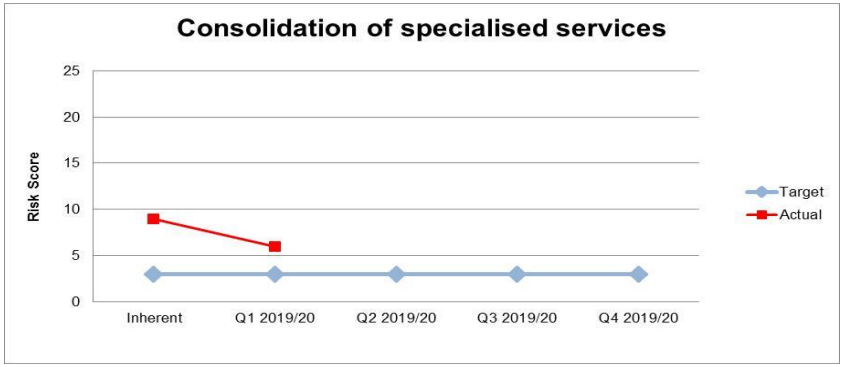
RISK CONSEQUENCES (What might happen if the risk materialises?):

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**

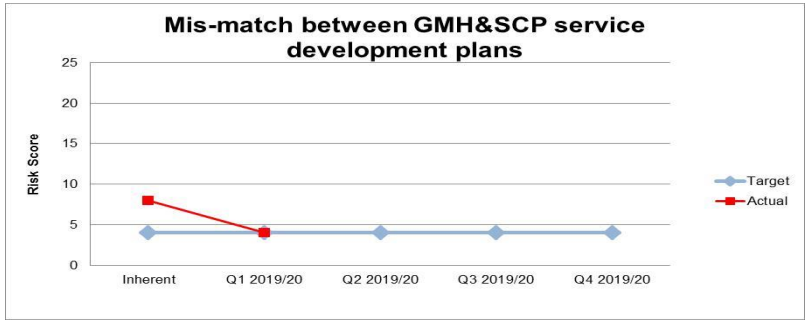
Associated Committee:
GROUP SERVICE STRATEGY COMMITTEE

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 A.6 Regular quality surveillance reviews undertaken and action plans for areas of non-compliance developed and scrutinised through annual planning process.	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 19/20 quality surveillance reviews. Overall compliance of 86% achieved. C.5 Outcome of Peer Reviews	D.1 No Gaps in Assurance	**3 (3X1)**	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	Underway	
						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	Q4 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 waves 1-3 of our clinical service strategies from key GM stakeholders C.6 The Joint Commissioning Board has agreed, subject to consultation, GM Models of care for breast, vascular and respiratory services.	D.1 Outcome of GM decisions in respect to paediatric medicine and cardiology models of care. D.2 Response from GM stakeholders to the MCS clinical strategies.	3 (3X1)	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	3 (3X1)
						B.1 Finalise MFT group clinical service strategy	MFT Strategy team	Q1 19/20	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 19/20	GSSC	Completed. Clinical services strategies completed and approved by BoD. GM stakeholders engaged and communications plan developed.	
						D.2 Complete service strategies for CSS, engaging with GM stakeholders in development.	MFT Strategy team	Q1 20/21	GSSC	Underway.	

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

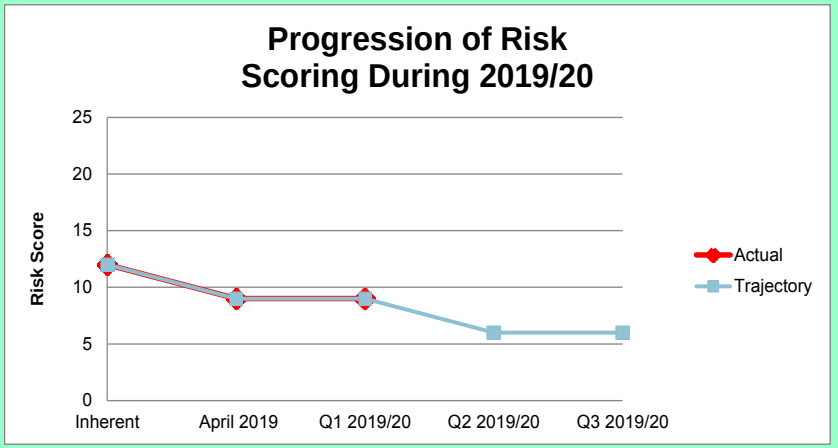
Associated Committee:
WORKFORCE & EDUCATION COMMITTEE

Operational Leads:
Group Director of Organisation Design and Development
Group Director of HR
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 & Workforce Education 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 agreed & Group and Hospital / MCS Committees in place A.8 Workforce Technology Framework A.9 Leadership and Culture Strategy	B.1 Policy development programme progressing due for completion in October 2020 B.2 People Strategy to be approved B.3 Mandatory Training Programme still needs embedding B.4 Workforce systems programme in early stages of implementation. B.5 Inadequate funding in training and development to match current and forecast demand B.6 Apprenticeship delivery programme 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 People strategy aligned to Trust service clinical strategy C.2 Trust Workforce systems and reporting e.g. 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 e.g.: TJNCC, HRD group, Workforce technology / Informatics Board C.14 Employee Health and Wellbeing Service Framework 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 People Strategy D.7 Capacity to deliver and 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 Teams to reflect priorities and delivery of the People Strategy including day to day transactional and operational business B.1 Complete policy reviews B.8 Scope and research global partnerships/organisations with exemplary workforce initiatives for shared learning and insights C.13 Review the Workforce, Education Committee refresh of membership and terms of reference	Workforce Team	March 2020	Human Resources Scrutiny Committee	***B.2 Draft People Strategy now in place and requires approval and supported resourcing plan.*** ***B.3 New governance and programme management arrangements in place to embed Mandatory Training*** ***B.6 Post Ofsted Inspection and ESFA audit plans in place and new Apprenticeship governance arrangements established.*** ***D.1 Delivery of key programme activities ongoing aligned to project delivery plans. Absence Manager programme implemented, moving into Phase 2 to embed and benefits realisation.*** ***D.2 All current committees Terms of Reference have been reviewed. Workforce Education Committee to be reviewed in September 2020.*** ***D.3.Workforce metrics reviewed and agreed for AOF and the BAF + report in place. Further development in line with People Strategy.*** ***D.4 Continue to review and finalise establishment with Finance to determine resource plan.*** ***B.1 Policies reviewed in line with implementation plan.*** ***C14 Wellbeing Assessments undertaken by Hospital / MCS, Terms of Reference agreed for oversight committee. Successful SEQOHS accreditation.***	**6 (3x2)**