MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING
(PUBLIC AGENDA)

To be held on Monday 12th September 2022
at 2:00pm

(DUE TO THE ONGOING IMPACT OF THE COVID-19 NATIONAL & LOCAL EMERGENCY RESTRICTIONS, THE MEETING WILL BE HELD VIRTUALLY AND 'LIVE-STREAMED' ON THE DAY)

A G E N D A

1. Apologies for absence

2. Declarations of Interest

3. To approve the minutes of the Board of Directors' meeting held on 11th July 2022. *(Enclosed)*

4. Matters arising

5. Chairman's Report *(Verbal Report of the Group Chairman)*

6. Chief Executive's Report *(Verbal Report of the Group Chief Executive)*

7. Operational Performance

7.1 To receive a progress report on the Hive/EPR programme *(Report of the Group Chief Operating Officer)*

7.2 To receive the Board Assurance Report *(Report of the Group Executive Directors)*

7.3 To receive the Group Chief Finance Officer's report M4 *(Report of the Group Chief Finance Officer)*

8. Governance

8.1 To note the Q1 Complaints report *(Report of the Group Chief Nurse)*

8.2 To note the Maternity Services Assurance Report (incorporating the Ockenden Report assurance framework, CNST MIS Safety Action update) *(Report of the Group Chief Nurse)*

8.3 To note the following Committees held meetings:

- 8.3.1 Group Risk Oversight Committee held on 4th July 2022
- 8.3.2 Charitable Funds Committee held on 18th July 2022
- 8.3.3 EPR Scrutiny Committee held on 19th July 2022
- 8.3.4 Quality Performance & Scrutiny Committee held on 10th August 2022
- 8.3.5 Finance Scrutiny Committee held on 24th August 2022
- 8.3.6 Human Resources Scrutiny Committee (due to the implantation of Hive, the meeting scheduled on 9th August 2022 was stood down)
- 8.3.7 Audit Committee (due to the implantation of Hive, the meeting scheduled on 7th September 2022 was stood down)

9. Date and Time of Next Meeting

The MFT Annual Members Meeting will take place on Tuesday 20th September 2022

The next Board of Directors' meeting will be held on Monday 14th November 2022 at 2:00pm

10. Any Other Business

NHS
Manchester University
NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS' MEETING

Meeting Date: 11th July 2022

(DUE TO THE IMPACT OF THE ONGOING COVID-19 NATIONAL & LOCAL EMERGENCY RESTRICTIONS, THIS WAS A VIRTUAL MEETING)

Present:	Professor Dame S Bailey (SB)*	Group Non-Executive Director
	Mr Peter Blythin (PB)	Group Director of Workforce & Corporate Business
	Mrs Julia Bridgewater (JB)	Group Chief Operating Officer
	Mrs Kathy Cowell (Chair) (KC)	Group Chairman
	Mr Barry Clare (BC)	Group Deputy Chairman
	Sir Mike Deegan (MD)	Group Chief Executive
	Mrs Jenny Ehrhardt (JEh)	Group Chief Finance Officer
	Mr David Furnival (DF)	Group Director of Operations
	Professor Luke Georghiou (LG)	Group Non-Executive Director
	Mr Nic Gower (NG)	Group Non-Executive Director
	Ms Angela Adimora (AA)	Group Non-Executive Director
	Mr Trevor Rees (TR)	Group Non-Executive Director
	Professor Jane Eddleston (JE)	Joint Group Medical Director
	Mrs Gill Heaton (GH)	Group Deputy Chief Executive
In attendance:	Mr N Gomm (NGo)	Director of Corporate Services/ Trust Board Secretary
	Mr John Wareing (JW)	Director of Strategy
	Ms Alison Lynch (AL)	Group Deputy Chief Nurse

* SB joined the meeting at 2.35pm.

230/22 Apologies for Absence

Apologies were received from Gaurav Batra, Chris McLoughlin, Darren Banks, Toli Onon, Cheryl Lenney and Barry Clare.

231/22 Declarations of Interest

There were no declarations of interest received for this meeting.

232/22 Patient Story

AL introduced the patient story which was a film of a family's experience of care at Wythenshawe Hospital.

Following the film, GH explained that she had met with the family who were very dignified and honest about the care they had received and were happy for the film of their experiences to be used to train staff and discuss at Committee meetings.

AL confirmed that the film had been shared across MFT to ensure lessons were learnt from the family's experience.

Board decision	Action	Responsible officer	Completion date
The Board noted the Patient Story and gave condolences, and expressed thanks, to the family.	None	n/a	n/a

233/22 Minutes of the Board of Directors' Meeting held on 9th May 2022, and the minutes of the Board of Directors' Seminar meeting held on 13th June 2022

The minutes of the Board of Directors' meeting of 9th May 2022 and the minutes of the Board of Directors' Seminar meeting held on 13th June 2022 were approved.

Board decision	Action	Responsible officer	Completion date
The Board approved the minutes.	None	n/a	n/a

234/22 Matters Arising

There were no matters arising.

235/22 Group Chairman's Report

KC began by noting MFT's success in treating all eligible patients who have waited more than 104 weeks for treatment by the end of June 2022 and congratulating all involved in achieving this significant feat.

KC continued by giving an overview of some recent events and achievements since the last meeting including:

- The launch of the Manchester Rare Conditions Centre and the commissioning of MFT as one of only two national centres for the rare condition, cystinosis.
- MFT's activities as part of National Volunteers' Week.
- The Armed Forces' celebration at Wythenshawe Hospital.
- Hosting an event for Chairs and Non-Executive Directors across Greater Manchester (GM) to listen to, and discuss, the new GM Integrated Care System (GMICS).
- The progress made by MFT's Be.Inclusive campaign.
- The shortlisting of MFT's Tuberculosis team, in partnership with GTD and Manchester Health and Care Commissioning, for a Health Service Journal award.

Board decision	Action	Responsible officer	Completion date
The Board noted the report.	None	n/a	n/a

236/22 Group Chief Executive's Report

MD began by echoing KC's comments regarding the 104 week waiting list achievement and reflecting on the patient story and how moving it was.

MFT continues to face significant, ongoing pressures including the legacy, and ongoing impact, of the COVID-19 pandemic, increased demand on urgent/emergency care, and the pressing need to reduce the backlog of care which has built up during the pandemic. The Trust is 60 days away from Hive Go-live and the whole organisation is focused on achieving a successful launch. The financial context for the NHS is challenging in 2022/23 with a need to ensure delivery of MFT's Waster Reduction Programme (WRP). Updates on all of these issues are included in substantive items on the agenda for this meeting.

Despite all the pressures, MFT continues to address all these issues in a coherent way, prioritising safety over everything else and making sure that decisions made are in the best interests of patients and support the health and wellbeing of Trust staff.

Board decision	Action	Responsible officer	Completion date
The Board noted the report.	None	n/a	n/a

237/22 Board Assurance Report

KC introduced the report, explaining that a review had taken place of the metrics included due to the endemic nature of COVID-19 prevalence and its impact on performance, and the need to ensure that domain metrics are aligned to national planning and performance guidance, and the updated NHS Oversight Framework. In light of this, there have been some changes to the metrics reported in this BAR compared to those which was presented to the Board of Directors in May.

JE introduced the Safety section of the report, explaining that the Patient Safety Oversight Panel monitored safety across the Trust, triangulating sources of data to achieve a complete overview. She continued to highlight MFT's performance regarding Never Events, Level 4/5 incidents, and mortality, noting that the CSS mortality ratings were unusually high as they were responsible for the 109 Intensive Care beds across MFT.

AL introduced the Patient Experience section and explained that much of the content would be picked up in her reports later on in the agenda. She noted that the Patient Experience team at Saint Mary's Hospital (SMH) were looking to improve their analysis so they could identify which feedback came from children/young people and which came from parents/carers.

DF explained that he would cover the data in the Operational Excellence section in his report later on the agenda.

PB introduced the Workforce section and explained that the indicators were reflective of operational pressures with a current absence rate across MFT of 10%, of which c.30% were due to Covid. He noted that there had been significant improvements in the levels of medical appraisals but work was still required on non-medical appraisals. Turnover of staff appears to be increasing and the issues would be discussed at a future Human Resources Scrutiny Committee (HRSC).

Board decision	Action	Responsible officer	Completion date
The Board noted the report.	None	n/a	n/a

238/22 Update on the Trust's ongoing response to the COVID-19-19 National Emergency

SB joined the meeting during this item

General Update, Performance Standards & Recovery Programme

DF presented the report, beginning by providing updated figures regarding the impact of the latest variant of COVID-19.

As of 10th July, 330 patients in MFT's beds had COVID-19 – 14% of MFT's bed stock and equivalent to 12 wards. In Greater Manchester (GM) hospitals, case numbers had doubled since the 19th June. However, there had been no increase in the numbers of Critical Care patients due to COVID-19. Another 12 wards-worth of patients are taken up by people with 'no reason to reside' leaving MFT with little flexibility of bed stock.

Performance against the A&E 4hr standard has remained stable during Q1 at 63.5%. The COVID-19 burden on general and acute beds continues to challenge flow across hospitals and overall MFT occupancy is at 90%, with medical ward capacity much higher at c.98-99%. Hospitals continue to focus efforts on improving flow out of the department and ensuring patient safety is maintained. Ambulance handover delays have shown an improving picture albeit this remains challenged. In May, 8.5% of conveyances had a delay of between 30 and 60 minutes which is consistent with the position across GM. Longer waits have also shown a steady improvement with work ongoing with the transformation team to improve process and increase accuracy of reporting.

Ongoing actions to address the urgent care and flow challenges focus on reducing ambulance handover times, adopting Virtual Wards, and re-organising Urgent Care services on the Wythenshawe site.

MFT delivered its target to reduce the number patients waiting 104 weeks + to zero by the end of June 2022. Sites will continue to focus on reducing long-wait backlogs even further with clearance required for 78-week-wait patients by March 2023. It is recognised that delivering the 78- week-wait target will be challenging and the Trust continues to work with Independent Sector Providers (ISPs) to support.

Focus continues on ensuring clinically urgent patients are being seen in a timely manner and this continues to be tracked through the weekly MESH (elective surgical hub). Sites are regularly challenged through the MESH process to ensure the delivery of both the P2 demand and the 104-week targets, ensuring clinical safety is maintained across the PTLs.

Ongoing actions to address the elective care challenges include improving theatre efficiency and data quality through the Theatre Efficiency Rapid Improvement programme.

The Outpatient programme continues to focus on key areas of national planning requirements and internal development areas. MFT is achieving 1.5% of patient initiated follow ups (PIFU) against a target of 4% by March 2023. There are currently approximately 14,000 active PIFU patients. Rollout of virtual triage to suitable services is 85% complete. HIVE will expand this to non-GP referrals in these services with c1,500 referrals being re-directed or provided with specialist advice through this route each month. Between April 2021 and April 2022, the Trust delivered 23% of clinic activity virtually against a target of 25%.

Total referrals for suspected cancer have returned to at least pre-Covid levels at aggregate across MFT sites, although there is variability both month on month and between tumour groups and sites

The increase in cancer referrals continues to place a significant drain on diagnostic resources, which is the key challenge for MFT to achieve timely pathways. Prioritisation reviews are undertaken through Trust MESH process and general PTL management to support the reduction of cancer waits above 104 and 62 days. At the end of April, MFT was behind trajectory by 114 to reduce the backlog of 104 and 62+ days.

MFT has a refreshed Cancer plan which is forming the basis of the recovery plans and trajectories in place across the Trust. The focused actions aim to increase the number of patients being seen within 7 days, reduce the diagnostic phase with more patients being given a diagnosis within 28 days and reduce the overall treatment times.

MD stated that, in order to successfully get through this challenging period there was a need to work smarter, not just harder, making full use of new services such as the Virtual Ward programme.

JE agreed, giving the example of the 'NHS at Home' national initiative, which is being rolled out, using a sector approach, across GM. The GP-led work in Tameside has shown positive results in reducing admissions and speeding up discharge from hospitals.

Board decision	Action	Responsible officer	Completion date
The Board noted the contents of the report.	None	n/a	n/a

<u>Update on COVID-19 Infection Prevention Control Response and Nosocomial Infections including COVID-19 Vaccine Programme</u>

AL introduced the report and noted that it had been completed prior to the upsurge in COVID-19 described in the previous item.

AL described the current prevalence of COVID-19, Monkeypox and other Healthcare Associated Infections within MFT, noting that all cases of MRSA and VRE bacteraemia undergo a root cause analysis with a report presented at hospital level accountability meetings chaired by the hospital Director of Nursing. The Trust IPC Board Assurance Framework has now been fully incorporated into MFT's overall Board Assurance Framework which is presented later on the agenda of this meeting.

AL presented the figures for staff uptake of flu and Covid-19 and highlighted that, of the 123 MFT staff referred for Monkeypox pre-exposure prophylaxis, 37.3% have been vaccinated or booked appointments, and 4% have declined.

KC noted that IPC issues continue to be considered in detail at the Quality and Performance Committee.

Board decision	Action	Responsible officer	Completion date
The Board noted the information provided in the report.	None	n/a	n/a

239/22 Chief Finance Officer's report

JEh presented the report which detailed MFT's financial performance as at Month 2 of the 2022/23 financial year. She noted that the report compared performance against the plan submitted in April 2022 rather than the most recent GM plan submitted in June 2022.

In May 2022, the Trust has delivered a Year-To-Date (YTD) deficit of £11.2m. In order to recover the YTD position, it is essential that work on delivery of Waste Reduction Programme (WRP) schemes is given the highest priority and focus across the entire organisation.

In May 2022, total expenditure was £202.9m. This is an increase of £7.3m compared to the April 2022 figure of £195.6m. An increase in 'bank costs', particularly around nursing, has driven up pay expenditure by £0.5m, and within non-pay, CPT drugs of £2.4m, adjustments to the SLA values for 22/23 of £1.9m, and increased expenditure on clinical supplies of £1.2m have driven the increase.

As at 31st May 2022, the Trust had a cash balance of £245.2m. The cash balance continues to reduce from the year-end position due to payments for capital expenditure in the previous financial year. The cash balance was lower than forecast by £17m which was primarily due to timing issues around annual contract payments, PDC income and VAT repayments.

In the period up to 31st May 2022, £11.2m of capital expenditure has been. The overall funding for the New Hospital Programme (NHP) has now been agreed with the national team, the plan has been updated in the June submission, which will require a re-statement of year to date variances at that time.

TR noted the challenging year ahead, particularly in meeting the WRP targets. The Finance and Digital Scrutiny Committee (FDSC) will be closely monitoring this.

JEh asked for specific Board approval for the land transfer, to and from Greater Manchester Mental Health Trust (GMMH), on the NMGH site.

Board decision	Action	Responsible officer	Completion date
The Board noted the report and approved the completion and exchange of agreements between MFT and GMMH for the transfer of land on the NMGH site, on condition that all necessary documentation is in place.	None	n/a	n/a

240/22 MFT Financial Plan for 2022/2023

JEh explained that the MFT Financial Plan for 2022/23 had been approved at a Board seminar held on the 13th June 2022 – the minutes of which were approved earlier in the agenda. The Board was asked to confirm it at this meeting.

NG confirmed that the plan had been scrutinised fully and agreed at the earlier meeting.

KC thanked JEh and her team for achieving a fully agreed plan across GM in what are very difficult circumstances as a result of the current financial challenges across the NHS.

Board decision	Action	Responsible officer	Completion date
The Board noted the report and confirmed the Financial Plan for 2022-23, as set out in this paper and submitted to GM and NHSE/I, as a breakeven position at a control total level	None	n/a	n/a

241/22 Progress report on the Hive/EPR Programme

JB presented the report which provided an update on the Hive programme and began by pointing out the extent to which Hive was integral to the future delivery of all the services and functions across the Trust..

The Programme is on track for the Go-Live date of 8th September 2022. As part of the Go Live readiness work, c.200 Hive staff are working with all Hospitals, Managed Clinical Services and the Local Care Organisation on system and user readiness activities.

71% of super users are now booked on the required training and 64% of end users are. The 60 day Go-live Readiness Assessments (GLRAs) are completed. Full scale Technical Dress Rehearsals (TDR) commenced on 20th June and will take place until August. This work will be overseen and monitored via the Go Live Readiness Assessments.90 discrete change projects have been identified linked to the Hive Programme. The majority of these have moved beyond the discover/ design phase and are now in the delivery phase.

The management of the Hive Programme has a robust risk management and strategy in place that aligns to and reports directly into the Trust Group Risk Oversight Committee

(GROC). Given the size and complexity of the overall Hive Programme the programme there are two overall risks that have been reported into and managed via GROC. These relate to potential impact on safety if the programme is not delivered effectively and the risk of Hospitals/Managed Clinical Services/Local Care Organisation not being operational ready for Go-live. There are three other specific Hive Risks that are reported into GROC. These are the management of complex pathways at North Manchester General Hospital, the inclusion of the Local Care Organisation into the Hive Programme (which was agreed later than the acute hospitals) and training. Each of these risks has dedicated mitigations in place which are reported into GROC and managed through the Hive Programme Governance process.

KC and LG underlined the point that this is a whole-organisation responsibility with LG reflecting on the challenges faced when Manchester University undertook a similar change to their IT system.

KC noted that the independent scrutiny role, played by Deloitte, was proving key in providing Board members with the assurance they needed.

Board decision	Action	Responsible officer	Completion date
The report was noted.	None	n/a	n/a

242/22 Update on Strategic developments

JW presented the report which provided an update on key strategic developments.

The development of the Greater Manchester ICS is progressing. Recruitment to senior posts in the new structures continues.

The development of the arrangements to facilitate joint working at place level are also progressing. Place leads for integration have been appointed across Greater Manchester. These roles will be responsible for driving the local integration of health and social care, connecting it to wider public services to address the social determinants of health.

In Manchester, Joanne Roney, Chief Executive of Manchester City Council, has taken on the role of Place-Based Lead for Integration. The Manchester Partnership Board will bring together the senior leaders of health and care across the locality and will be called Manchester Integrated Care Partnership Board.

In Trafford, Sara Todd, Chief Executive of Trafford Local Authority, has taken on the role of Place-Based Lead for Integration. The Trafford 1-system Board will bring together the senior leaders of health and care across the locality and will be called Trafford Integrated Care Partnership Board.

The development of the operating models for those services that are provided across MRI, WTWA and NMGH is progressing. Changes to the management and leadership arrangements that will better facilitate the achievement the benefits of the Single Hospital Service are being implemented in services including head & neck, GI medicine, orthopaedics, breast, cardiac and infectious diseases.

In conjunction with partners across GM (GM Cancer Alliance, Northern Care Alliance, The Christie), MFT is leading work to support the roll out of lung health checks in Greater Manchester. Lung Health Checks will be delivered close to peoples' homes through the use of both fixed and mobile diagnostics capacity. This programme is part of the wider NHS commitment to diagnose patients with lung cancer at an early stage when the disease is more treatable.

Having been successful in its bid for funding as part of the national Community Diagnostics Centre Programme in 21/22 and 22/23, MFT is now working with local and GM partners to develop a business case for both capital and revenue funding for a further 2 years. The business case is due to be submitted to NHS England in July. If successful it would see the expansion of CDC services across Manchester and Trafford, including mobile diagnostic services across North Manchester and a capital development at the Withington Community Hospital site.

Board decision	Action	Responsible officer	Completion date
The Board noted the report.	None	n/a	n/a

243/22 NHS England Oversight Framework for 2022/2023

JW presented the report which presented the NHS Oversight Framework for 2022/23 which takes effect from 1 July 2022. It is similar to last year's but the operating environment has changed due to the introduction of Integrated Care Systems.

NHS England regional teams will lead the oversight of ICBs on delivery against the domains in the NHS Oversight Framework and, through them, gain assurance of place-based systems and individual organisations. Where necessary regional teams will lead and coordinate support requirements identified for the ICB. ICBs will lead the oversight of NHS providers, assessing delivery against the domains, working through provider collaboratives where appropriate. ICBs will consult with their NHS England regional team on areas of concern, specific support requirements and any issues requiring formal intervention by NHS England.

Board decision	Action	Responsible officer	Completion date
The Board noted the report.	None	n/a	n/a

244/22 MFT Staff Survey

PB presented the report which detailed MFT Staff Survey results for 2021. He began by summarising the key issues:

- The Trust staff engagement score is 6.7 compared to 7.0 in 2020.
- MFT is within 0.1 of the average sector score for 6 of the 7 national People Promise elements and 2 of the themes and 0.2 for the element 'We Work Flexibly".
- For the first time the survey includes a valid and robust measure of 'burnout' as part of the 'We are Safe and Healthy' reporting element.
- As part of the 'We Have a Voice Element' there has been a significant improvement since 2020 with a +2.79% difference in staff feeling secure about raising concerns about unsafe clinical practices.

- Staff engagement and morale themes have both shown a statistically significant decline with Morale at 5.6 in 2021 compared to 6.0 in 2020.
- Analysis suggests that for those staff working remotely during the pandemic, including from home, scores were higher across all the national People Promise elements. Scores were generally lower for those staff who were working on a COVID-19 ward and/or redeployed, particularly for 4 of the 7 People Promise themes “We are Rewarded and Recognised”, 'We are Safe and Healthy', “We are Always Learning”, “We Work Flexibly”, along with “Morale.”

PB is completing a stocktake of the survey results in the context of existing workforce policies and initiatives including the MFT People Plan, “All here for you, Together we can”. The work will involve Group Executives, senior leaders across MFT and Staff Side colleagues.

The results have been disseminated to Hospitals / Managed Clinical Services / Local Care Organisations and Corporate Leadership Teams to consider, reflect and develop action plans. Action plans are now aligned to localised versions of the MFT People Plan. Work is also underway to extract local Equality, Diversity, and Inclusion data for each Hospital / Managed Clinical Service / Local Care Organisation / Corporate Services to understand the lived experience of staff with protected characteristics.

The MFT leadership and culture programme of work, that underpins the MFT People Plan, has been updated in line with national changes and is based on MFT Staff Survey insights to ensure a targeted measurable approach is taken to embedding a culture of compassion, inclusion, and staff engagement. Additionally, a new MFT line manager framework, Managing@MFT, has been introduced to help and support line managers at all levels to understand the expected standards as well as access to the learning, resources and support capacity and capability.

KC thanked PB and recognised the values in hearing from as many of our staff as possible. PB responded by citing the CSS staff awards which showed some great examples of staff engagement work within their MCS.

AA explained that her and PB were meeting to discuss further and consider how to monitor that improvement actions were being carried out consistently across the whole of MFT.

Board decision	Action	Responsible officer	Completion date
The Board noted the report	None	n/a	n/a

245/22 Update on Workforce Race Equality and Workforce Disability Equality Standards

PB introduced the report which presented MFT’s position in respect of the Workforce Race Equality Standards (WRES) and Disability Equality Standards (WDES). The report has already been discussed in detail at the Human Resources Scrutiny Committee.

PB highlighted the increased opportunities for staff to discuss, and raise, equality and discrimination issues across MFT. There is much work underway but more is still required.

AA agreed, noting that the numbers raising concerns should be seen as a positive indicator of openness but that it was crucial that actions to address any issues are delivered and monitored.

Board decision	Action	Responsible officer	Completion date
The Board noted the report.	None	n/a	n/a

246/22 Annual Complaints Reports

AL presented the Annual Complaints report for 2021/22 and described some of the main elements of the report.

Comparative data from 2019/20 has been included as the number of complaints received reduced very significantly during 20/21 as a result of the impact of the pandemic. Data from NMGH has been included for the first time.

The total number of PALS concerns received in 2021/22 was 7,722. This is an increase of 2,822 (57.59%) when compared with the 4,900 received in 2020/21 during the period of the pandemic. In 2019/20 5,897 PALS concerns were received.

The total number of complaints received in 2021/22 at MFT was 1,665. This is an increase of 606 (57.22%%) when compared to the 1,059 complaints received, in 2020/21. In 2019/20 1,628 complaints were received.

AL explained that the report details examples of learning and change as a direct result of feedback received from complaints and concerns. Examples of learning from complaints have been published in each quarter during 2021/22 as part of the Board of Directors Quarterly Complaints and PALS Report.

Significant improvements delivered in 2020/21 include:

- Reopening of NMGH PALS office and Reception
- Launch of an in-house Customer Service PALS and Complaints Module 1 e-learning package
- Review, updating and ratification of MFT's Concerns and Complaints Policy ▪ Implementation of a dedicated Complaints Triage System
- Development of an in-house PALS and Complaints Customer Service Advanced e-learning package.

Equality and Diversity Audits have been carried out, AL described that the report recognises that the equality data captured from people contacting MFT with complaints, concerns or queries about their care or treatment requires strengthening to enable a fuller analysis.

The Complaints Review Scrutiny Group, now chaired by NG, met five times in total during 2021/22 and reviewed 10 cases involving 9 Hospitals/MCS/LCOs across MFT. For each participating Hospital/MCS/LCO and presented case, an evaluation of the effectiveness of actions taken and a progress review of any actions from the previous occasion was undertaken.

NG confirmed that the purpose of the Group was to ensure that any compliant was dealt with appropriately and that the learning from it was applied across the organisation.

The Board noted the report and approved it for publication on the MFT website.

Board decision	Action	Responsible officer	Completion date
The Board noted the report and approved it for publication on the MFT website.	None	n/a	n/a

247/22 Annual Accreditation Report for

AL presented the Annual Accreditation Report which provides an overview and analysis of the 2021-2022 Accreditation Programme and a summary of the changes implemented in response to feedback from key stakeholders. The reporthas already been reviewed at the Quality and Performance Scrutiny Committee. The accreditation process had been adapted during the pandemic, to take into account restrictions in place, its re-introduction throughout 2021-2022 had been successful, as demonstrated throughout the report.

The distribution of awards demonstrated 24 areas (13.8%) achieved Bronze, 84 areas (48.3%) achieved Silver and 66 areas (37.9%) achieved Gold. There were no White areas identified. In comparison to the previous year 41 areas improved their award, 74 areas maintained the same award, 33 areas demonstrated a deterioration in their award, and 26 areas had not previously been accredited.

From the 'areas of success' documented, thirty-five themes were recognised, with leadership being identified as the main area of success and 65% of these areas were presented a Gold award. From the 'areas for improvement' documented, twenty-one themes were recognised, with lack of patient feedback being the main area identified as requiring improvement.

The accreditation programme for 2022-23 will see a further 56 clinical areas added to the accreditation rota, demonstrating the Trust's continued commitment for ensuring high-quality care and the best possible patient experience.

GH explained that, from her time as Interim Chief Executive at WTWA, she saw the huge difference it made to staff when they had a positive accreditation, how proud they felt. and the pleasure they got from being recognised for the work they had done.

The Board noted the report.

Board decision	Action	Responsible officer	Completion date
The Board noted the report.	None	n/a	n/a

248/22 Annual Infection Prevention Control Report

AL presented the Annual Infection Prevention and Control Report (IPC) for 2021/22 which details IPC activity from April 2021 to March 2022.

Throughout 2021/2022 the Trust continued to respond to the continuous fluctuating levels of the background levels of the COVID-19 virus maintaining a balance of risk between patients who were admitted on COVID-19 and non-COVID-19 pathways. Staff have supported visitors and each other to implement policies and procedures to reduce the risk of transmission of COVID-19. The Chief Nurse has carried out IPC 'end of the year' reviews with all Hospitals/MCSs/LCOs.

AL highlighted the UK HSA COVID-19 whole genome sequencing laboratory at MFT which has recently increased capacity to 3000 genomes per week to provide a service to the North of England. Data from COVID-19 sequencing at MFT has provided valuable information to assist with the management of the pandemic as well as providing clinically useful information to guide the management of patients, especially during the early phase of the Omicron variant wave.

KC noted that the QPSC had been scrutinising IPC activity throughout the year and had received considerable assurance within a context of new variants and changing national guidance.

The Board noted the report and approved it for publication on the MFT website

Board decision	Action	Responsible officer	Completion date
The Board noted the report and approved it for publication on the MFT website.	None	n/a	n/a

249/22 Annual Safeguarding Report

AL presented the Annual Safeguarding report for 2021/22 which provides assurance to the Board that MFT is fulfilling its statutory safeguarding responsibilities as outlined in Section 11 of the Children Act 20041 and in the Care Act 2014.

In the context of the COVID-19 pandemic, 2021-2022 has been an extremely busy year for Safeguarding and Looked after Children Services with challenges, changes and opportunities within the Trust and across Manchester and Greater Manchester. Changes to legislation, national policy and guidance continue to influence the safeguarding and Looked after Children agendas.

The Safeguarding and Looked after Children service is delivered as a single corporate, Trust-wide service, with teams based at two community and four hospital sites. The service provides a resilient, visible, and accessible offer across all Hospitals/MCSs/LCOs. The Trust has also invested in a new team of safeguarding practitioners to lead and support safeguarding at NMGH.

There has been a notable increase in reporting of adult, unborn, children and young people safeguarding concerns this year. The increase in the Trust footprint has attributed to some but not all of the increased reporting indicating that frontline staff are increasingly recognising and responding to safeguarding concerns. Concerns related to neglect in the care of adults and children, domestic abuse and the impact of mental health concerns on safeguarding are the most frequent categories of concern reported to the safeguarding team. This is consistent with the national data.

During 2021/22, the Trust has completed the Manchester Safeguarding Partnership's self-assessment 'Section 11' of the Children Act 2004 audit, the Adult Assurance self-assessment and the Greater Manchester (GM) Safeguarding Contractual Standards 2021-22 audit tool to measure compliance with the NHS Assurance and Accountability Framework for Safeguarding (Safeguarding Vulnerable People in the NHS 2015)4 . The outcome of these audits has demonstrated that MFT is compliant with statutory requirements and has an action plan in place to improve safeguarding standards in the application of the mental capacity act and recognition and response to self-neglect.

KC noted that MFT benefit from Chris Mcloughlin leading this area from a Non-Executive Director perspective.

AL noted that during the year, MFT has responded to the learning from Child and Adult Safeguarding Reviews, and Domestic Homicide Reviews, and improved practice as a result.

Board decision	Action	Responsible officer	Completion date
The Board noted the reports and approved the Complaints and IPC reports for publication on the MFT website.	None	n/a	n/a

250/22 Maternity Safety Assurance

AL introduced the report and noted that it had been discussed at Quality and Performance Scrutiny Committee.

As reported to the Board of Directors in January, March and May 2022, Saint Mary's Managed Clinical Service (SMMCS) has completed all Ockenden actions required by provider organisations from the initial report published in December 2020. Three outstanding actions, which sat with Greater Manchester and Eastern Cheshire Local Maternity and Neonatal System (GMEC LMNS), relating to a process on how the system is to receive maternity training data have now been completed.

As reported to the Board of Directors in May 2022, the second and final Ockenden Report identified a further 15 Immediate and Essential Actions (IEAs) which all providers must implement and report their compliance. A date by which compliance must be achieved is yet to be set. SMMCS has completed a detailed review of the 15 IEAs in April 2022. This review demonstrates over 65% compliance with the IEAs and progress towards completion is monitored through an action plan to address the remaining areas of non-compliance, through Saint Mary's Quality and Safety Committee and Group Quality and Safety Committee and completed by December 2022.

In line with Year 4 MIS Safety Action 9 requirements, SMMCS provided assurance to the Board of Directors on the progress and plans relating to the national ambition to achieve Midwifery Continuity of Carer (MCoC) as the default maternity offer by March 2023.

In May 2022, SMMCS reported to the Board of Directors that progress on the current MCoC action plan would be paused in response a letter on 1st April 2022 from the NHS Chief Nursing Officer for England (CNO) requiring all providers to review current MCoC teams against current staffing levels following the release of the final Ockenden Report. This required suspension of the MCoC model until, and unless, safe staffing is shown to be present.

On 6th May 2022, NHS England released further guidance regarding MCoC. This, along with amendments within Year 4 MIS, have confirmed that MCoC as a default maternity offer should be achieved by March 2024.

The MCoC staffing risk assessment demonstrated an increased risk to SMMCS' maternity services should the plan to roll out additional MCoC teams continue without additional recruitment. SMMCS' MCoC action plan is a phased approach over 6 years and is projected to be achieved by Q3 2027/2028. This approach aims to ensure safety and stability of the maternity service during a period of transformational change in delivering maternity care.

TR confirmed that the Patient Safety Learning Committee had, in April 2022, received a presentation regarding the maternity triage process which had provided assurance that improvements had been made to improve patient care.

Board decision	Action	Responsible officer	Completion date
The Board noted the report and approved the decision to suspend 5 MCoC teams based on the risk assessment provided and delay the roll of the next MCoC team until Q3 23/24 with a phased approach over 6 years, acknowledging that this will not meet the current national ambition of offering MCoC as a default model of care by March 2024. The Board also approved the proposal to delegate receipt of a maternity patient story to the SMMCS Quality and Safety Committee.	None	n/a	n/a

251/22 MFT's Group Risk Appetite Statement

JE presented the report which sought Board ratification of the Group Risk Appetite Statement which had been developed in consultation with Board members and been agreed at the Group Risk Oversight Committee.

NG confirmed that the statement had been well thought through and considered by Board members. It accurately summed up the Board' current position with regard to risk appetite.

Board decision	Action	Responsible officer	Completion date
The Board ratified the Trust's Risk Appetite Statement.	None	n/a	n/a

252/22 Board Assurance Framework

PB introduced the Board Assurance Framework (BAF) for June 2022 which presents the risks which have the most potential to impede MFT's delivery of its Strategic Aims. These risks are also overseen by the Board of Directors' Scrutiny Committees.

PB explained that discussions have begun with Executive Directors, Non- Executive Directors, Internal Auditors, and MFT's Group Director of Clinical Governance to consider how the BAF can be improved to ensure that it focuses on providing assurance regarding progress toward achieving MFT's strategic aims; is directly linked to MFT's Strategic Risk Register and Risk Appetite statement; and is clearly formatted and user friendly.

NG noted that the BAF had had a rating of Significant Assurance from the Internal Auditors in 2022 and welcomed the desire for continual improvement despite this positive rating.

Board decision	Action	Responsible officer	Completion date
The Board accepted the latest BAF (June 2022).	None	n/a	n/a

253/22 Committee Meetings

The Chairman asked the Board of Directors to note that the following meetings had taken place:

- EPR Scrutiny Committee held on 27th April 2022
- Group Risk Oversight Committee held on 16th May 2022
- Audit Committee held on 14th June 2022 and Private Audit Committee held on 27th June 2022
- Human Resources Scrutiny Committee held on 14th June 2022
- Quality & Performance Scrutiny Committee held on 15th June 2022
- Finance & Digital Scrutiny Committee held on 22nd June 2022

Board decision	Action	Responsible officer	Completion date
The Board noted the meetings which had taken place	None	n/a	n/a

254/22 Date and Time of Next Meeting

The next meeting of the Board of Directors will be held on **Monday, 12th September** at **2:00pm**.

255/22 Any Other Business

No issues were raised.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING (Public)

ACTION TRACKER

Board Meeting Date: 11th July 2022		
Action	Responsibility	Completion date

Board Meeting Date: 9th May 2022		
Action	Responsibility	Completion date
Board briefing to be prepared identifying how Hive will benefit patients and staff and the wider potential offered by a single electronic patient record across the whole of MFT.	JB	Complete
Patient stories to be presented at the beginning of every Board of Directors' meeting	CL	Complete
A comparison with pre-pandemic complaint numbers to be included in the Complaints Annual report	CL	Complete
Angela Adimora's declaration of interests to be amended to include her employer's name.	Trust Board Secretary	Complete

Mrs Kathy Cowell, OBE DL
Group Chairman …… …../……./…….
Signature *Date*

Mr Nick Gomm
Director of Corporate Services / ……. …../……./……..
Trust Board Secretary *Signature* *Date*

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Julia Bridgewater, Group Chief Operating Officer/Hive SRO
Paper prepared by:	Dave Pearson, Programme Director
Date of paper:	September 2022
Subject:	Update on the HIVE programme
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 implementation of Hive supports the delivery of MFT's Vision and all of its Strategic Aims.
Recommendations:	The Board of Directors is asked to note the ongoing work on the Hive programme.
Contact:	Name: Julia Bridgewater Tel: 0161 701 5641

Update on the HIVE Programme

1. Background and recap

1.1 As one of the largest NHS Foundation Trusts in the UK, MFT requires a future Electronic Patient Record (EPR) solution which supports its vision to be a world-class academic and teaching organisation.

1.2 Following an extensive procurement exercise, MFT signed a contract with Epic following approval of the EPR Full Business Case by the Board of Directors in May 2020. This was extended to cover North Manchester General Hospital following the formal acquisition of NMGH on 1st April 2021 and also now includes the Manchester Local Care Organisation.

1.3 MFT's future EPR solution is called Hive reflecting the importance of clinical transformation and wide-spread change and improvement in every part and process of the organisation to benefit patients and staff. It complements the work underway to deliver the Trust Digital Strategy and supports the Trust research portfolio.

1.4 Hive will Go-Live on 8th September 2022 supported by a robust programme management approach to oversee the implementation. The roll out will continue post 8th September once the initial phase is live.

1.5 From September 2021, Julia Bridgewater, Group Chief Operating Officer has been providing dedicated Executive level oversight and leadership for the Hive Programme.

2. Benefits Hive will bring

2.1 Hive will transform how everyone works across MFT. It will bring benefits to both the staff and patient experience.

2.2 From Go Live, there will be immediate benefits to staff such as reduced administration time, duplication of processes and reduced transcription. For patients, there will be immediate benefits including reduced duplication of tests, improved prescribing and safety.

2.3 However, benefits will build over time and lead to improvements to scheduling, throughput, efficiency, patient communication, patient self-management, staff communication and safety.

2.4 Overall, the benefits Hive will bring are:

- Improving clinical quality, patient and staff experience, operational effectiveness and driving research and innovation.

- Improving how Hospitals and Managed Clinical Services deliver services and support better clinical decision making, helping MFT deliver its strategic vision.

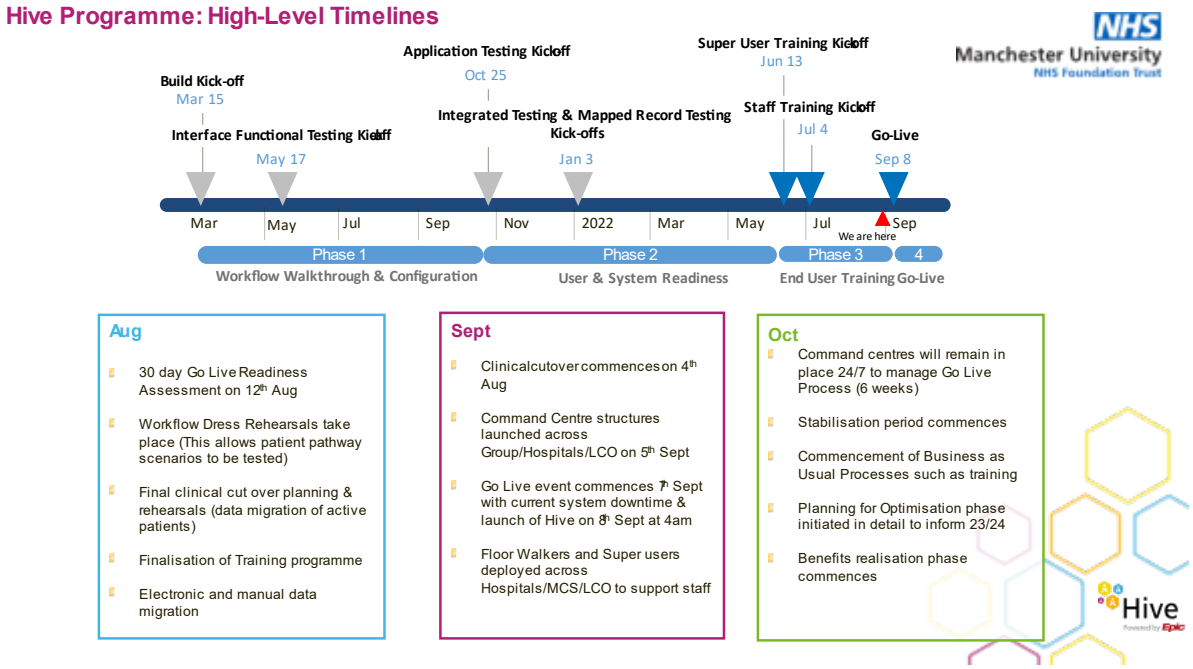
- Enabling staff to work more efficiently by accessing the information they need to care for patients wherever and whenever they need and promoting the introduction of more digitally enabled interaction with patients and users of services.

- Improving the patient experience by giving patients more control over their own care through a patient portal and phone app, MyMFT. This will reduce the need for people to give the same information to different members of staff.

- Increasing patient safety by holding one record for each patient and providing alerts for potential medication errors, allergies, and infection risks.

3. Progress to Go Live

3.1 The Programme is on track for the Go-Live date of 8th September 2022. The key tasks and high-level timeline for the Go Live and immediate post Go Live Period are outlined below.



3.2 As part of the Go Live readiness work, the Hive team have been supporting staff in Hospitals and Managed Clinical Services with Workflow Dress Rehearsals. This allows staff to track a patients journey from end to end using the Epic Production Environment which will be used at Go Live.

3.3 The system and user readiness activities also include manual data migration and clinical data migration. These are important activities to ensure the Hive processes are tested but are also valuable training exercises.

3.4 The Hive governance and programme management functions are well developed and embedded. These have been refined further in July and August to ensure that the critical

path for final design, building, testing, data migration and training are delivered with *Board to Ward* oversight.

3.5 The Hive governance assurance process includes Go Live Readiness Assessments (GLRAs) at 120, 90, 60 and 30 days prior to Go Live. There are two types of GLRA:

- Local GLRAs:
  These take place in each Hospital/ Managed Clinical Service/ Local Care Organisation and are chaired by their respective Chief Executives. They focus on their local readiness activities and outputs feed into the central GLRA.

- Central GLRA:
  Chaired by Julia Bridgewater, the panel includes Group Executives, Hive Programme Team, Hospital/ Managed Clinical Service/ Local Care Organisation Executives and Deloitte representatives *(Deloitte provides external assurance).*

3.6 All the GLRAs have now taken place with the 30-day Central GLRA taking place on 12th Aug. There were four rated Critical (off track) at the 30-day central GLRA – Training, Pharmacy, Data Migration Electronic and Pathology (Labs). All of these areas already had identified escalation management plans in place with group executive ownership. Following the GLRA, significant progress has been made on all four areas with the delivery and achievement of the key Go Live Critical milestones:

- Data Migration – 98% Production Success rate on error rates which meets Epic Go Live criteria
- Pharmacy – Protocol build competed for Adult and Paediatrics with validation on track
- Pathology Labs – Clinical content validation complete (meeting national requirements)
- Training – 81% of MFT staff have completed the training requirements for Hive access at Go Live

3.7 Robust external assurance arrangements remain in place with Deloitte providing regular gateway reviews. The final Gateway review (Gateway 4) before Go Live was received at the start of July 2022 and focussed on testing, training, programme governance risk management and readiness for *Go Live.*

3.8 Given the size and complexity of the programme, a standalone EPR Scrutiny Committee meets on a bi-monthly basis chaired by Barry Claire, Non-Executive Director. The Deloitte External Assurance Reports are reported to this committee.

3.9 The final EPR Scrutiny Committee before Go Live took place on 24th August 2022. The Committee revised the detailed outputs of the 30-day GLRA, reviewed progress since the last Deloitte Gateway report and received a formal update from the Epic Executive Lead. The Committee noted the progress, current risks and mitigation plans and supported proposed Go Live date of 8th September 2022.

3.10

3.11 The Hive Programme entered **Phase 3: User Training & Go Live** in June 2022. As previously reported, his marked a key juncture in the programme as all staff across the entire organisation begin training, all the medical devices are tested to ensure they are Hive compliant, and testing and build are finalised.

4. Training

4.1 The new Learning Management System (LMS), which was launched on 12th April 2022, has allowed staff to complete their bespoke eLearning modules and book onto their face-to-face training sessions.

4.2 Over 140 full time staff are delivering face to face training in over 80 dedicated Hive training rooms. All rooms have been kitted out with Hive equipment to ensure users are trained on the actual systems that will be used.

4.3 Super User training face to face training commenced on 13th June and all other staff training started on 4th July. The staff who are trained as Super Users will be deployed across each Hospital/MCS at Go Live to give 'at the elbow support'.

4.4 Doctors, dentists, nurses, midwives and other allied health professions have been trained to be Peer Trainers. The MFT Peer trainers have supported the training sessions ensuring that they are clinically led.

4.5 In mid-August a supplementary *Just in Time* (JiT)Training package was launched which is aimed to staff who have been unable to attend face to face training. The JiT training is bespoke eLearning based on an individuals' role/profession and staff must still pass the end of training assessment to confirm competence before they will be allowed Hive access. Following JiT training staff are also given the opportunity for local face to face peer and superuser support sessions.

5. Communications and Engagement

5.1 As we approach imminent Go Live, the Communications and Engagement Strategy came to the end of the Go Live readiness phase and was focussed on supporting readiness work across sites, building staff knowledge through key readiness materials.

5.2 There also is a clear focus on patient, GP and external stakeholder communications including other Trusts, Greater Manchester and national bodies in the run up to Go Live. This is supported by a comprehensive plan for launch press and social media.

5.3 Key communications activities that have been completed this quarter include:

- GP communications moved to weekly with stronger engagement on key local issues such as the transfer from TQuest-to-ICE. Stakeholder briefing issued on 8th August to NHSEI, NHS Trusts and NWAS.

- Creation and dissemination of the Hive Handbook. An all-staff readiness guide (both digital and physical) to support staff through Go Live.

- Refocussed staff facing communication channels to more flexible “readiness” and training focussed messages in order to be agile and responsive to readiness information.

- Creation of staff guidance materials in different formats including Go Live trust video, “supporting you” animation and “how to talk to patients about Hive” short.

- Go Live material and marketing was cascaded. Support posters to all sites were delivered including escalation processes, “Three things to do before Go Live” and lift vinyls and wall art swapped out for final marketing stage.

- Super User and Floor Walker support guide drafted and designed which will be provided to all Super Users and Floor Walkers. The Super Users and Floor Walkers will be provided with t-shirts so that they are easily recognisable to staff and can provide ‘at the elbow support’.

- Development of a marketing materials and website/social media content to support sign up of patients to MyMFT, and to build staff and patient awareness about the benefits MyMFT will bring.

- Launch posters for patients to raise awareness of change and message to “please bear with us” during the Go Live period.

- Supporting Hospital and MCS executive teams , Super Users, Readiness Facilitators and Digital Matrons to share information as widely as possible with targeted key messages.

6. Transformation

6.1 The Hive High Impact change projects have been managed within the GLRA process to enable tracking of progress at a local level alongside the critical path.

6.2 The Transformation team have continued to focus on engagement events in the months leading up to Go Live with frontline teams to support operational readiness.

6.2 In July and the beginning of August specific workshops and sessions have been undertaken around Admission, Transfer and Discharge alongside the referral management and outpatient pathways. Bespoke sessions are also being supported across Hospitals and MCSs on these engagement activities.

6.3 The transformation team are supporting the development and delivery of Workflow Dress Rehearsals which take place at the end of August across the hospital sites and are also supporting teams in A&E departments with shadow charting activities.

7. Technical Deployment

7.1 The Technical Programme has implemented the infrastructure which is being used to host Hive, this was made live in June. Data migration commenced with the loading of the Master Patient Index in July.

7.2 Clinical and Administrative data commencing loading into Hive in August, which has been within Epic recommended success rates, For the initial load of day cases and surgical waiting lists the success rates enabled manual migration to be completed with the identified resources.

7.3 Technical Dress Rehearsals (TDRs) commenced in June and has seen the testing of over 14,000 devices, as of 24th August 83% of the devices had passed testing with a plan for the remaining to be completed by 2nd September.

7.4 Medical Device installation for the integration between devices and Hive has been completed and testing signed off on all 586 devices.

7.5 Final preparations are underway with the deployment of iPhones as Rover Devices and Ipads for Consenting are due to be deployed from 30th August.

8. Risk Management

8.1 The management of the Hive Programme has a robust risk management and strategy in place that aligns to and reports directly into the Trust Group Risk Oversight Committee (GROC). This ensures that there has been clear executive ownership on Hive risks and also that the risks are assessed and mitigated in line with interdependences on all the other Trust workstreams.

8.2 Given the size and complexity of the overall Hive Programme the programme there are two overall risks that have been reported into and managed via GROC. These relate to potential impacts on safety if the programme is not delivered effectively and the risk of Hospitals/Managed Clinical Services/Local Care Organisation not being operational ready for Go Live.

8.3 There are three other specific Hive Risks that are reported into GROC. These are the management of complex pathways at North Manchester General Hospital, the inclusion of the Local Care Organisation into the Hive Programme (which was agreed later than the acute hospitals) and training. Each of these risks had dedicated mitigations in place which are reported into GROC and managed through the Hive Programme Governance process.

9. Benefits Realisation

9.1 Given the significant impact of COVID on the operating environment and changes to the financial regime, the Hive benefits case has been reviewed. In terms of cash releasing benefits, the review work focused on re-baselining and planning of benefits with either expected early delivery or material financial value, or both.

9.2 Review and planning work continues between Group and Hospital / MCS teams on key programmes of early implementing cash-releasing benefits, including: Automation, redesign and process change in clinical administration and Outsourced typing; Informatics legacy systems shutdown; Electronic Document Management Storage; and paper-lite operations.

9.3 This planning and development process follows the same rigorous governance process undertaken in each Hospital/ MCS in respect of the normal year-on-year safety, efficiency and productivity programmes.

9.4 Work has also been undertaken to review and further develop a benefit register for all types of benefit, including the identification of appropriate key performance indicators to measure delivery of the benefit post Hive implementation.

9.5 An updated benefits register, with defined key performance indicators, was agreed through Executive Director team on 13th June. Work continues, with domain teams, to ensure that baseline performance data for all types of benefits is available, or that there is an agreed method and timing to collect this data.

10. Next Steps

10.1 The Hive Programme is on track to ensure a successful Go-Live on 8Th September 2022.

10.2 This will be a key milestone underpinning the delivery of the MFT Digital Strategy.

10.3 September 8th represents the beginning of a process of continuous improvement in patient experience and of our digital capability.

10.4 Assurance will continue to be provided to the EPR Scrutiny Committee supported by further updates to the Board of Directors.

11. Recommendation

11.1 The Board of Directors is asked to note the progress made.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Directors
Paper prepared by:	Alfie Nelmes, Head of Information Services
Date of paper:	September 2022
Subject:	Board Assurance Report – July 2022
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 bi-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: Alfie Nelmes, Head of Information Services Tel: 0161 276 4878

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS

BOARD ASSURANCE REPORT

(July 2022)

1. Introduction

The Board Assurance Report is produced every two months 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 (BAR) 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.

The established Accountability Oversight Framework (AOF) process reviews the performance for all MFT Hospitals / MCS and LCOs and is reported into MFT's Quality and Performance Scrutiny Committee.

It was agreed at the start of this year that the metrics within both the BAR and AOF, and the scoring logic for the AOF, would benefit from a full-scale review due to:

- the endemic nature of COVID-19 prevalence and the impact on performance; and
- the need to ensure that domain metrics are aligned to national planning and performance guidance, and NHS Oversight Framework.

In light of this, there have been some changes to the metrics reported in this BAR compared to that which was presented to the Board of Directors in July. The metrics added are as follows:

- Transfer of patients outside Saint Mary's MCS due to capacity/delays
- Avoidable admissions to the neonatal unit

3. Key Priority Areas

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

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

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.

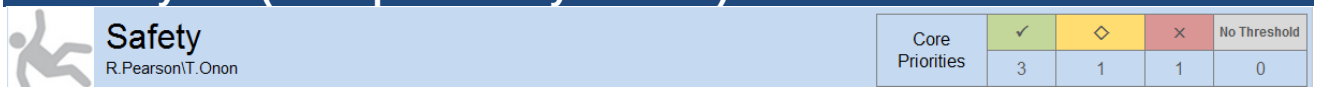
The narrative is provided by the lead Director accountable for the individual priority areas.

‘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. Each domain is structured as follows:

Summary Bar (Example –Safety Domain)



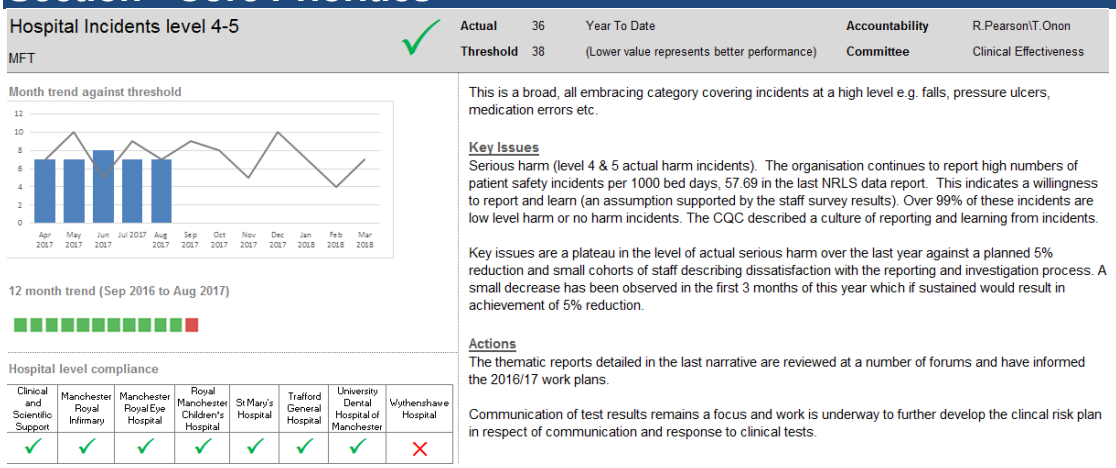
The bar at the very top of each page identifies the domain and accountability. To the right of the top bar is a summary of the core priority indicators associated with the domain. For the example of Patient Safety:

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

Headline Narrative

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

Section - Core Priorities



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

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

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

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

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

NHS
Manchester University
NHS Foundation Trust

> Board Assurance

July 2022

Safety

J.Eddleston\T.Onon

Core Priorities	✓	◇	✕	No Threshold
	8	0	5	0

Headline Narrative

In February 2021 the Trust implemented a group wide safety management system which enables the timely contextualisation of multi-source information about the safety of the care we provide to patients. This approach ensures a smart approach to identifying opportunities for high impact and transferable learning, accelerated improvement and smart assurance through:
- the capture of 'safety II' data (ensuring learning from the majority of patient outcomes that are as, or exceed expectations)
- the use of SPC analysis to help understand our data about harm, this has enabled us to identify, explore and understand the risk associated with any special cause variation.
- the consideration of multi sources of intelligence in relation to patient safety (qualitative and quantitative) through a Trust wide daily huddle
- a weekly Trust-wide Patient Safety Oversight Panel

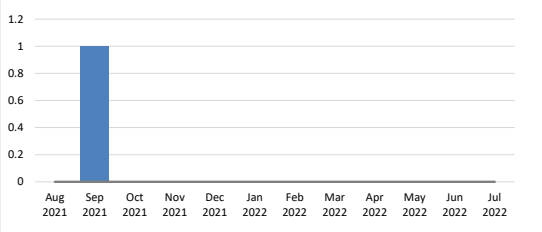
The Trust continues to identify Never Events within its incident profile, however, in relation to benchmarking, the Trust overall demonstrates performance the 'same' as other Trusts when Never Events are analysed as total events with statistical comparison to bed days (NHSI OBIEE NRLS StEIS (26 Mar 2022)). A Trust-Wide risk is being managed strategically which focuses on the optimisation of human/system interaction in the way to understand, respond to and improve patient safety, the proportion of reported patient safety incidents resulting in harm remains consistent with that of other Trusts. The national Patient Safety Incident Response Framework has now been launched and the Trust is developing an implementation plan to support the transformation in the approach to patient safety required.

Safety - Core Priorities

Mortality Reviews - Grade 3 (Review Date) ✓

Actual	0	YTD (Apr 22 to Jul 22)	**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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✓	✓	✓	✓	✓	✓	✓	NA
0	0	0	0	0	0	0	0	NA

The number of mortality reviews completed where the probability of avoidability of death is assessed as 'Definitely Avoidable'.

Key Issues

All deaths where the outcome is judged as probably or definitely avoidable are subject to further evaluation aligned to the Trust's Patient safety Insight, Learning and Response Policy. The Structured Judgement review process is used proactively where potential learning is identified through complaints, incident management or medical examiner processes. Learning is routinely considered and contextualised through the Trust's safety oversight system. Key issues identified for further evaluation have included the timeliness of referrals into tertiary services and also the effective transfer between MFT sites for treatment and the implementation of the ReSPECT process. It should be noted that data is currently only provided by WTWA for this indicator, therefore the compliance data for other sites is not available. This position has been reviewed and actions being developed to ensure a consistent approach to repoting avoidability. The completion of timely Structured Judgement Reviews to support the LeDeR process (mortality reviews relating to patients with a learning disability or who are autistic is currently an emergent issue across the Trust.

Actions

Optimising transferable high impact learning across MFT is a key priority for 2022/23. The Safety Oversight System allows for continual triangulation of intelligence. Safety II, learning from when things have gone well, and translating that into the mortality review process is also a key focus. The Annual Learning From Deaths report will be presented to the Group Quality and Safety Committee in October 2022. A key focus for the next two months is strengthining the governance associated with Structured Judgement Reviews, with a particular focus on those relating to patients with a learning disability or who are autistic.

Manchester University NHS Foundation Trust

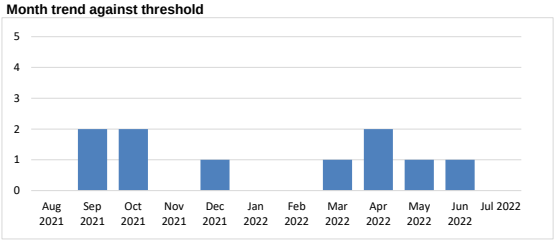
> Board Assurance

July 2022

Never Events

Actual	4	YTD (Apr 22 to Jul 22)	**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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✗	✗	✓	✓	✓	✓	✓	✓	✓
1	3	0	0	0	0	0	0	0

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

Key Issues

Never events are those clinical incidents that should not happen if appropriate policies and procedures are in place and are followed. The list is determined nationally. There continue to be key themes within the Never Events (and associated near-miss incidents) in relation to culture, psychological safety, communication, the use of checklists, the availability of guidance and the ergonomics of clinical environment design and the difference between 'work as imagined' (policy) and 'work as done' (clinical practice). A Trust-wide consensus building programme in relation to Local Safety Standards for Interventional Procedures (LocSSIPS) has been completed to support the integration of key controls into the EPR.

Detailed reports have been presented Group Risk Oversight Committee and Quality and Performance Scrutiny Committee. The Trust commissioned an external review in relation to its approach to learning from Never Events, this has now been received and has been used alongside the draft results of an Internal Audit of the effectiveness of controls in place to ensure learning related to patient safety to develop the Group and Site/MCS/LCO level Patient Safety Incident Response Plans. The Group wide Patient Safety Plan will be approved at Group Quality and Safety Committee in August 2022.

Actions

The Trust-Wide risk, which is being managed strategically, focuses on the optimisation of human/system interaction in the way to understand, respond to and improve patient safety aligned to the Trust's approach to integrating safety I and safety II data to enhance our learning and improvement.

Significant rapid learning and improvement is underway in relation to the role of the independent check for medication, invasive procedures and the differential between work as done and work as imagined this requires a Trust-wide focus. All incidents relating to prevented never events are subject to a high impact learning review to increase opportunities for learning.

Manchester University NHS Foundation Trust

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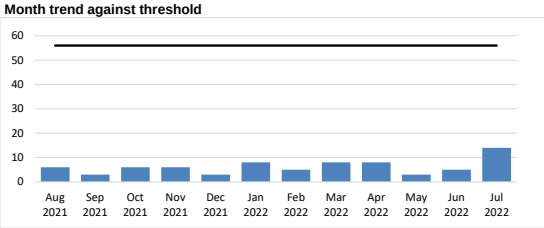
Hospital Incident level 4-5

Actual	30	YTD (Apr 22 to Jul 22)	**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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✓	✓	✓	✓	✓	✓	✓	✓
5	2	0	4	1	0	15	3	0

This data represents the incidents reported across the Trust where the nature of the incident reaches the threshold for the declaration of a serious incident, relating to the level of harm experienced by the patient or the implications of its outcome.

Key Issues

Patient safety incidents are analysed using Statistical process control, rather than counts, in line with the implementation of the Patient Safety Incident Response Framework, all notifiable (under Duty of Candour) incidents are analysed in this way. At a group wide level, 0.13% of incidents were graded as level 4/5 harm between 1/8/21 and 31/7/22. 1.3% of incidents being notifiable (3 and above). All sites/MCS/LCOs receive routine detailed profiles of types of patient safety incidents and clinical area based incidents to identify potential risk or opportunities for change and improvement. The profiles are currently being used to develop the site/MCS/LCOs draft Patient Safety Incident Response plans. The themes identified within the serious and notifiable incident profiles across the Trust are aligned to those identified in following investigation into never events.

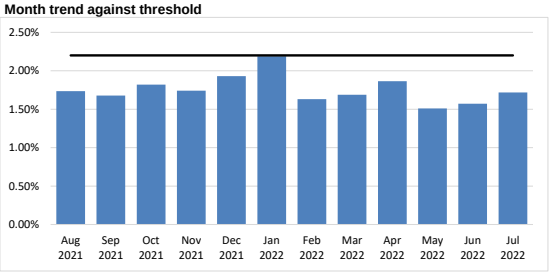
Actions

Routine examination of themes and trends through the safety oversight system which has led to additional high impact learning/assurance work in relation to a number of areas including:
- falls prevention
- recognition and management of a deteriorating patient
- the effective application of the Duty of Candour
- the conistent approach to MDT meetings
- the safe and effective management of tracheostomies
- the role of the independent check
-the differential between work as done and work as imagined
-the impact of inequality on patient safety

Crude Mortality

Actual	1.67%	YTD (Apr 22 to Jul 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	2.20%	(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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✗	◇	✓	✓	✓	✓	✗	✗	NA
10.68%	2.15%	0.22%	0.25%	0.31%	0.00%	2.73%	3.01%	NA

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

Key Issues

Crude mortality reflects the number of in-hospital patient deaths divided by the total number of patients discharged as a percentage and with no risk adjustment. The effective benchmarking of this data is currently under review, and sites where the threshold is exceeded actively interrogate the data to explore meaningful trends. There is a Trust-wide focus on understanding mortality data in a more sophisticated way through the use of the HED system, enabling scrutiny of a wider range of mortality indicators. The variation in crude mortality will be subject to review at the Learning From Deaths Committee.

The areas of non-compliance will be a focus for discussion and assurance at the Group Learning from Deaths Committee.

Manchester University NHS Foundation Trust

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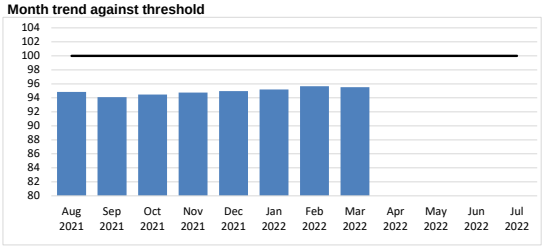
Summary Hospital-level Mortality Indicator (SHMI)

Actual	95.5	R12m (Apr 21 to Mar 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	100	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Hospital level compliance

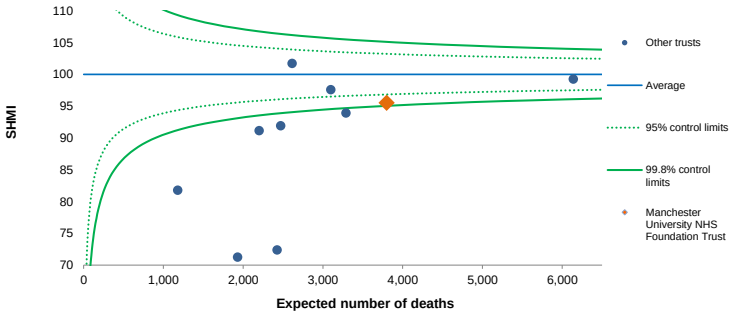
Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✓	NA	NA	NA	NA	✓	✗	NA
NA	93.6	NA	NA	NA	NA	90.6	111	NA

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

Performance across the Trust is well within the expected range.
The SHMI at NMGH is currently under review along with the crude mortality rate.

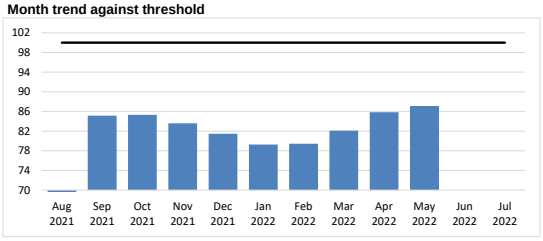
Summary Hospital-level Mortality Indicator for the Shelford Group, Apr 21 - Mar 22



Hospital Standardised Mortality Ratio (HSMR)

Actual	87.0	R12m (Jun 21 to May 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	100	(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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✓	NA	NA	NA	NA	✓	✗	NA
NA	77.2	NA	NA	NA	NA	85.3	105.9	NA

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 services.

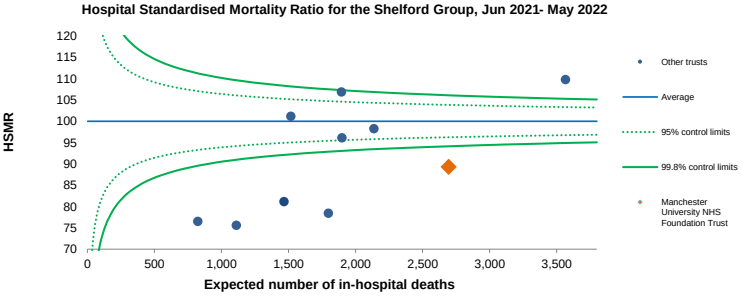
HSMR is a weighted metric for all adult acute settings (RMCH, REH, UDHM and SMH are excluded)

Performance is well within the expected range.

Progress

The Group HSMR is within expected levels.

Hospital Standardised Mortality Ratio for the Shelford Group, Jun 2021- May 2022



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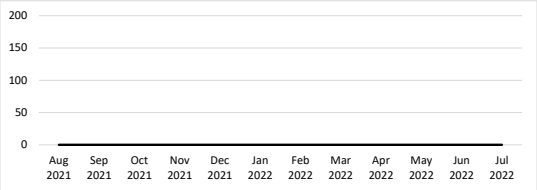
HM Coroner Prevention of Future Deaths Report

✓

Actual	0	R12m (Aug 21 to Jul 22)	**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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✓	✓	✓	✓	✓	✓	✓	✓
0	0	0	0	0	0	0	0	0

Report provided by the coroner following an inquest, where the coroner believes action should be taken to prevent future deaths.

Progress

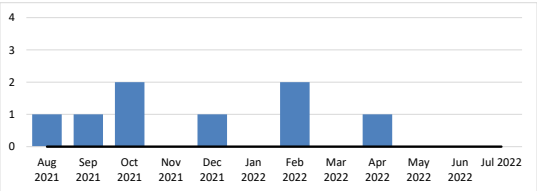
The information provided for Aug 2021 to July 2022 return is zero.

MRSA Attributable bacteraemia

✗

Actual	1	YTD (Apr 22 to Jul 22)	**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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✓	✓	✓	✓	✓	✗	✓	✓
0	0	0	0	0	0	1	0	0

Each case investigated to determine whether the case is linked with a lapse in the quality of care provided to the patient.

Progress

A total of 4 cases have been reported so far in 2022/2023: 1 of which was trust-attributable. There were no trust-attributable MRSA cases reported for July 2022.

Manchester University NHS Foundation Trust

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July 2022

Reportable organism infections - attributable (MSSA) bacteraemia

Actual 27 YTD (Apr 22 to Jul 22) **Accountability** J.Eddleston\T.Onon

Threshold TBC (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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
-	-	-	-	-	-	-	-	-
0	10	4	1	0	0	8	4	0

Each case investigated to determine whether the case is linked with a lapse in the quality of care provided to the patient.

Progress

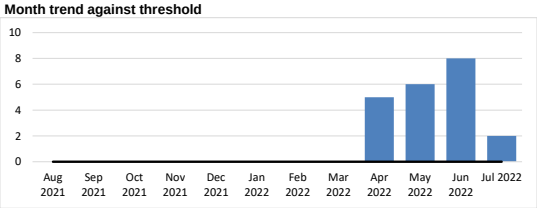
A total of 82 cases have been reported so far in 2022/2023: 27 of which was trust-attributable. There were 7 trust-attributable MSSA cases reported for July 2022.

Reportable organism infections - attributable (VRE) bacteraemia

Actual 21 YTD (Apr 22 to Jul 22) **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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✗	✓	✓	✓	✓	✗	✗	✓
0	15	0	0	0	0	3	3	0

Each case investigated to determine whether the case is linked with a lapse in the quality of care provided to the patient.

Progress

There have been 19 trust-attributable cases so far this year. There were only 12 trust-attributable cases reported for the same period last year (2021/2022). There were 2 trust-attributable cases reported for July 2022. Enhanced surveillance for VRE acquisitions has been introduced to monitor the situation.

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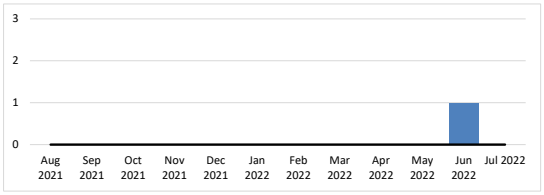
Reportable organism infections -attributable (CPE) bacteraemia

Actual	1	YTD (Apr 22 to Jul 22)	**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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✗	✓	✓	✓	✓	✓	✓	✓
0	1	0	0	0	0	0	0	0

Each case investigated to determine whether the case is linked with a lapse in the quality of care provided to the patient.

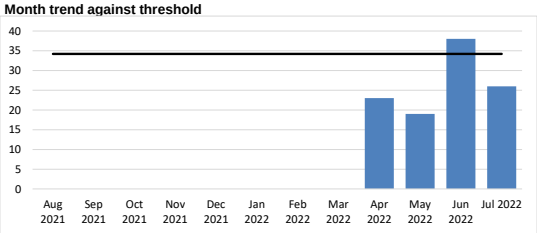
Progress

There has been 1 trust-attributable case reported so far this year. There were no trust-attributable cases reported for July 2022.

Reportable organism infections - attributable (Gram -ve bacteraemia)

Actual	106	YTD (Apr 22 to Jul 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	137	(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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✗	✓	✓	✓	✓	✓	✓	✓
0	50	17	5	0	0	20	14	0

Each case investigated to determine whether the case is linked with a lapse in the quality of care provided to the patient.

Progress

A total of 302 cases have been reported so far in 2022/2023: 106 of which were trust-attributable against a trajectory of 136. There were 26 trust-attributable cases reported for July 2022.

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July 2022

Avoidable admissions to neonatal unit

Actual	29	YTD (Apr 22 to Jul 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	0	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold

Number of babies admitted to the neonatal unit where the admission could have been avoided

Progress

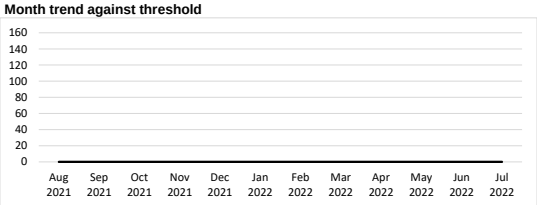
Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	NA	NA	✗	NA	NA	NA	NA	NA
NA	NA	NA	29	NA	NA	NA	NA	NA

Transfer outside SMH MCS due to capacity / delays

Actual	0	(July 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	0	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Number of women who are transferred outside SMH MCS due to capacity or other delays

Progress

The information provided for Aug 2021 to July 2022 return is zero.

Hospital level compliance

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

NHS Manchester University NHS Foundation Trust

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July 2022

Patient Experience

C.Lenney

Core Priorities	✓	◇	✕	No Threshold
	2	1	1	2

Headline Narrative

The number of new complaints received across the Trust in July 2022 was 173, which was an increase of 27 when compared to the volume received in June 2022. In July 2022 the percentage of formal complaints that were resolved in the agreed timeframe was 91.2%, this is a slight increase from 90.0% from the previous month. Performance is monitored and managed through the Accountability Oversight Framework (AOF).

The Trust overall satisfaction rate for FFT July 2022 was 85.9% compared to 87.8% in June 2022. There is a continued focus for all areas of the Trust to use both positive and negative FFT feedback to improve the patient experience.

Infection prevention and control remains a priority for the Trust. A recent review of all attributable HCAI was performed and presented to the Group Infection Control Committee in January: key themes were recorded and actions for reduction were determined. End of year HCAI reviews are currently being undertaken by all sites/CSU and overseen by IPC.

Trust performance is above trajectory for both MRSA and CDI:

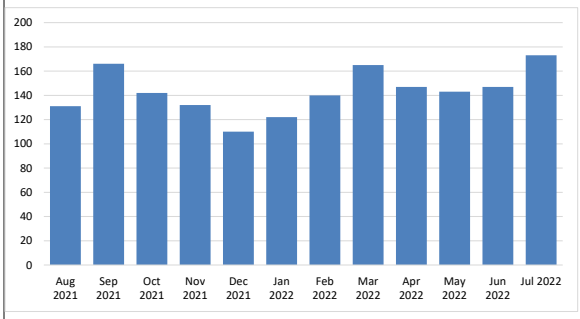
There were 196 trust-attributable CDI reported for 2021/2022, against a threshold of 166. There is a zero tolerance approach to MRSA bacteraemias, and a 15% reduction objective applied to E.coli bacteraemias. There were 10 trust-attributable MRSA bacteraemias and 150 E. coli bacteraemia reported during the 2021/2022 financial year. For the current year (2022/2023), Trust performance is above trajectory for both MRSA and CDI, but under trajectory for GNBSI. The IPC/TV team continue to work with Hospital Sites and CSU to determine appropriate action plans where necessary.

Complaints: Volumes

-

Actual	610	YTD (Apr 22 to Jul 22)	**Accountability**	C.Lenney
Threshold	None	(Lower value represents better performance)	**Committee**	Quality & Safety Committee

Month trend against threshold (includes corporate complaints)



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
-	-	-	-	-	-	-	-	-
24	147	67	75	15	13	146	74	24

NOTE: MFT total includes Corporate data not represented in Hospital Compliance chart and table
The KPI shows total number of complaints received. Complaint volumes allow the Trust to monitor the number of complaints and consider any trends.
Data from August 2021 to July 2022 has been updated at request of Lorraine Cliff.

Key Issues
The number of new complaints received across the Trust in July 2022 was 173. Compared to the 146 received in June 2022, this is an increase of 27. Of the 173 complaints received by the Trust, the highest volume was attributed to WTWA, with 44 (25.4%) being received, which is an increase when compared with the 24 received in June and 41 in May 2022.

Of the 44 complaints received by WTWA no specific areas were identified, however, the top three themes were 'Clinical Assessment (Diagnostic scan)', 'Communication' and 'Discharge/Transfer'.

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

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

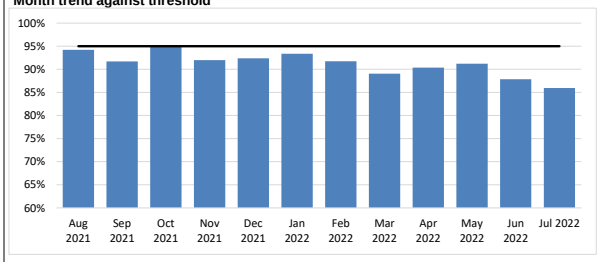
Progress
All Hospitals/ MCS's/LCO's have established their governance frameworks to focus on the management of complaints, specifically those that exceed 41 days with a view to expediting closure and identifying the learning to inform future complaints prevention and management.

FFT: All Areas: % Extremely Likely and Likely

◇

Actual	93.0%	YTD (Apr 22 to Jul 22)	**Accountability**	C.Lenney
Threshold	95.0%	(Higher value represents better performance)	**Committee**	Quality & Safety Committee

Month trend against threshold



Hospital level compliance - latest month performance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✕	✕	◇	✓	✓	✕	✕	✓
97.91%	80.39%	88.33%	92.90%	96.58%	96.25%	88.70%	86.69%	97.91%

The Friends and Family Test (FFT) is a survey that assesses the experience of patients using NHS services. Since April 2020, NHS Trusts have simplified the FFT question to allow a better understanding of the patients experience which now asks 'Thinking about your recent visit, overall how was your experience of our service?'. Patients can rank their answer by choosing one of the following options; Very good; Good; Neither good nor poor; Poor; Very poor; Don't know". Patients are also asked the following "free text" question: 'Please can you tell us what was good about your care and what we could do better".

Progress

The Trust overall satisfaction rate for FFT for July 2022 was 85.9%, which is an decrease from the 87.8% received in June 2022 and 91.2% March 2022.

There is a continued focus for all areas of the Trust to use both positive and negative FFT feedback to improve the patient experience.

Actions
Each Hospital/MCS/LCO continue to review and monitor their FFT response rates and patient feedback in order to identify areas for improvements, increase response rates and act upon the feedback received.

Manchester University NHS Foundation Trust

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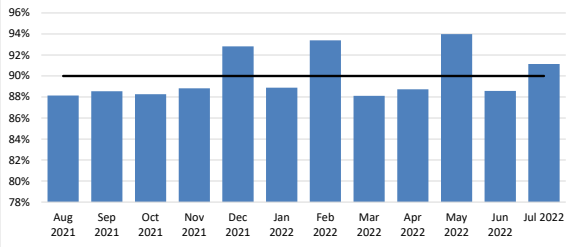
Complaints: Resolved Within Agreed Timeframe

Actual	90.6%	YTD (Apr 22 to Jul 22)	**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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
◇	✓	✓	◇	✓	◇	✓	✓	✓
73.3%	93.1%	100.0%	80.6%	94.1%	81.3%	100.0%	94.0%	90.9%

The Trust has a responsibility to resolve complaints within a timeframe agreed with the complainant. The timeframe assigned to a complaint is dependent upon the complexity of the complaint and is agreed with the complainant.
Note: Data from August 2021 to July 2022 has been updated at request of Lorraine Cliff.

Progress

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

The July 2022 data identifies that 91.2% of complaints were resolved within the agreed timescales, this is a slight increase of 1.2% compared to 90.0% in June 2022 and 94.0% in May 2022. The largest contributory factor for delays, was awaiting external contribution to the response.

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

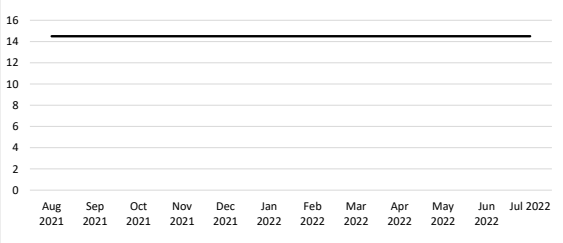
Actions

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

Cdiff: Lapse of Care

Actual	0	YTD (Apr 22 to Jul 22)	**Accountability**	C.Lenney
Threshold	15	(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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✓	✓	✓	✓	✓	✓	✓	NA
0	0	0	0	0	0	0	0	NA

Each Clostridium difficile infection (CDI) incident is investigated locally to determine whether the case was linked with a lapse in the quality of care provided to patient. The KPI shows the number of CDI incidents that were linked to a lapse in the quality of care provided to a patient.

Progress

A total of 302 cases have been reported so far in 2022/2023: 63 of which were trust-attributable against a trajectory of 44. Cases from October 2021 onwards are currently being peer-reviewed to determine lapse in care status. There were 16 trust-attributable CDI cases reported for July 2022: No lapses in care identified at the time of report submission.

Manchester University NHS Foundation Trust

> Board Assurance

July 2022

PALS – Concerns

-

Actual	2621	YTD (Apr 22 to Jul 22)	**Accountability**	C.Lenney
Threshold	None	(Lower value represents better performance)	**Committee**	Quality Committee

Month trend against threshold (includes corporate complaints)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
-	-	-	-	-	-	-	-	-
167	622	182	377	143	74	693	258	53

NOTE: MFT total includes Corporate data not represented in Hospital Compliance chart and table
Data from August 2021 to July 2022 has been updated at request of Lorraine Cliff.

Key Issues

A total of 627 PALS concerns were received by MFT during July 2022, which is a decrease from the 636 received in Junel 2022.

Of the 627 PALS concerns received in July 2022, the highest volume was attributed to MRI with 165 (26.3% of the total) being received. This is an increase for MRI when compared to the 150 received in June 2022. The top three themes for MRI related to 'Appointment Cancellation/Delay' (54), Communication (49) and 'Treatment and Procedure' (32).

Of the 165 MRI PALS concerns received, the Directorates with the highest number of concerns raised were the ENT Outpatients and Gastroenterology which were identified in concerns relating to 'Appointment/Delay/Cancellation (OP)', 'Communication' and 'Treatment and Procedure'.

Actions

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

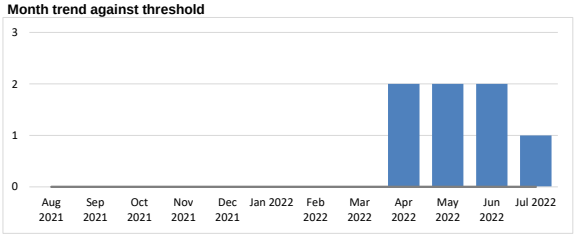
Work continues to reduce the time taken to resolve PALS enquiries with formal performance management processes in place for cases over 5 days.

PHSO Enquiries

✗

Actual	7	YTD (Apr 22 to Jul 22)	**Accountability**	C.Lenney
Threshold	0	(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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✗	✗	✓	✗	✓	✗	✓	✓	✓
1	2	0	2	0	2	0	0	0

The number of new PHSO enquires received in July 2022 was 1. When compared to June 2022 this is a decrease of 1.

Progress

12 PHSO cases received prior to the 1st April 2022 remain open:
- 4 of which are being scoped
- 7 of which are awaiting a provisional report, final report or actions to be completed
- 1 in which WTWA have disputed the PHSO decision and the case remains open and further communications received from the PHSO.

7 PHSO cases cases received on or after the 1st April 2022 remain open:
- 4 of which are being scoped
- 3 of which are awaiting a provisional report

Manchester University NHS Foundation Trust

> Board Assurance

July 2022

Operational Excellence

D.Furnival

Core Priorities	✓	◇	✕	No Threshold
	1	0	14	0

Headline Narrative

MFT's elective recovery plan continues to utilise all available opportunities as Covid numbers continue to decrease. MFT and GM continue to experience peaks in emergency demand across both adult and paediatrics, which has required ad-hoc reduction in elective bed capacity to manage the non-elective demand.

Notwithstanding these operational challenges, MFT continues to progress actions aimed at improving performance against national operational standards. MFT completed 2022/23 planning requirements in line with the national planning guidance developing associated trajectories and refreshed action plans in conjunction with CCGs.

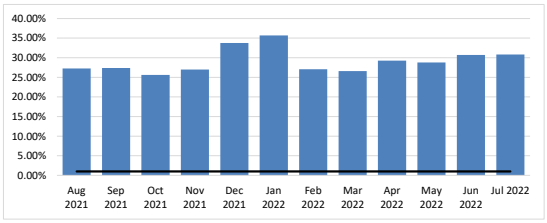
July summary:
• The overall RTT elective waiting list stood at 174,700 which is growth of 9.0% (14,438) on the position reported in April 2022. The number of patients waiting longer than 52 weeks was 19,146 which represents an overall growth of 31.0% on that reported in April and accounts for 11.0% of the current waiting list.
• The number of patients waiting longer than 104 weeks at the end of July submitted snapshot was 142 (0.1%) of the overall waiting list and continues to fall in line with plans to reduce long waits.
• National performance against the 4 hour wait standards for Emergency Departments has steadily reduced since April 21, with the performance across GM and MFT closely following the same trend. This downward trend appears to have plateaued over the last quarter at around 62.7% and generally reflects MFT Emergency Departments ongoing challenges to meet the demand whilst maintaining screening and separating possible Covid patients.
• As a result of operational pressures and capacity constraints, there were 9 breaches of the 12 hour DTA quality standard in July with 206 in the year to date, following route cause analysis (RCA), none of these have been found to have contributed to patient harm. Corporate Governance retain oversight.
• A cancer recovery programme is in place to improve timely access for patients. None of the national standards were met in July.

Operational Excellence - Core Priorities

Diagnostic Performance ✕

Actual	30.8%	(July 22)	**Accountability**	D.Furnival
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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✕	✕	✕	✕	✕	✕	◇	✕	NA
19.0%	24.9%	79.5%	60.9%	No Data	No Data	53.9%	42.1%	NA

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
• Impact of Covid and associated restrictions, reduced capacity and activity as a resul
• Increased volumes of unplanned tests linked to increased Non Elective attendance / admissions
• Increased short notice staff sickness

Actions
Whilst there is not an individual workstream related to diagnostics, this is a critical consideration and cuts across all outpatient, elective and cancer workstreams.
• Activity has been undertaken for clinically urgent / priority patients, improvements in the reporting backlog were achieved as a result of less demand during the pandemic.
• Diagnostic clinical prioritisation undertaken.
• Additional CT scanning lists secured on a weekend
• Focus on reducing long waits given the tail of the waiting list is increasing
• Strategic overview of operating principles, processes and practices underway W/C 20th June to improve performance and deliver a singular process across MFT.

Progress
• The strategic overview was undertaken and a report on its findings is to be presented to Resilience and Recovery.
• Overall waiting list continues to maintain growth as does the volume over 6 weeks across a number of key modalities. There are areas of focus that will form part of a targetted approach to booking / scheduling in conjunction with best principles and Elective Access policy application across a number of sites in key modalities, particulalry Endoscopy and CT.
• Work continues in building an overarching reporting module within Power BI that will enable operational teams easier access to the performance data they need to improve processes.

Manchester University NHS Foundation Trust

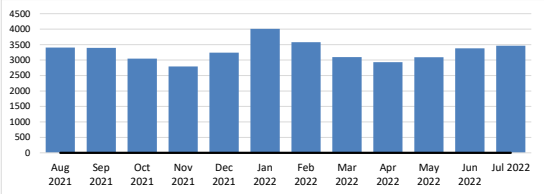
> Board Assurance

July 2022

Diagnostic wait > 13 weeks

Actual	3462	(July 22)	**Accountability**	D.Furnival
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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✗	✗	✗	✗	-	-	✗	-	NA
940	215	301	6	No Data	No Data	2000	No Data	NA

The number of patients waiting over 13 weeks for ony one of 15 key diagnostic tests.

Key Issues

- Impact of the Covid waves and reduction in capacity and activity as a result.
- Increased volumes of unplanned tests linked to increased Non Elective attendance / admissions
- DNA rate increased particularly within CT which is adding to the backlog
- Increased internal demand
- Increased short notice staff sickness

Actions

Whilst there is not an individual workstream related to diagnostics, this is a critical consideration and cuts across all outpatient, elective and cancer workstreams.

- Activity has been undertaken for clinically urgent / priority patients, improvements in the reporting backlog continue to be achieved as a result
- Diagnostic clinical prioritisation undertaken.
- Additional CT scanning lists secured on a weekend
- Focus on waiting list validation and Access policy application continues
- Focus on reducing long waits given the tail of the waiting list is increasing particularly within CT / ENDO
- Develop a singular PTL for diagnostics in line with elective care.

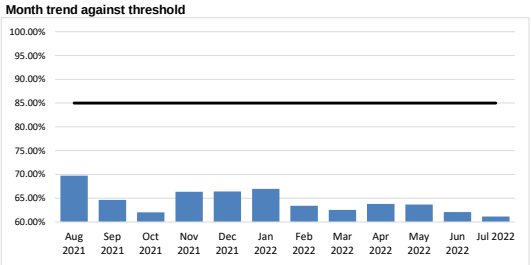
Progress

- Strategic review report to be presented at next Resillience & Recovery.
- Ongoing development of singular PTL underway with inclusion of NMGH data to give a Trust wide position on a daily basis for the first time to enable operational oversight.

A&E - 4 Hours Arrival to Departure

Actual	61.1%	(July 22)	**Accountability**	D.Furnival
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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	◇	◇	✓	✓	NA	✗	✗	NA
NA	51.2%	70.6%	95.0%	99.9%	NA	58.3%	60.9%	NA

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 national 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

- Covid restrictions although reducing continue to impact flow through ED and receiving wards.
- Reductions to delayed handovers of patients alongside the numbers of ambulance holds continues.
- Bed capacity constraints due to Covid patients consuming the bed base along with higher than optimal levels of patients who are medically fit and have no reason to reside in hospital and are awaiting discharge.
- GM and MFT system continue to experience capacity / flow pressures, whilst overall activity is at pre-pandemic levels there are days of extreme pressure at levels not seen previously, both in adults and paediatrics.
- Staff absence whilst improving continues to impact flow management, safety is maintained by utilising staff as flexibly as possible within and across hospitals / MCSs.

Actions

- Hospital Senior leadership teams at MFT are responding to current performance pressures and have well developed action plans. Patient safety remains a key priority.
- These plans are underpinned by a number of key programmes of operational improvement and transformational programmes of work. Key areas include, but are not limited to:

I. Working with system partners to promote redirection at streaming stage through initiatives such as helicopter nurse;
ii. Continued development of Same Day Emergency Care capacity across sites;
iii. Expansion and stronger promotion of appointments for urgent care available to 111 at ED and Urgent Treatment Centre services;
iv. Care and management of mental health patients presenting in conjunction with Mental health services;
v. Further integrated work with system partners to support discharge process and timely transfers of patients; and
vi. Review of workforce capacity and out of hours presence (medical and nursing).

MFT ED safety standards are a key focus for sites. MFT Urgent Care Recovery work is aligned to GM urgent care recovery work.

Progress

- July 2022 saw 1,370 attendances per day compared to 1,331 in April, this is reflective of the increasing acuity of patients across the footprint.
- MFT performance continues to decline marginally month on month, although does track closely to GM and the national trends, ~63.0% in Q1 compared to 61.4% in GM and 71.1% nationally.
- The number of patients with 7+ and 21+ days length of stay in MFT beds at 31st July was 1145 and 778 respectively. Hospital teams are focused on long length of stay reviews.

Manchester University NHS Foundation Trust

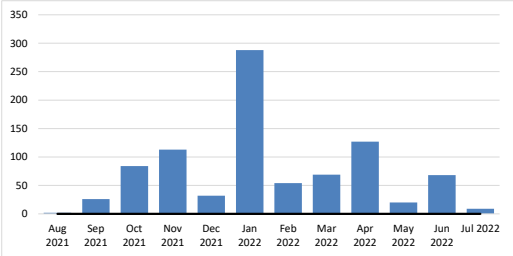
> Board Assurance

July 2022

12 hour trolley waits

Actual	224	YTD (Apr 22 to Jul 22)	**Accountability**	D.Furnival
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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✗	✓	✓	NA	✓	✗	✗	NA
NA	7	0	0	NA	0	7	210	NA

The waiting time for an emergency admission via A&E is measured from the time when the decision is made to admit, or when treatment in A&E is completed (whichever is later) to the time when the patient is admitted.

Key Issues

Whilst pressures are evident across the trust footprint they are specifically exacerbated at NMGH where:
- Bed capacity, currently -37 beds compared to 2019, this is exclusive of the increase in activity demand from April 21 which would contribute a further 16 beds.
- Department capacity is constrained due to IPC restrictions and physical estate.
- Higher than optimal reason to reside patients which restricts bed capacity and flow out of the emergency department has remained stubbornly high with OOH area patients a particualr concern at NMGH.

Actions
- Flexible use of space between paeds and adult ED to address demands.
- Refreshed and relaunched site escalation flow charts, including the ED and workforce triggers.
- New site patient flow team 24/7 - This team adds an additional layer of focus on patient flow.
- Continued focus supported by the MFT Transformation team to review decision to admit processes.
- Refreshed over-arching Urgent Care Improvement Plan and governance & assurance process to support the improvements.
- Organisational escalation SOP in place for the reporting of long waits both in and out of hours.
- Discharge Resilience programme led by the MLCO with Hospitals to improved on delayed discharges and flow out of the hospital.

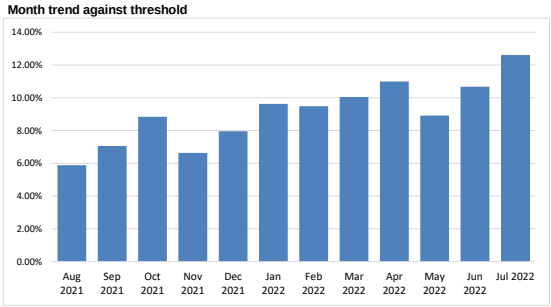
Progress

As a result of significant operational pressures the Trust has reported 224 breaches of the standard as at 31st July. North Manchester site accounts for 210 of these DTA breaches, the majority of which were related to bed capacity constraints. Harm reviews are undertaken for all patients, with no harm identified in any of these breaches following RCA. Learning from the root cause analysis undertaken for any breach of the standard has been implemented.

Over 12 hour waits in ED

Actual	12.6%	(July 22)	**Accountability**	D.Furnival
Threshold	2.0%	(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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✗	✗	-	-	NA	✗	✗	NA
NA	18.0%	1.6%	No Data	No Data	NA	15.2%	11.3%	NA

Number of Patients spending more than 12 hours in A&E.

Key Issues
- Covid restrictions impacting on flow within the ED.
- Bed capacity constraints due to Covid patients consuming the bed base along with higher than optimal levels of patients who are medically fit and have no reason to reside in hospital and are awaiting discharge.
- GM and MFT system continue to experience capacity / flow pressures, whilst overall activity is at pre-pandemic levels there are days of extreme pressure at levels not seen previously, both in adults and paediatrics.
- Staff absence whilst improving continues to impact flow management, safety is maintained by utilising staff as flexibly as possible within and across hospitals / MCSs

Actions
- Hospital Senior leadership teams at MFT are responding to current performance pressures and have well developed action plans. Patient safety remains a key priority.
- These plans are underpinned by a number of key programmes of operational improvement and transformational programmes of work. Key areas include, but are not limited to:

I. Working with system partners to promote redirection at streaming stage through initiatives such as helicopter nurse;
ii. Continued development of Same Day Emergency Care capacity across sites;
iii. Expansion and stronger promotion of appointments for urgent care available to 111 at ED and Urgent Treatment Centre services;
iv. Care and management of mental health patients presenting in conjunction with Mental health services;
v. Further integrated work with system partners to support discharge process and timely transfers of patients; and
vi. Review of workforce capacity and out of hours presence (medical and nursing).
MFT ED safety standards are a key focus for sites. MFT Urgent Care Recovery work is aligned to GM urgent care recovery work.
- Finalise the performance thresholds with Hospitals / MCS.

Progress
- Transformational teams continue to develop plans with site teams which includes reviewing existing protocols for admission and flow through the departments into the wider site
- Focused work with NWAS to increase avoidance strategies (See and treat)

Manchester University NHS Foundation Trust

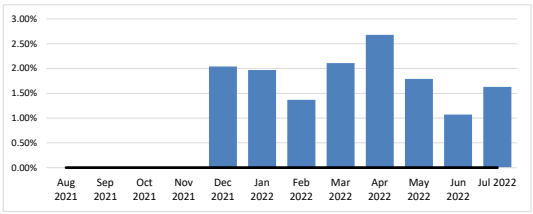
> Board Assurance

July 2022

MFT - Ambulance hold % Attend

Actual	1.6%	(July 22)	**Accountability**	D.Furnival
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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✗	-	-	NA	NA	✗	✗	NA
NA	0.7%	No Data	No Data	NA	NA	0%	4.9%	NA

The ratio of NWAS conveyances to the Trust compared to those that have been "held" . Holds are determined where NWAS have not been able to transfer their patients to the department >15 minutes after arrival.

Key Issues

• Bed capacity constraints due to Covid patients consuming the bed base along with higher than optimal levels of patients who are medically fit and have no reason to reside in hospital and are awaiting discharge.
• GM and MFT system continue to experience capacity / flow pressures, whilst overall activity is at pre-pandemic levels there are days of extreme pressure at levels not seen previously, both in adults and paediatrics.
• Staff absence whilst improving continues to impact flow management, safety is maintained by utilising staff as flexibly as possible within and across hospitals / MCSs

Actions

• Hospital Senior leadership teams at MFT are responding to current performance pressures and have well developed action plans. Patient safety remains a key priority.
• Full capacity protocols (FCPs) are being reviewed on all sites, to ensure early triggers are in place and enacted to support surge earlier in the day, an MFT overview of FCPs will be completed as part of the follow up summit.
• These plans are underpinned by a number of key programmes of operational improvement and transformational programmes of work. Key areas include, but are not limited to:
I. Working with system partners to increase avoidance / redirection at streaming stage, eg See and Treat in relation to NWAS.
ii. Continued development of Same Day Emergency Care capacity across sites;
iii. Expansion and stronger promotion of appointments for urgent care available to 111 at ED and Urgent Treatment Centre services;
iv. Care and management of mental health patients presenting in conjunction with Mental health services;

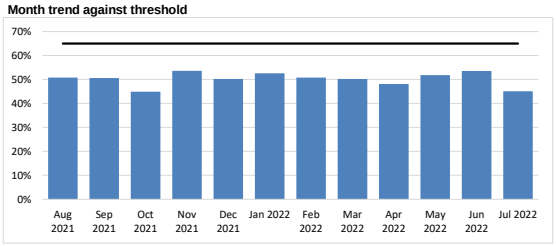
Progress

• Continued increasing volumes of UTC attends, in line with national guidance / best practice. MFT accounts for 99% of all UTC bookings reported within GM with around 3,000 each month equating to ~28% of the North regions bookings (131 sites) with MRI being the highest contributor across each of the last three months. These continue to contribute to reduced NWAS conveyance along with increased avoidance via See & Treat.

Handover between Ambulance and A&E - within 15 minutes

Actual	45.1%	(July 22)	**Accountability**	D.Furnival
Threshold	65.0%	(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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✗	-	-	NA	NA	✗	✗	NA
NA	48.3%	No Data	No Data	NA	NA	35.4%	55.9%	NA

% of patients transferred from ambulance to A&E within 15 mins.

Key Issues

• Bed capacity constraints due to Covid patients consuming the bed base along with higher than optimal levels of patients who are medically fit and have no reason to reside in hospital and are awaiting discharge.
• GM and MFT system continue to experience capacity / flow pressures, whilst overall activity is at pre-pandemic levels there are days of extreme pressure at levels not seen previously, both in adults and paediatrics.

Actions

• The Transformation Team continues to support the sites with improving ambulance handover turnaround times. A follow up summit is planned for the 21st of June, with representatives from all MFT Emergency Departments, system partners and the Northwest Ambulance Service.

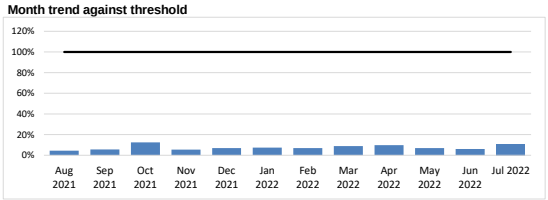
Progress

• Progress is already being made at all sites around process improvement which has contributed to the upturn since may, leave and flow issues are evident within July performance along with downturn in overall AED % within 4 hours.
• Accuracy of reporting has been identified as an issue and a rapid improvement process is underway to simplify handover with a turnaround standard operating procedure at all sites being developed jointly with NWAS.
• Full capacity protocols (FCPs) are being reviewed on all sites, to ensure early triggers are in place and enacted to support surge earlier in the day, an MFT overview of FCPs will be completed as part of the follow up summit.

Handover between Ambulance and A&E - > 60 minutes

Actual	11.0%	(July 22)	**Accountability**	D.Furnival
Threshold	100%	(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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✗	-	-	NA	NA	✗	✗	NA
NA	9.4%	No Data	No Data	NA	NA	13.6%	9.1%	NA

% of patients transferred from ambulance to A&E within 60 mins.

Key Issues

• Bed capacity constraints due to Covid patients consuming the bed base along with higher than optimal levels of patients who are medically fit and have no reason to reside in hospital and are awaiting discharge.
• GM and MFT system continue to experience capacity / flow pressures, whilst overall activity is at pre-pandemic levels there are days of extreme pressure at levels not seen previously, both in adults and paediatrics.

Actions

• The Transformation Team continues to support the sites with improving ambulance handover turnaround times. A follow up summit is planned for the 21st of June, with representatives from all MFT Emergency Departments, system partners and the Northwest Ambulance Service
• Implementation of virtual ward
• A detailed assessment of the current utilisation of medical SDEC service has taken place and clear actions have been identified to improve utilisation

Progress

• Full capacity protocols (FCPs) are being reviewed on all sites, to ensure early triggers are in place and enacted to support surge earlier in the day, an MFT overview of FCPs will be completed as part of the follow up summit.

Manchester University NHS Foundation Trust

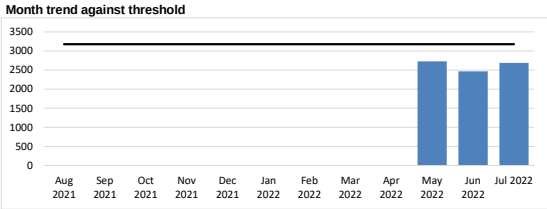
> Board Assurance

July 2022

RTT - 78 Weeks (Incomplete Pathways)

Actual	2689	(July 22)	**Accountability**	D.Furnival
Threshold	3178	(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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✗	✗	✓	✓	✗	✗	✗	✓	✓
8	1033	232	757	105	86	540	417	0

The number of patients waiting over 78 weeks on an incomplete pathway.

Key Issues
- Bed capacity constraints due to Covid patients consuming the bed base along with higher than optimal levels of patients who are medically fit and have no reason to reside in hospital and are awaiting discharge.
- Impact of the Covid waves and reduction in capacity and activity as a result.
- Patient choice linked to Covid.

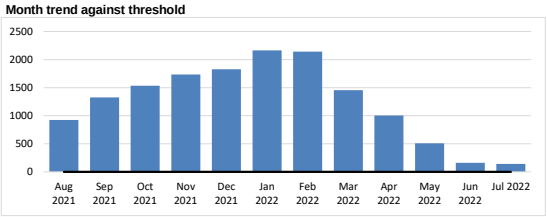
Actions
- Develop a trajectory to reduce long waits in line with national priority expectations and review in line with hospitals / MCS.
- Develop reporting framework using similar method for current long waits and circulate to operational teams weekly.

Progress
- In line with planning guidance and focus on reducing long waits, a trajectory on reducing long waits in year has been produced and shared with Hospitals / MCS to review and operationalise. This will be managed weekly in line with current long waits reductions
- Next steps to produce weekly monitoring report by site and include metrics within EDT reporting outputs.

RTT - 104 Weeks (Incomplete Pathways)

Actual	142	(July 22)	**Accountability**	D.Furnival
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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	✗	✗	✗	✗	✗	✗	✗	✓
0	26	7	69	1	2	36	1	0

The number of patients waiting over 104 weeks on an incomplete pathway.

Key Issues
- Bed capacity constraints due to Covid patients consuming the bed base along with higher than optimal levels of patients who are medically fit and have no reason to reside in hospital and are awaiting discharge.
- GM and MFT system continue to experience capacity / flow pressures with consequential impact on elective capacity

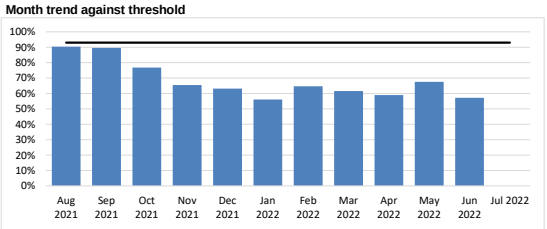
Actions
- Planning work was undertaken with hospitals / MCS to ensure reduction in long waits in line with national priorities to reach 0 by the of June.
- Daily circulation of performance vs trajectory with particual focus on dating patients, DQ, transacting outcomes and reviewing "pop ons".

Progress
- The Trust achieved its business plan of reporting 0 104 week breaches with the exception of a small cohort who either exercised choice, were complex cases or medically unfit to treat in month.
- Long waits have reduced significantly given the joint working between hospitals and group teams. As at 31st July there were 140 patients who had waited longer than 104 for treatment, this number contains an element of complexity, short term unsuitability and choice.There has been a reduction of over 2,000 long waiters since 1st January 22.

Cancer Urgent 2 Week Wait Referrals

Actual	61.5%	Q1 (Apr to Jun 22)	**Accountability**	D.Furnival
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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✓	✓	✗	NA	NA	✗	✗	NA
NA	96.2%	96.8%	92.7%	NA	NA	56.8%	33.8%	NA

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
- Demand has increased to >100% of pre Covid position, with some tumour groups remaining at high levels. Breast and Head and Neck are the main drivers with the biggest referral increases. Breast performance for Q1 was 16.5% and Head and Neck 40%.

Actions

Breast recovery is based on plans to utilise mammogram only clinics to clear the backlog and rapidly step down patients for a cohort of patients alongside insourcing. Head and Neck across MRI and WTWA are now a single front door and use of capacity across both sites. Insourcing is being used at both NMGH and MRI/WTWA to reduce the backlog and first appointment waiting time - NMGH are also in process to double 2ww slots from 25 to 50 a week.

Progress
- Cancer 2ww referrals remain high in colorectal, head and neck and gynaecology services. Breast has returned to the pre surge rate of c. 2000 per month from high volumes of up to 2700 referrals.

Manchester University NHS Foundation Trust

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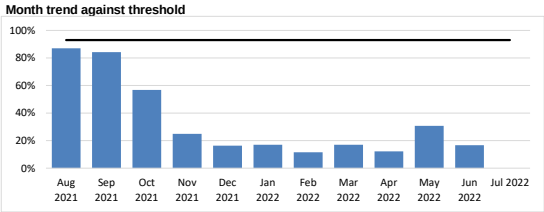
July 2022

Cancer 2 Week Wait breast Symptom

Actual	20.2%	Q1 (Apr to Jun 22)	**Accountability**	D.Furnival
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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	NA	NA	NA	NA	NA	✗	✗	NA
NA	NA	NA	NA	NA	NA	25.1%	9.1%	NA

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

Key Issues

Demand pressures, support to other providers in GM, Impact of Covid19.

Actions

•All referrals are being triaged with high risk patients invited to attend a face to face appointment, and physical examination.
• improvement work as above for 2ww cohort.

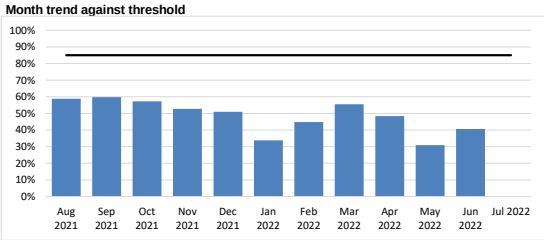
Progress

August predictions sit at 19.6% at NMGH and 25.9% at WTWA

Cancer 62 Days RTT

Actual	39.8%	Q1 (Apr to Jun 22)	**Accountability**	D.Furnival
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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✗	NA	✗	NA	NA	✗	✗	NA
NA	45.0%	NA	19.5%	NA	NA	41.2%	32.0%	NA

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

• Historical underperformance against the standard due to demand pressures, and diagnostic delays.
• The impact of Covid has resulted in capacity constraints and affected the ability of cancer systems across the UK to deliver planned cancer treatment for all its cancer patients.
• Demand for cancer pathways has increased to 110% of pre-pandemic levels with some tumour group at peak levels.

Actions

• All sites have action plans in place to improve performance.
• Referral rates have increased to above pre-Covid levels whilst the Trust is still reducing its backlogs due to diagnostics delays and patient choice.
• The wider GM system has put a number of actions in place to coordinate system capacity, including mutual aid for capacity coordinated via a GM Cancer Surgical Hub. In addition, GM wide work is taking place on the introduction of a single PTL for 4 specialist diagnostic tests.
• Capacity being utilised in the independent sector and the Christie to support timely treatment. In June patients have been sent for mutual aid for treatment in LGI and Gynaecology alongside the MFT@Christie urology lists. with further patients sent in August for Urology.
• Reviews of the most challenged pathways in place alongside a general CSS diagnostic review, which includes the intoduction of a cancer specific radiology PTL meeting.

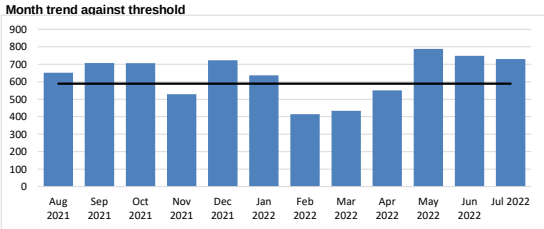
Progress

• Demand has increased to pre-pandemic levels with peaks across tumour groups.
• Performance - 62 day performance remains low and is not expected to improve whilst the backlog clears
• 62 day backlog plans in place with regular review.
• Safety remains a key priority and harm reviews continue to be undertaken for the longest wait patients.
No tumour group reached the required performance levels with urology being highest at 60.4%

Cancer 62 Days Backlog

Actual	730	(July 22)	**Accountability**	D.Furnival
Threshold	589	(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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✗	NA	✓	NA	NA	✗	✗	NA
NA	201	NA	52	NA	NA	306	171	NA

Reduction in number of patients waiting to be seen over 62+ days and back to 19/20 baseline.

Key Issues

• The continued increased referral rate and pathway delays in the diagnostic portion of the pathway.

Actions

• Regular review meetings in place with hospital teams in order to expedite action plans and reductions
• Insourcing being utilised in some areas to reduce backlogs.
• Head and Neck has the highest backlog which should be reduced via the actions reported in the 2ww section - the biggest volume of this backlog is caused by long waits to first appointment.

Progress

• The IT outage at NMGH led to some of the increase as pathways could not be closed and reported. However there was an increase in backlog at all sites from the end of April position. Backlog has started to decrease in mid June.

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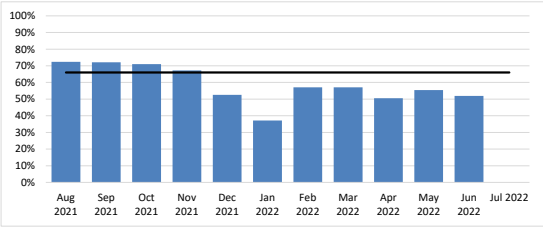
> Board Assurance

July 2022

Cancer Faster Diagnosis

Actual	51.9%	(June 22)	**Accountability**	D.Furnival
Threshold	66.0%	(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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
NA	✓	NA	✗	NA	NA	✗	✗	NA
NA	71.1%	NA	64.5%	NA	NA	56.0%	27.7%	NA

Percentage of Service Users waiting no more than 28 days from urgent referral to receiving a communication of diagnosis for cancer or a ruling out of cancer

Key Issues

- Issues in some specialties with time to first seen (WTWA Head and Neck and Breast across sites)
- Diagnostic delays are reducing performance both CSS and non CSS. Pathology turnaround is a specific issue in some areas such as skin and gynaecology and CSS are working on shorter term improvements.

Actions

- Review of provision of BPTP (Best Practice Timed Pathways)
- Other improvements mentioned in 2ww and 62 day sections also apply to the FDS standard.
- Radiology specific PTL and tracker in implementation to reduce TAT

Progress

August predictions are c62.5% compliance

Manchester University NHS Foundation Trust

> Board Assurance

July 2022

Workforce and Leadership

P. Blythin

Core Priorities	✓	◇	✕	No Threshold
	1	2	6	0

Headline Narrative

The Workforce Directorate continues to oversee a variety of workforce workstreams which underpin the Hive programme and its transition to business as usual. These include the delivery of Hive programme training pre-go live and subsequent phases of training post go live. Additionally plans are progressing to support workforce transformation, organisational development, and resourcing processes for new starters. The Group HR team is working closely with Hospitals/MCS/LCO to develop robust plans throughout this period of change to ensure the effective management of workforce resources and workforce engagement.

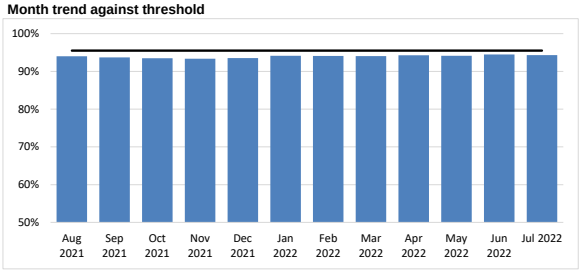
Workforce and Leadership - Core Priorities

Attendance

Actual 94.3% (July 22) **Accountability** P. Blythin

Threshold 95.5% (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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
◇	✕	✕	✕	✕	✕	✕	✕	✕
95.3%	93.3%	94.5%	94.4%	93.0%	92.6%	93.8%	94.3%	93.9%

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

Key Issues

The Group attendance rate for July was 94.3% which is marginally lower than the previous month's figure (94.4%). At the same point last year (July 2021) the attendance rate was 0.3% lower (94.1%).

The latest figures released by NHS Digital show that for March 2022 the monthly NHS staff sickness absence for the whole of the North West HEE region was 6.6% or 93.4% attendance rate (these figures include all provider organisations and commissioners) and were the highest in England. The London region reported the lowest sickness absence rate in March 2022 at 5.2% or 94.8% attendance rate.

The attendance rate does not include COVID-19 related absences. A COVID-19 absence dashboard was created by the Workforce Directorate and all absences are reported into the Executive Strategic Group.

Actions

Attendance is one of the key metrics which is closely monitored through the Accountability Oversight Framework (AOF). Focused 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 through the Corporate Directors' Group.

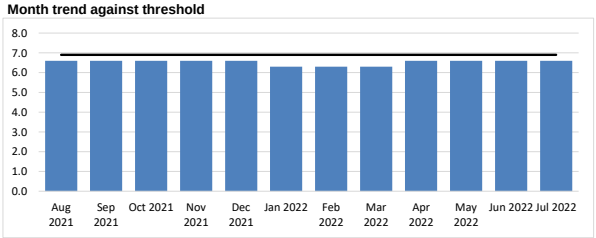
The Absence Manager system is in place across all MFT sites. Using recovery monies four new Absence Coordinator posts have been introduced across the Trust to support our managers to make best use of the Absence Manager system in the effective management of absence and to support the health and wellbeing of our staff.

Engagement Score (quarterly)

Actual 6.6 July 22 **Accountability** P. Blythin

Threshold 6.9 (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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✕	✕	✕	✕	✕	✕	✕	◇	✓
6.5	6.4	6.6	6.5	6.4	5.8	6.3	6.7	7.0

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

Key Issues

The staff engagement score for the MFT Group is 6.6. The only Hospital or MCS that has met the target threshold of 6.9 was the Local Care Organisation.

Actions

The Staff Engagement team provide organisational and local results and presentations to each site within 3 weeks of the data collection submission.
The Staff Engagement and Recognition committee are kept informed of all related activity and are integral in the dissemination of key messaging and associated actions determined by the committee.
Staff Engagement scores are shared at local level to enable HRD's to share with divisional leads, managers and leaders to enable them to respond, celebrate and take action in response to the results to demonstrate to staff they are listening in line with the MFT People Plan – We feel valued and heard.
Local activities include showcasing You Said, We Did, regular staff engagement meetings, links and support from OD leads and utilising staff forums to share best practice are some of the activities that take place to support a positive working experience for our staff. Group and local action plans are developed to address areas of lower scores.

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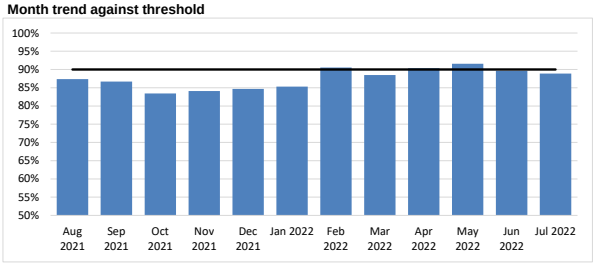
> Board Assurance

July 2022

Appraisal - Medical

Actual	88.9%	(July 22)	**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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✓	◇	◇	◇	◇	✗	◇	✓	✓
91.6%	85.7%	88.6%	88.7%	87.7%	80.8%	88.7%	94.9%	96.0%

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

Key Issues

Compliance decreased by 0.7% across the Group in July 2022. Only CSS, NMGH, and the LCO are meeting the 90% target.

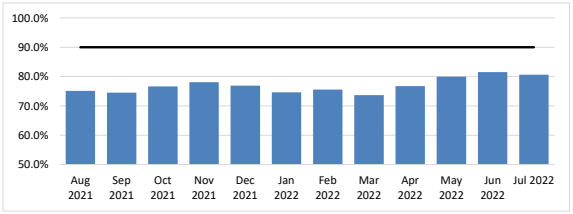
Actions

Appraisal reporting and compliance remains a key focus area with weekly and monthly reporting provided. Virtual sessions on effective appraisals have continued twice a month to support line managers. The Management Brilliance - OD Resource Portal provides line managers with access to guidance and toolkits. Work continues now in four areas: completion of an internal audit by KPMG to provide even greater assurance; accelerated support for NMGH; support for line managers detailed in our People Plan; and initiation of research and work to deliver a digital appraisal.

Appraisal - Non-Medical

Actual	80.6%	(July 22)	**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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✗	✗	✗	✗	✗	◇	✗	✗	◇
73.6%	81.3%	84.8%	84.7%	82.5%	88.0%	83.7%	84.3%	85.3%

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

Key Issues

Compliance decreased by 1% across the Group in July 2022. No Hospital or Managed Clinical Service is currently meeting the 90% threshold target for this KPI. This was last achieved by the Eye Hospital in October 2021 at 90.6%. The only other Hospital to reach this target in the last year is the Dental Hospital.

Actions

Appraisal reporting and compliance remains a key focus area with weekly and monthly reporting provided. Virtual sessions on effective appraisals have continued twice a month to support line managers, with over 100 managers attending sessions in first 3 months of launch in November 2020. NMGH was supported from day 1 and a new Management Brilliance - OD Resource Portal ensured line managers have access to guidance and toolkits. Work continues now in four areas: completion of an internal audit by KPMG to provide even greater assurance; accelerated support for NMGH; support for line managers detailed in our People Plan; and initiation of research and work to deliver a digital appraisal.

Manchester University NHS Foundation Trust

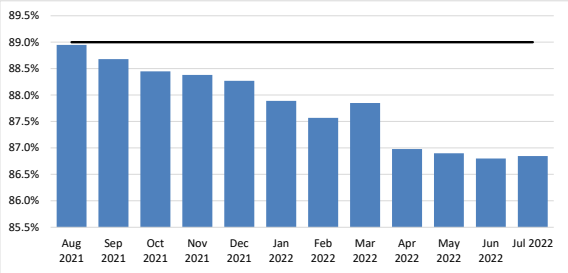
> Board Assurance

July 2022

Retention - rolling 12 months

Actual	86.8%	R12m (Aug 21 to Jul 22)	**Accountability**	P. Blythin
Threshold	89.0%	(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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✗	✗	◇	✗	◇	✗	✗	✗	✗
84.9%	82.2%	87.0%	83.9%	87.5%	78.4%	82.3%	83.4%	83.9%

The Retention figure shows employees as a percentage that have been at the Trust for 12 months or more.

Key Issues

The Group retention rate for July was 86.8% which is equal to the previous month's figure. No Hospital or Managed Clinical Service is currently meeting the 89.0% threshold target for this KPI.

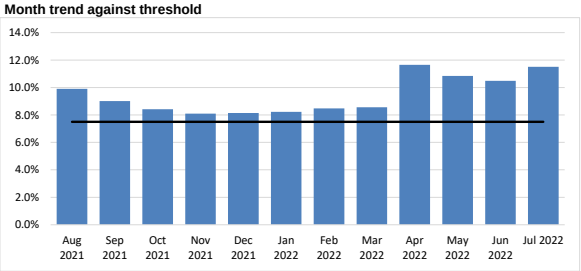
Actions

All Hospitals/MCS/LCO continue to focus on staff turnover with regular staff engagement sessions and facilitating internal moves to mitigate staff leaving the organisation. Workforce Planning to continue sharing the monthly Nursing Leavers Analysis report whilst developing an 'All Staff Groups' version of the report in Power BI.

All Vacancies

Actual	11.5%	(July 22)	**Accountability**	P. Blythin
Threshold	7.5%	(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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✗	✗	✗	✗	✗	✗	✗	◇	✗
11.1%	15.0%	15.4%	12.6%	14.5%	22.8%	11.2%	9.4%	11.8%

This metric shows the number of vacancies at the Trust by taking the establishment figure and minusing the staff in post to show the number of vacancies. This is then divided by the establishment to get the percentage.

Key Issues

The Group vacancy rate for July was 11.5% which is higher than the previous month's figure (10.5%). No Hospital or Managed Clinical Service is currently meeting the 7.5% threshold target for this KPI.

Work is ongoing to understand the differences between what establishment is held in the ledger and staff that are not on ESR which is causing an inflated vacancy percentage. There could be Junior Doctors for example which are included in the establishment but not on ESR which is causing some of the discrepancies.

Actions

Work continues at pace to identify and remove blockages within the recruitment process, as a result of the ongoing streamlining programme of work. A key part of this programme is the provision of accurate reports to all Hospitals / MCSs and LCO on vacancies and applicants.

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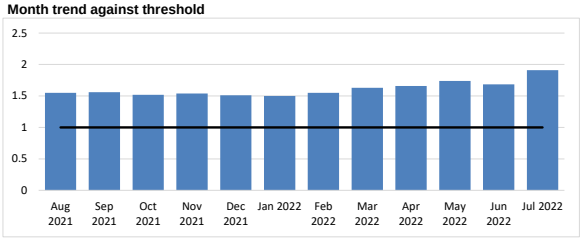
Relative Likelihood of White Staff vs BME Staff being Appointed

Actual	1.91	(July 22)	**Accountability**	P. Blythin
Threshold	1.00	(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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✗	✗	✗	✗	◇	✓	✗	◇	✗
1.94	1.86	1.98	2.47	1.10	1.00	1.67	1.34	2.44

Relative likelihood of White staff being appointed from Shortlisting across all posts compared to BME staff being appointed from Shortlisting across all posts.

Key Issues

The Group relative likelihood of white staff being appointed compared to BME staff for July was 1.91 which is higher than the previous month's figure (1.68). Only the Dental Hospital is currently meeting the 1.00 threshold target for this KPI.

The information provided for Aug 2021 to July 2022 return is zero.

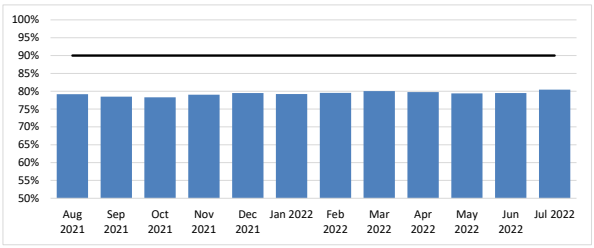
The Trust continues with the Removing the Barriers Programme to increase the proportion of black and minority ethnic staff in senior leadership roles. The Programme sets out work comprising of three interlinked components and associated priorities:

- Diverse Panels Scheme
- Reciprocal Mentoring Scheme
- Ring fenced secondments

Level 2 & 3 Mandatory Training

Actual	80.4%	(July 22)	**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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
✗	✗	✗	✗	✗	✗	✗	✗	✗
80.1%	79.3%	78.2%	84.9%	82.4%	82.2%	81.7%	73.6%	83.1%

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

Compliance for Level 2 & 3 CSTF Mandatory Training has increased by 0.9% across the Group in July 2022. No Hospital or Managed Clinical Service is currently meeting the 90% threshold target for this KPI or has met this target in the last year.

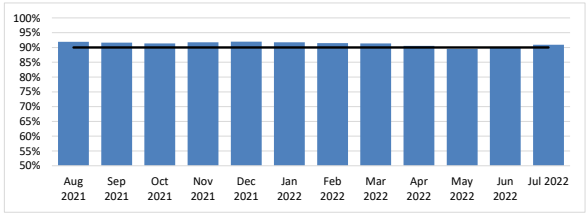
Actions

Work continues to drive compliance through weekly reporting sent to HR staff from all MCS/Hospital sites and Corporate HR and discussions via the Accountability Oversight framework (AOF) meetings. A communication campaign encouraged staff members to 'get ahead' with Mandatory Training prior to Go Live of HIVE.

Level 1 CSTF Mandatory Training

Actual	90.9%	(July 22)	**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	Saint Mary's	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital	LCO
◇	✓	◇	✓	✓	✓	✓	✓	✓
88.5%	91.5%	89.7%	93.4%	93.8%	95.1%	91.4%	90.3%	92.0%

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

Compliance is monitored against the aggregate of all 11 Core Level 1 subjects. In July 2022 the aggregate compliance increased by 1.1% to 90.9%. Only CSS and RMCH have a compliance score below the 90% Trust target.

Actions

The governance of Mandatory Training has now transferred from the PMO project team into BAU and is now led by the Learning & Development Support Services team. Work continues to drive compliance through weekly reporting sent to HR staff from all MCS/Hospital sites and Corporate HR and discussions via the Accountability Oversight framework (AOF) meetings. A communication campaign encouraged staff members to 'get ahead' with Mandatory Training prior to Go Live of HIVE.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Jenny Ehrhardt – Group Chief Finance Officer
Paper prepared by:	Paul Fantini, Head of Group Reporting & Financial Planning ,Rachel McIlwraith, Operational Finance Director
Date of paper:	September 2022
Subject:	Financial Performance for Month 4 2022/23
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
Key Points and Recommendation	The Board of Directors is recommended to note the Month 4 position against the 22/23 plan and Cash and Capital positions for the Trust.
Contact:	Name: Jenny Ehrhardt Tel: 0161 276 6692

Executive Summary

1.1	**Delivery of financial plan**	The financial regime for 2022/23 is focussed on recovery of elective activity, reduction of waiting lists that have reached historic highs and the continued drive to prevent hospital admissions. The move away from PbR is further reflected in the way funding flows work in 22/23 as is the move away from the COVID funding regime that was still in place in H2 last year. For MFT this means that income related to COVID now forms a very small part of our income allocation in 22/23, with a greater focus of funding on Elective recovery (ERF). Overall, there is little change in the income envelope between years with the tariff uplift and ERF increase being offset by the efficiency requirement in the tariff and the cessation of COVID funding. The implication of this 'flat cash' environment is, with rising inflation and an increasing workforce, historic high levels of cost reduction through the waste reduction programme (WRP) are required to achieve the financial plan balance for 22/23. This is also in the context of a continued range of workforce implications and ongoing health and wellbeing concerns that, due to the persistence of COVID variants, could not be fully addressed in 21/22. The Trust submitted a plan to NHSE in June which delivers a break-even position at year-end, as part of the GM ICS overall break-even submission. This includes additional funding from NHSE of £28.8m to MFT to partially offset inflationary pressures. This additional funding was awarded across England with a number of conditions, including delivering break-even, staying within the agency cap and including internal audit work on the Trust's financial processes. To July 2022, the Trust has delivered a YTD deficit of £13.2m against a planned YTD breakeven position. In order to recover the YTD position, it is essential that work on delivery of WRP schemes is given the highest priority and focus across the entire organisation.
1.2	**Run Rate**	In July 2022 total expenditure was £198.2m. This reflects an increase of £7.6m compared to the June figure of £190.6m. YTD balance sheet flexibilities were included in the position last month accounting for £3.8m of this movement, with an increase in cost pass through drugs expenditure (offset by an increase in income) of £3.8m accounting for the remaining movement. Income was £7.9m higher than last month, the majority due to cost pass through drugs, as per expenditure, with the balance being numerous smaller favourable differentials described under Financial Performance.
1.3	**Cash & Liquidity**	As at 31st July 2022, the Trust had a cash balance of £223.0m. The cash balance continues to reduce from the year-end position, largely due to payments for capital expenditure incurred in the previous year but not settled at the year end. The cash balance at the end of July was lower than forecast by £53.7m, this was due to timing issues around VAT repayments, PDC receipts and annual contract payments as well as the cash impact of budgeted but unrealised WRP savings.

1.4	**Capital Expenditure**	The Trust will operate within the agreed GM final capital allocations. These assume that £15m of the HIVE programme will be funded by additional PDC capital funding. As reported to the Board on 13th June 2022, whilst MFT have agreed to adopt this reporting position, if the £15m is not obtained by means of PDC, all other provider Trusts have agreed to limit their expenditure to ensure there is sufficient CDEL cover for the funding required to finalise the HIVE programme. The Trust's element of the final GM capital submission is a total plan value for 2022/23 of £136.4m, with the GM envelope component being £68.6m. For the period up to 31st July 2022, £26.5m of GM envelope expenditure was incurred against the original plan of £18.4m, an overspend of £8.1m. The overspend is materially made up of £1.2m H&S backlog which is ahead of plan but no expected risk of overspend, and £9.3m for Hive. These are offset by underspends of £1.7m for IT Disaggregation, due to £2.2m being classified as revenue spend following a review, and £1.4m Project Red due to delays in the schemes. The £9.3m overspend on Hive against the GM envelope plan is partially offset by the £6.7m underspend on Hive PDC spend. For the full year, there is no forecast overspend assuming the £15m PDC funding is secured.

Financial Performance

Income & Expenditure Account for the period ending 31st July 2022

I&E Category	NHSI Plan M4	Year to date Actual - M4	Year to date Variance
INCOME	£'000	£'000	£'000
Income from Patient Care Activities			
NHS England and NHS Improvement	298,904	299,239	335
Clinical commissioning groups	411,965	412,171	206
NHS Trust and Foundation Trusts	1,276	1,275	(1)
Local authorities	11,879	11,879	(0)
Non-NHS: private patients, overseas patients & RTA	3,164	3,595	431
Non NHS: other	2,968	3,327	359
Sub -total Income from Patient Care Activities	**730,156**	**731,486**	**1,330**
Research & Development	21,787	22,129	342
Education & Training	27,146	28,371	1,225
Misc. Other Operating Income	28,211	27,188	(1,023)
Other Income	**77,144**	**77,688**	**544**
TOTAL INCOME	**807,300**	**809,173**	**1,874**
EXPENDITURE			
Pay	(473,107)	(495,677)	(22,570)
Non pay	(291,674)	(291,544)	130
TOTAL EXPENDITURE	**(764,781)**	**(787,221)**	**(22,440)**
EBITDA Margin	**42,519**	**21,952**	**(20,566)**
INTEREST, DIVIDENDS & DEPRECIATION			
Depreciation	(25,637)	(19,226)	6,411
Interest Receivable	200	783	583
Interest Payable	(16,305)	(15,890)	415
Loss on Investment	0	0	0
Dividend	(777)	(777)	0
Surplus/(Deficit)	**0**	**(13,158)**	**(13,158)**
Surplus/(Deficit) as % of turnover	**0.0%**	**-1.6%**	
Impairment	**(27,747)**	**(21,792)**	**5,955**
Non operating Income	**1,504**	**2,385**	**881**
Depreciation - donated / granted assets	**(414)**	**(417)**	**(3)**
Surplus/(Deficit) after non-operating adjustments	**26,657**	**6,666**	**(19,991)**

For month 4, July 2022, the Trust has delivered a YTD deficit of £13.2m against a planned YTD breakeven position.

There is a favourable variance against income YTD to month 4 of £1.9m which is primarily due to CPT drugs use being lower than plan by £2.0m, despite an increase over month 3. This is due primarily to lower use of two extremely costly drugs - Zolgensma in RMCH and Voretigene in the Eye Hospital. This has been offset by higher than planned income for pass-through devices, mainly TAVI (Transcatheter Aortic Valve Implantation) implants. All pass-through movements are also reflected in non-pay expenditure making the impact nil to the Trust's control total.

Additionally, a contract variation for the Genomics service has been undertaken in month 4 along with other variations within the LCO.

Non-clinical operating income is above plan by £0.5m with under delivery across hospital sites on a range of income sources accounting for an adverse variance of £1.0m offset by above plan income for R&D (+£0.3m) and Education & Training income (+£1.2m).

Pay expenditure remains well above plan YTD to month 4 by £22.6m (£15.9m above plan in month 3), reflecting the profile of the revised plan. The main reason for this is under-delivery against the WRP target of £11.5m, most of which is sitting against pay related codes. The majority of the remaining adverse variance against pay is down to the continued increase in bank and agency pay costs due to sickness rates rising once again after falling back in months 1 and 2, and gaps in rotas.

Agency medical pay cost represented the highest monthly value recorded at MFT of £2.3m in month 3, and although this has fallen back in month 4 to £1.9m this still reflects an increase over the average monthly cost in 21/22 of over £0.5m. Agency spend overall is £12.5m YTD which is adverse to the plan submitted to NHSI by £2.7m. YTD the Trust is above the "cap" by £3.3m since capitalised agency costs are included within the "cap" measure although they do not form part of the I&E total or variance to plan. Bank costs, accounting for a further £32.0m YTD expenditure, are also adverse to the NHSI plan by £6.3m.

The table below shows agency expenditure against the plan YTD and the current forecast outturn by staff group. There is a gap of 15.8% to the "cap" (including the capitalised agency costs) that will need closing before the year end.

Agency Expenditure by Staff Category

Agency Staff Category	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Forecast Outturn £000	Forecast Variance £000
Medical Staff	6,077	7,621	(1,543)	18,229	21,064	(2,834)
Nursing & Midwifery Staff	1,665	1,091	574	4,994	2,785	2,208
Scientific, Therapeutic & Technical Staff	1,449	1,762	(313)	4,346	5,309	(963)
Clinical Support Staff	585	553	33	1,756	1,377	379
Non Clinical Staff	0	1,433	(1,433)	0	2,852	(2,852)
Total	**9,776**	**12,459**	**(2,683)**	**29,325**	**33,388**	**(4,063)**

Note: excludes YTD capitalised costs of £585k

Group are working on an apportionment of the cap to each hospital/MCS/LCO, Corporate and Estates and Facilities which has been communicated to them in August with the expectation that plans are drawn up to reduce agency expenditure, and subsequent forecasts, within these limits.

The decrease in agency expenditure in month 4 of £0.5m was offset slightly by increased costs on substantive staff of £0.2m. The premium pay decreases were mainly in WTWA (£0.4m reduction), MRI (£0.2m reduction) and LCO (£0.2m) although increased costs were seen at NMGH (£0.2m increase) and CSS (£0.1m increase).

Non-pay expenditure, including depreciation, YTD to month 4 22/23 was favourable to plan by £7.4m. However, there were some offsetting adverse and favourable variances making up this total. Balance sheet

flexibilities for month 4 have been included here at £2.0m, there is a favourable plan reprofile difference of £8.7m, Depreciation and Interest are a combined £1.7m favourable to plan and movements in the bad debt provision account for a further £1.3m favourable. These were offset by adverse variances within the hospitals/corporate of £4.6m in WTWA (primarily undelivered WRP), £2.9m in CSS (undelivered WRP) and £2.0m in Corporate (Informatics professional fees relating to Hive) with some favourable variances of £1.6m in MRI (accruals releases) and £1.1m in NMGH (cost pass through drugs).

Comparing non-pay run rates to month 3 there has been an adverse movement of £7.1m, with CPT Drugs costs described earlier accounting for £3.8m of this (£3.1m adverse movement in RMCH, £0.5m in MRI, £0.2m others) and the balance sheet flexibilities adverse movement of £3.8m (£5.8m were included in month 3 and only £2.0m in month 4). Several small movements across other non pay categories accounted for a total favourable movement of £0.5m to offset some of the adverse movements.

Although the Trust is reporting a month 4 position that is similar to month 3, and much improved compared to months 1 and 2, this still reflects a deficit against the in-month break-even plan of £1.0m. Overall, the run rate implied by a deficit of £13.2m, YTD to month 4, would lead to an outturn deficit of £39.6m so there will need to be a high degree of focus on delivering the WRP savings in 22/23 if the Trust is to achieve the breakeven plan.

Waste Reduction Programme

Within the respective Hospital, MCS, LCO and Corporate Control Totals for the year is a Waste Reduction target totalling £65.8m, made up of £15.8m undelivered savings from 21/22 and the 22/23 target of £50m.

The tables below outline the 22/23 progress against the planned savings. On a consolidated basis all areas together have achieved £27.6m against schemes that have progressed to L3 or higher on WAVE. This reflects a small adverse variance of £0.2m compared to the plan against L3 or higher schemes. However this falls short of the overall YTD target of £38.4m by £10.8m, meaning that the Trust continues to ‘play catch up’.

The schemes delivering savings in month 4, plus others at L3 or above that have not yet begun, are forecast to deliver £81.0m of savings by the end of the year, a deficit of £36.2m compared to the Trust target of £117m – this reflects an improvement of circa £3m compared to the forecast at month 3.

Workstream	Savings to Date Plan (YTD) £'000	Actual (YTD) £'000	Variance (YTD) £'000	Financial BRAG	Forecast 22/23 Position Plan (22/23) £'000	Act/F'cast (22/23) £'000	Variance (22/23) £'000	Financial BRAG
Admin and clerical	327	315	(12)	96%	1,015	1,003	(12)	99%
Budget Review	821	821	0	100%	2,269	2,269	(0)	100%
Contracting & income	1,797	1,781	(16)	99%	2,777	2,761	(16)	99%
Hospital Initiative	3,692	3,692	(0)	100%	10,877	10,877	(0)	100%
Length of stay	262	265	3	101%	846	849	3	100%
Non Pay Efficiencies	93	84	(9)	90%	815	806	(9)	99%
Outpatients	25	14	(11)	56%	87	76	(11)	87%
Pharmacy and medicines management	1,249	1,248	(1)	100%	2,896	2,846	(50)	98%
Procurement	871	808	(63)	93%	3,625	3,256	(370)	90%
Theatres	0	0	0	100%	1	1	0	100%
Workforce - medical	467	434	(33)	93%	1,316	1,319	3	100%
Workforce - nursing	756	705	(51)	93%	2,630	2,579	(51)	98%
Workforce - other	202	202	(0)	100%	599	599	(0)	100%
Total (L3 or above)	**10,563**	**10,370**	**(194)**	**98%**	**29,754**	**29,241**	**(513)**	**98%**
Trust Initiative	17,261	17,261	0	100%	51,784	51,784	(0)	100%
MFT Total	**27,824**	**27,631**	**(194)**	**99%**	**81,538**	**81,024**	**(513)**	**99%**

Summary against Target M1-4	YTD
Target	38,401
Actuals (L3 or above)	27,631
Variance to Target	- 10,770
Lost opportunity (value of schemes below L3)	2,283
Variance to target if all schemes delivered as plan	- 8,487

Summary against Target 22/23	Act/F'cast (22/23)
Target	117,246
Actuals/Forecast (L3 or above)	81,024
Variance to Target	- 36,222
Value of schemes below L3 (M5-12)	12,350
Variance to target	- 23,871

Financial BRAG

The BRAG 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. An example is Divisional Non Pay where Corporate is risk rated green where as the overall scheme is risk rated Red.

Financial Delivery less than 90%
Financial Delivery greater than 90% but less than 97%
Financial Delivery greater than 97%
Schemes fully delivered with no risk of future slippage

Hospital/MCS	22/23 Target	22/23 Actual/Forecast	22/23 Variance	% Variance
Corporate	5.5	0.7	(4.8)	-88%
CSS	13.3	8.4	(4.9)	-37%
Eye	1.2	0.8	(0.4)	-32%
Dental	0.9	0.2	(0.6)	-72%
LCO	7.9	0.4	(7.5)	-95%
MRI	6.8	5.9	(0.9)	-14%
NMGH	4.4	1.6	(2.8)	-63%
RMCH	8.5	5.4	(3.1)	-36%
St. Mary's	3.9	2.1	(1.7)	-45%
WTWA	13.1	3.7	(9.4)	-72%
Hospital/MCS/LCO Subtotal	**65.5**	**29.2**	**(36.2)**	**(55%)**
Trust	51.8	51.8	(0.0)	-0%
MFT Total	**117.2**	**81.0**	**(36.2)**	**(31%)**

Statement of Financial Position

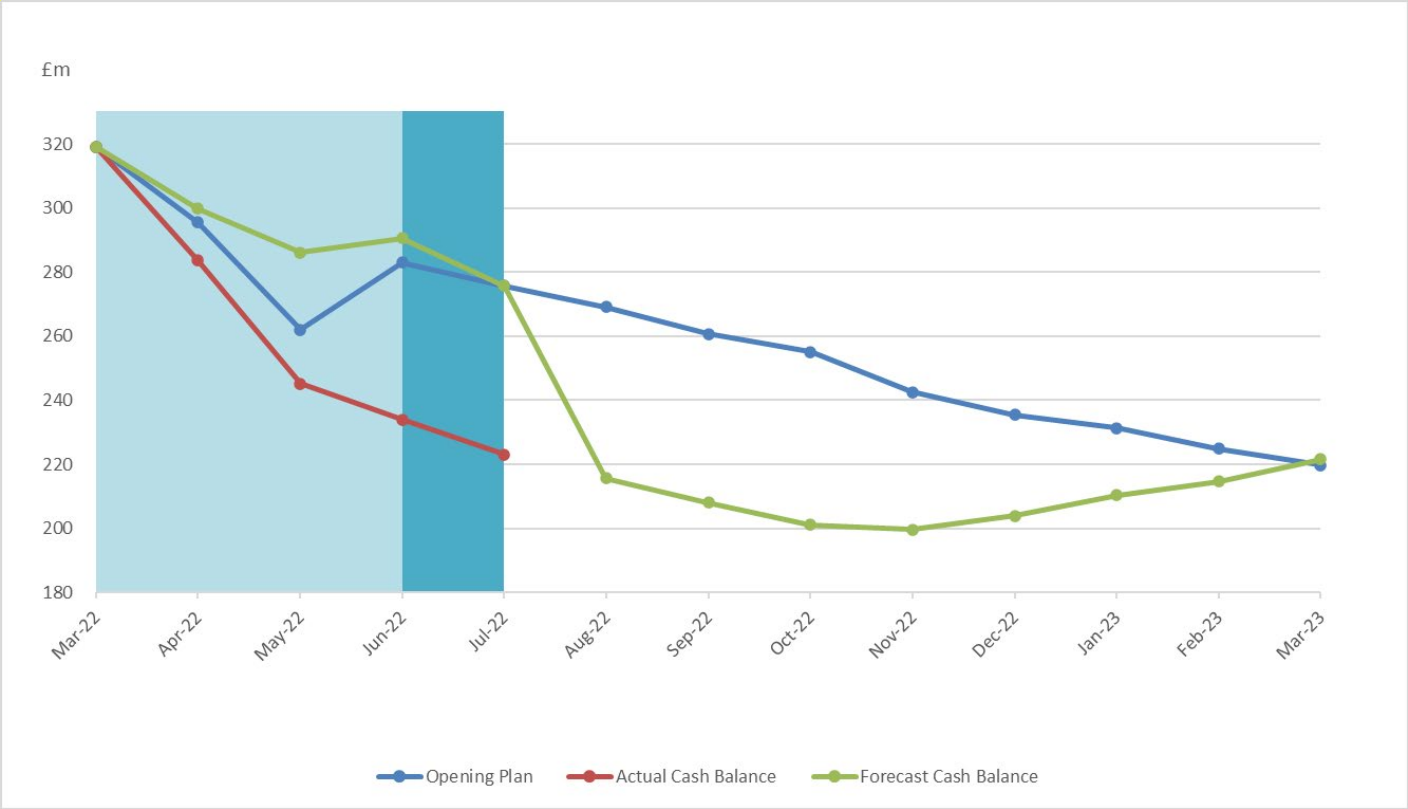
	31-Mar-22 £000	31-Jul-22 £000	Movement in YTD £000
Non-Current Assets			
Intangible Assets	16,107	28,244	12,137
Property, Plant and Equipment	798,636	1,006,262	207,626
Investments	870	870	0
Trade and Other Receivables	15,657	14,758	(899)
Total Non-Current Assets	**831,270**	**1,050,134**	**218,864**
Current Assets			
Inventories	21,809	21,696	(113)
NHS Trade and Other Receivables	26,500	60,858	34,358
Non-NHS Trade and Other Receivables	61,879	82,482	20,603
Non-Current Assets Held for Sale	2,510	2,510	0
Cash and Cash Equivalents	319,112	223,020	(96,092)
Total Current Assets	**431,810**	**390,567**	**(41,243)**
Current Liabilities			
Trade and Other Payables: Capital	(43,000)	(22,458)	20,542
Trade and Other Payables: Non-capital	(339,849)	(333,429)	6,420
Borrowings	(24,001)	(44,518)	(20,517)
Provisions	(52,636)	(52,256)	380
Other liabilities: Deferred Income	(59,360)	(80,234)	(20,874)
Total Current Liabilities	**(518,846)**	**(532,895)**	**(14,049)**
Net Current Assets	**(87,036)**	**(142,328)**	**(55,292)**
Total Assets Less Current Liabilities	**744,234**	**907,805**	**163,571**
Non-Current Liabilities			
Trade and Other Payables	1	-	(1)
Borrowings	(371,694)	(567,731)	(196,037)
Provisions	(13,903)	(13,158)	745
Other Liabilities: Deferred Income	(2,386)	(3,650)	(1,264)
Total Non-Current Liabilities	**(387,982)**	**(584,539)**	**(196,557)**
Total Assets Employed	**356,252**	**323,266**	**(32,986)**
Taxpayers' Equity			
Public Dividend Capital	408,780	408,780	0
Revaluation Reserve	97,411	97,412	1
Income and Expenditure Reserve	(149,940)	(182,927)	(32,987)
Total Taxpayers' Equity	**356,251**	**323,265**	**(32,986)**
Total Funds Employed	**356,251**	**323,265**	**(32,986)**

The capital programme expenditure and accruals movements continue to affect the Property, Plant and Equipment value in the accounts, resulting in an increase in Property, Plant and Equipment and a reduction in cash and capital payables. In addition, there is also a continued unwinding of accruals made in M12 as part of hospitals closing their year-end financial position; an increase in both NHS and non-NHS trade receivables driven by an increase in central accrued income and timing of the receipt of local authority invoices, respectively; and an increase in deferred income driven by a timing difference that has arisen in relation to HEE income.

The changes to IFRS16 lease accounting are reflected in a £219m movement in borrowings as leases were brought onto the balance sheet on 1st April 2022 on first adoption of the standard. This is also reflected in the increase in Property, Plant and Equipment shown.

The figures as at the 31st March 2022 in the table above have been restated in light of audit adjustments agreed in June 2022. Key movements include: an adjustment between intangible assets and tangible assets to reflect AUC additions (£14m) and a decrease in trade creditors and an increase in provisions (£20m) to reflect the band 2/3 accrual.

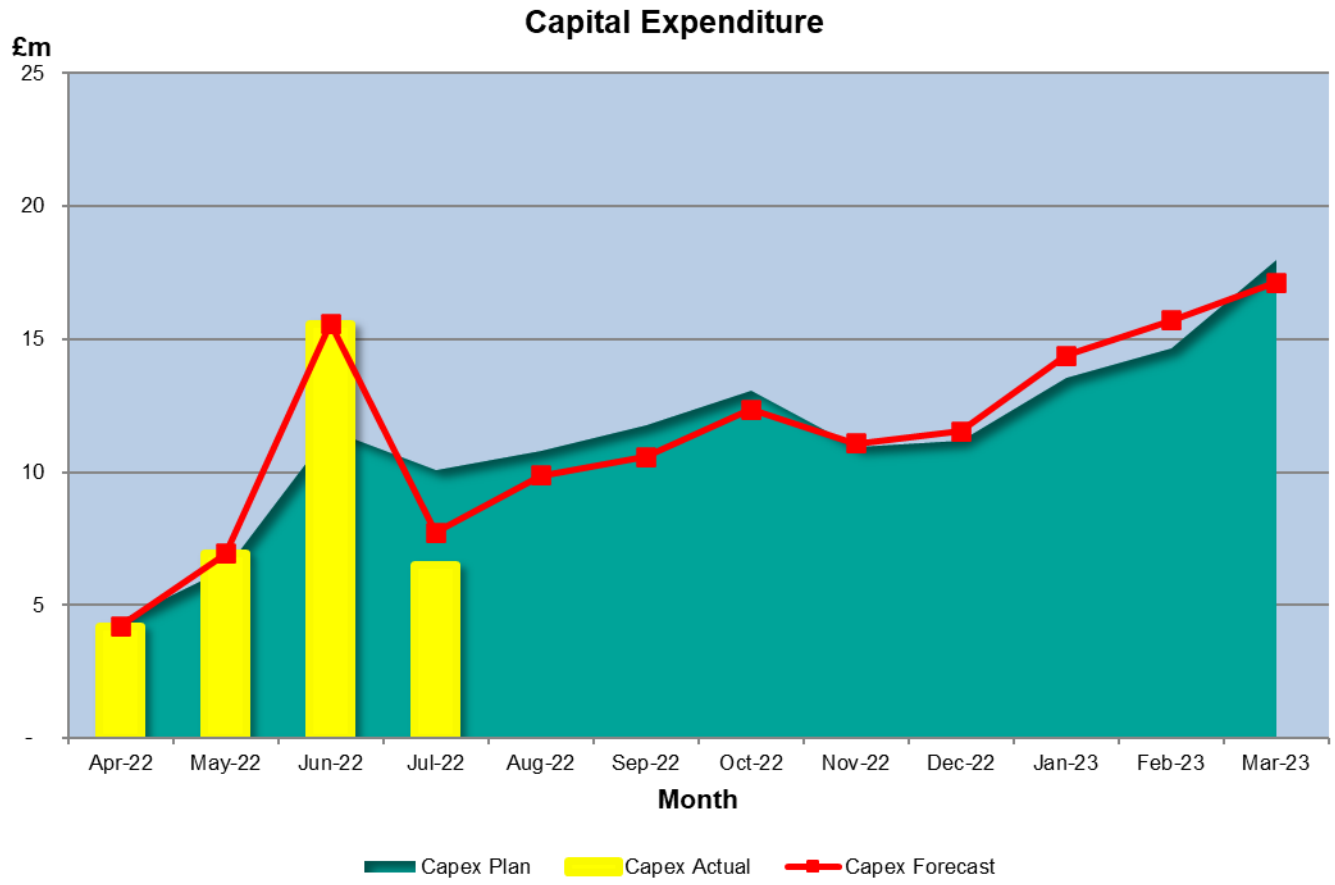
Cash Flow



The cash balance as at 31st July is lower than the £275.7m forecast due to a number of timing differences, including: VAT receivables received after the month end (£8m); PDC receipts forecast but not yet received (£10m) and amounts owed by the Charity to the Trust (£1.2m). There has also been an increase in YTD capital payments (£5m); unrealised YTD WRP savings (£11m) and additional YTD pay overspend compared to forecast (£11m).

Significant detailed work has been undertaken on the cash forecast and the forecast cash figures for the remainder of the year have been adjusted to reflect the above variances. However, the forecast is expected to align with the plan by the year-end as the timing differences realign over the coming months.

Capital Expenditure



In the period to 31st July 2022, £33.2m of capital expenditure has been incurred against the updated plan of £32.5m, an overspend of £0.7m. The overspend is driven by:

- a £2.6m overspend on Hive – this is due to increases in service provider costs
- a £1.2m overspend on Estates health and safety backlog – representing costs incurred ahead of plan and
- a £0.8m overspend on the GMCA decarbonisation grant scheme, where additional funding has been secured.

These overspends have been partially offset by a number of underspends, notably:

- £1.2m underspend relating to timing slippage relating to the NHP project,
- £1.4m underspend on Project Red as a result of initial timing delays and
- an underspend of £1.7m for IT Disaggregation, due to £1.2m being classified as revenue spend following a review of the nature of the spend.

The Trust will operate within the agreed GM final capital allocations. These assume that £15m of the HIVE programme will be funded by PDC capital funding. As reported to the Board on 13th June 2022, whilst MFT have agreed to adopt this reporting position, if the £15m is not obtained by means of PDC, all other provider Trusts in GM have agreed to limit their expenditure to ensure there is sufficient funding and CDEL cover to finalise the HIVE programme.

The Trust has a total capital plan value for 2022/23 of £136.4m. £68.6m of this plan relates to the Trust's allocation against the GM envelope component.

For the period up to 31st July 2022, £26.5m of GM envelope expenditure was incurred against the original plan of £18.4m, an overspend of £8.1m, of which £6.7m relates to the £15m assumed Hive PDC funding which is still to be secured within GM.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

GROUP BOARD OF DIRECTORS (PUBLIC)

Report of:	Professor Cheryl Lenney, Group Chief Nurse
Paper prepared by:	Gail Meers, Corporate Director of Nursing, Quality and Patient Experience Claire Horsefield, Head of Customer Services
Date of paper:	September 2022
Subject:	Complaints & PALS Report: Quarter 1, 2022/23
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 of Directors is asked to note this Complaints and PALS report, including information relating to Q1 2022/2023, on the following topics: • Complaints & PALS activity • Brief analysis of identified themes • Summary of achievements and improvements planned • Overview of complainants' satisfaction survey
Recommendations:	The Board of Directors is asked to note the contents of this report.
Contact:	Gail Meers, Corporate Director of Nursing, Quality & Patient Experience.

1. Introduction

1.1 This report relates to Patient Advice and Liaison Service (PALS) and Complaints activity across Manchester University NHS Foundation Trust (MFT) during Q1 (April – June) 2022/23.

1.2 Our aim is to provide timely resolutions when people raise concerns or complaints about their experiences of the care they have received. We aim to remedy the situation as quickly as possible, ensuring the individual is satisfied with the response they receive. Learning from complaints provides a rich source of information to support sustainable change.

1.3 This report provides:

- A summary of activity for Complaints and PALS across the Trust
- An overview and brief thematic analysis of complaints raised
- A summary of feedback received through Care Opinion and NHS Websites
- A summary of improvements achieved, and those planned to ensure learning from complaints is embedded in everyday practice
- A summary of the Complainants' Satisfaction Survey and planned improvement activity
- Equality and Diversity information and planned improvement activity
- Supporting information referred to throughout the report is included at **Appendix 1**.

1.4 The report refers to all Hospitals/Managed Clinical Services (MCS) and Local Care Organisations (LCO) across the MFT Group.

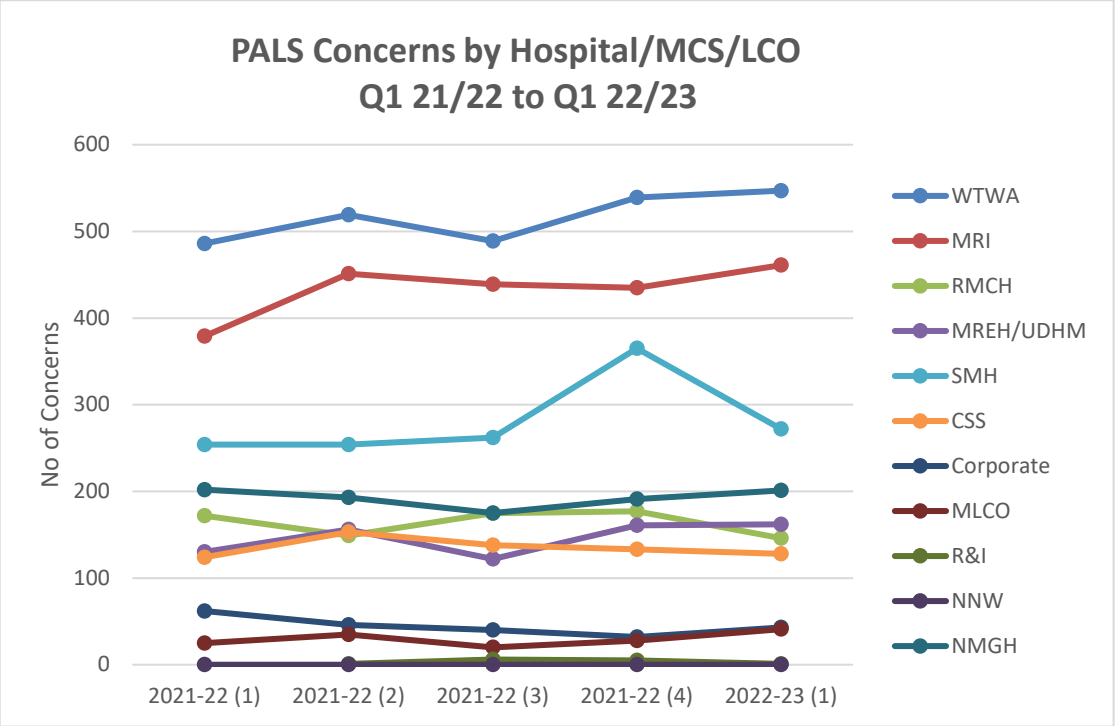
2. An overview of PALS and Complaints activity Q1 2022/23

- 2,002 PALS concerns were received in comparison to 2,066 received in the previous quarter, a decrease of 8.39% (168) for the same period in Q1, 2021/22[1].
- 434 new complaints were received in comparison to 427 received in the previous quarter. This shows a slight increase of 5.06% (22) for the same period in Q1, 2021/22[2].
- Of the 434 new complaints received 121 related to in-patient services. This shows a decrease of 14% (17) in comparison to 138 received in the previous quarter.
- MRI received the greatest number of complaints with 108 being received during this quarter; an increase of 30% (32) in comparison to the 76 MRI received in the previous quarter. Of the 108 complaints received at MRI there were no single themes or trends. (See Section 3.1)
- 100% of complaints were acknowledged across the Group within 3 working days; this position was maintained throughout all quarters in 2020/21 and 2021/22.
- The Trust has a target of 90% of complaints to be responded to within an agreed timescale and 90.5% of complaints were responded to within this agreed timescale compared to 90.0% in the previous quarter[3].
- 44 (10.4%) complaints investigated were upheld, 285 (67.3%) were partially upheld and 76 (18.0%) were not upheld (please refer to Section 5:3).
- The PHSO closed 0 cases during this quarter and opened 5 cases. Details of the 'open' PHSO cases are set out in **Appendix 1, Table 1**.

- There was a total of 72 re-opened complaints received. This compares to 74, a 0.6% decrease compared to the previous quarter.
- 29 virtual or face to face complaint local resolution meetings were held. This compares to 31, a 7% decrease compared to the previous quarter.
- The Complaints Review and Scrutiny Group (CRSG) met twice during Q1. The senior management teams from MREH, UDHM, CSS and NMGH each presented a case. The learning identified from these cases is detailed in Section 5 of this report.

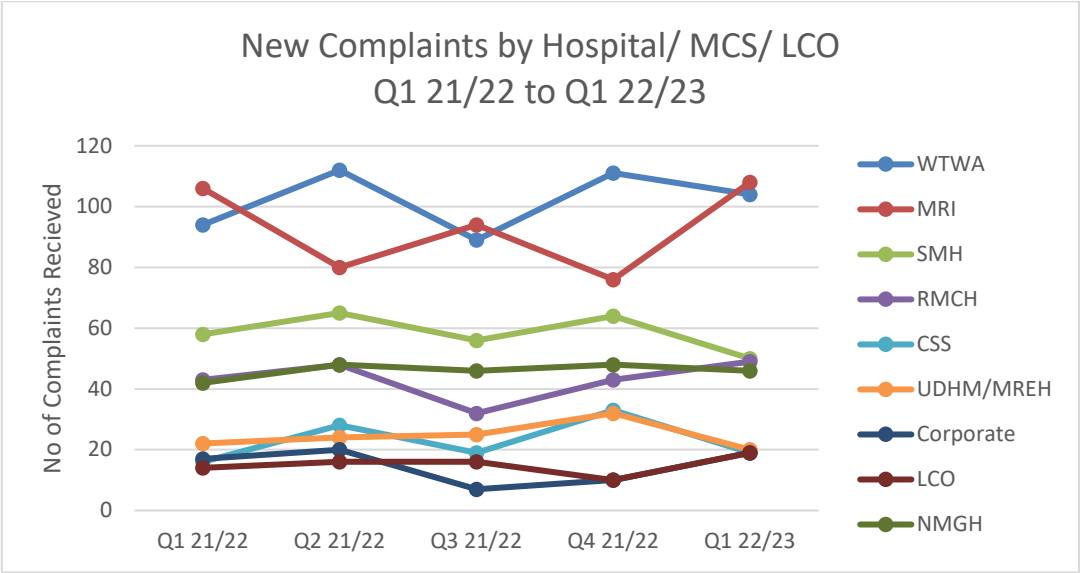
3.0 An overview and brief thematic analysis of PALS and Complaints contacts

3.1 In Q1 the Trust saw a slight decrease in PALS concerns from the previous quarter with 2,002 PALS concerns being received. Graph 1 below shows the number of concerns received by each Hospital / MCS / LCO each quarter. As in the previous four quarters WTWA received the greatest number of PALS concerns. Overall, the greatest decrease in PALS concerns was in SMH with a 34.1% decrease being noted compared to the previous quarter. Further detail is provided in **Table 2, Appendix 1**.



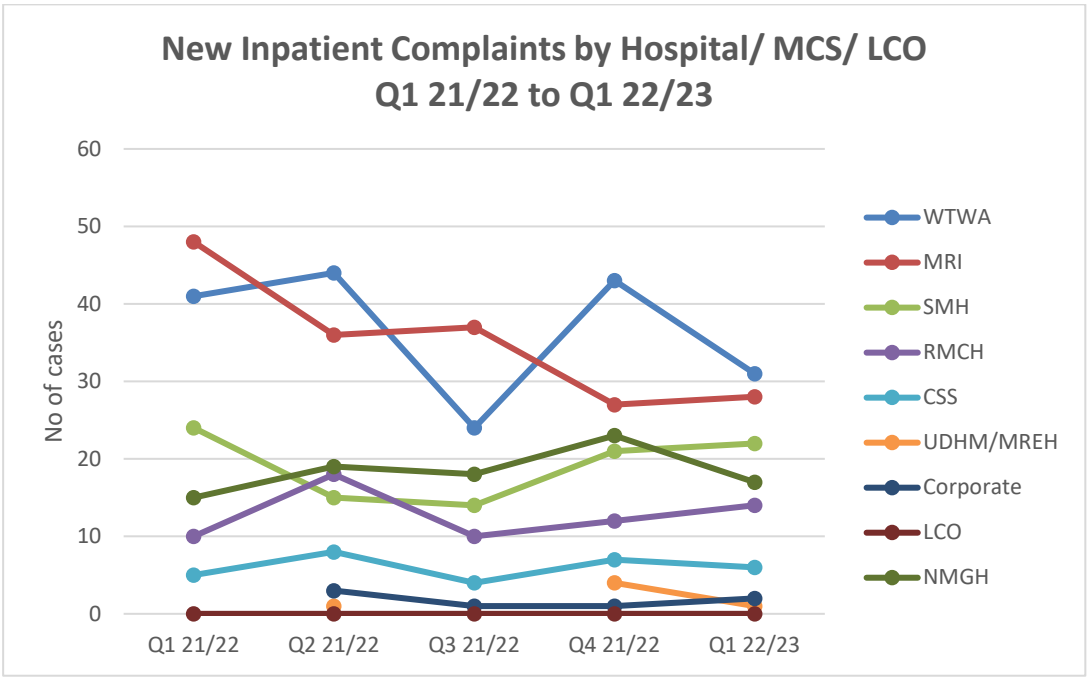
Graph 1: PALS Concerns Received by Hospital/MCS/LCO

3.2 As in Q4, 2021/22, the Trust noted a further increase in complaints in Q1 with 434 new complaints being received. Graph 2 below shows the number of complaints received by each Hospital / MCS / LCO each quarter. MRI received the greatest number of complaints. Further detail is provided in **Table 3**, **Appendix 1**.

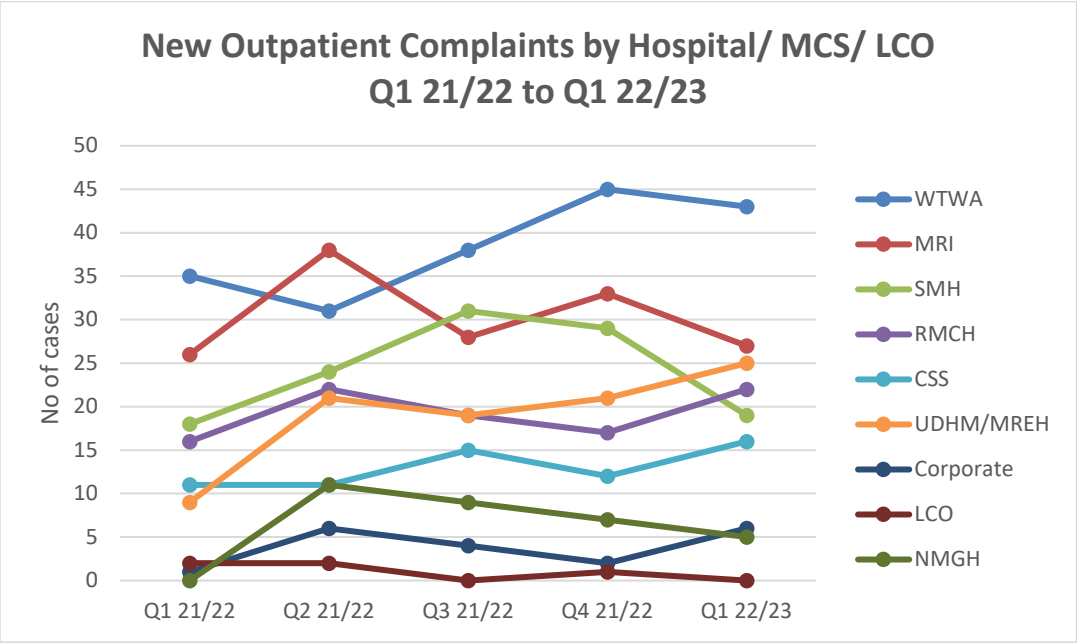


Graph 2: New Complaints Received by Hospital/MCS/LCO

3.3 **Graphs 3 and 4** illustrate the number of new complaints relating to inpatient and outpatient services during Q1 2021/22 – Q1 2022/23. Overall, the greatest increase in complaints relates to out-patient services with a slight reduction in complaints relating to in-patient services being noted.



Graph 3: Number of new complaints relating to inpatient services by Hospital/MCS/LCO



Graph 4: Number of new complaints relating to outpatient services by Hospital/MCS/LCO

3.4 Under the NHS Complaints Regulations (2009) there is a requirement that all new complaints are acknowledged within 3 working days of receipt of the complaint, MFT are committed to achieving this in 100% of cases. The Trust met this indicator, **Appendix 1, Table 4** demonstrates the complaints acknowledgment performance.

4.0 Complaints resolved within agreed timescales

4.1 90.5% of complaints were closed within the agreed timescale representing a slight increase in comparison to the previous quarter, **Appendix 1**, **Table 5** provides the comparison of complaints resolved within agreed timeframe during the last 5 quarters.

4.2 The oldest complaint case closed during Q1 was registered within NMGH on 19th November 2021 and was 105 days old when it closed on 29th April 2022. The arranging of two local resolution meetings impacted the overall response time. The complainant was kept updated and was fully supported throughout this process.

4.3 The oldest complaint case open at the end of Q1 was within WTWA; it was 154 days old at the end of Q1, 21/22. The complaint also involves a serious incident high-level investigation impacting in the Trust's overall response time. The complainant continues to be kept updated and fully supported throughout the process.

5.0 Outcomes from Complaint Investigations

5.1 All NHS organisations and those delivering NHS services are required to submit quarterly returns to NHS Digital. The Hospital and Community Health Services Complaints Collection (KO41a) has been accepted by the Standardisation Committee for Care Information (SCCI) and is now mandatory. The information obtained from the KO41a collection monitors written hospital and community health service complaints received by the NHS. It also supports the commitment to ensure both equity and

excellence are key drivers to improve the patient experience and provide opportunity to listen to the public voice.

5.2 Often complaints relate to more than one issue. In conjunction with the Hospital/ MCS/LCO investigating teams, the Corporate Complaints team review each of the issues raised to determine what happened. If failings are found in all the issues raised, and substantive evidence (evidence based on which a fact is proven) is identified to support the complaint, then the complaint is recorded as fully upheld. If failings are found in one or more of the issues, but not all, the complaint is recorded as partially upheld. Where there is no evidence to support any aspects of the complaint made, the complaint is recorded as not upheld.

5.3 During Q1, 44 (10.4%) of the complaints investigated and responded to were fully upheld, 285 (67.3%) were partially upheld and 76 (18.0%) were not upheld. **Appendix 1, Table 6** demonstrates the outcome status of all complaints between Q1 2020/21 and Q1 2022/23.

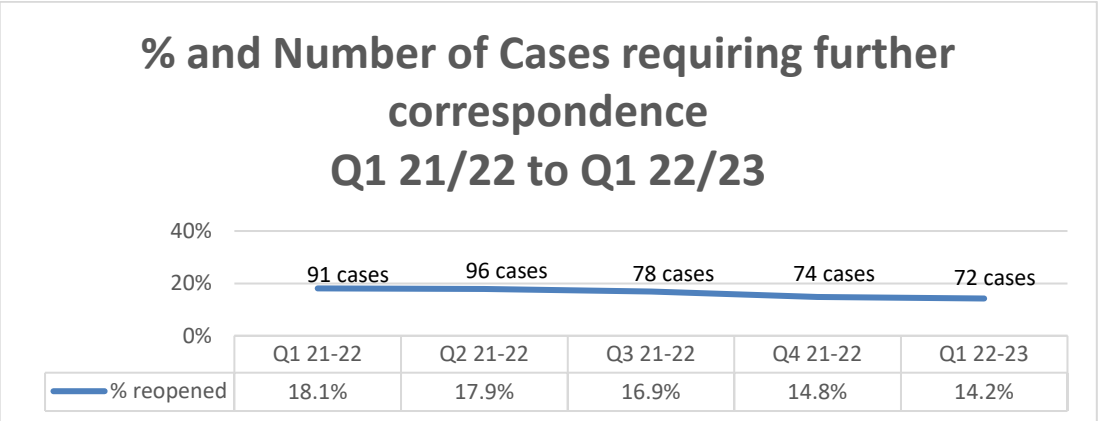
6.0 Re-opened complaints

6.1 A complaint is considered 're-opened' if any of the following categories can be applied:

- Where there is a request for a local resolution meeting following receipt of the written response
- When new questions are raised following information provided within the original complaint response
- The complaint response did not address all issues satisfactorily
- The complainant expresses dissatisfaction with the response

6.2 The number of re-opened complaints is used as a proxy indicator to measure the quality of the initial response. During Q1, 14.2% of complaints were reopened (72 cases in total) against the Trust tolerance threshold of 20%. In the previous quarter, 14.8% of complaints were reopened (74 cases in total).

6.3 **Graph 5** demonstrates the number of complaints re-opened from Q1 2021/22 – Q1 2022/23. **Appendix 1, Table 7** provides an overview of the primary reasons for the complaint being re-opened by Hospital/MCS/LCO during Q1.



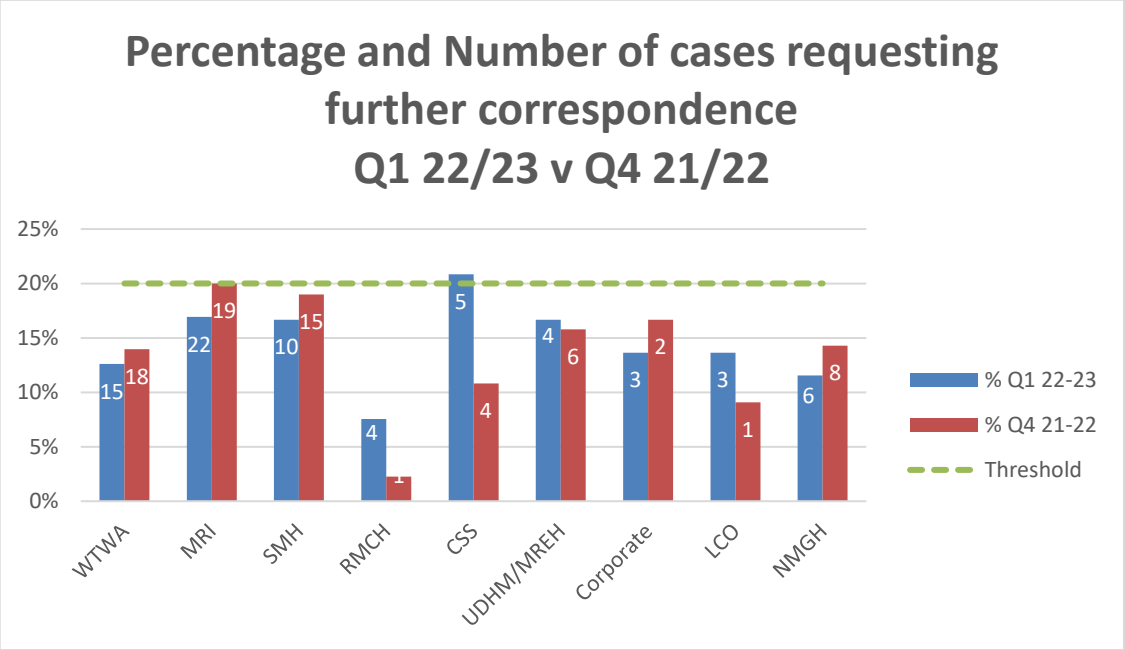
Graph 5: Total Re-opened complaints Quarter 1, 2021/22 to Quarter 1, 2022/23

6.4 In 44 of the 72 complaints requiring re-opening, the primary reason was due to the complainant being 'dissatisfied with the response', with MRI and WTWA receiving the greatest number, 12 and 7 respectively.

6.5 The 20% threshold was exceeded by CSS at 20.8% **(Graph 6)**

6.6 Small fluctuations in the total number of complaints received in a Hospital/MCS/LCO or Corporate Services can result in large percentage changes for those areas where the overall number of complaints are low, which is the case for CSS, UDHM/MREH, Corporate Services and the LCO.

6.7 The Corporate Complaints team letter writing training programme continues to support improvements in the content and quality of responses with a review to ensuring that the complainant's concerns are fully answered in the first response.

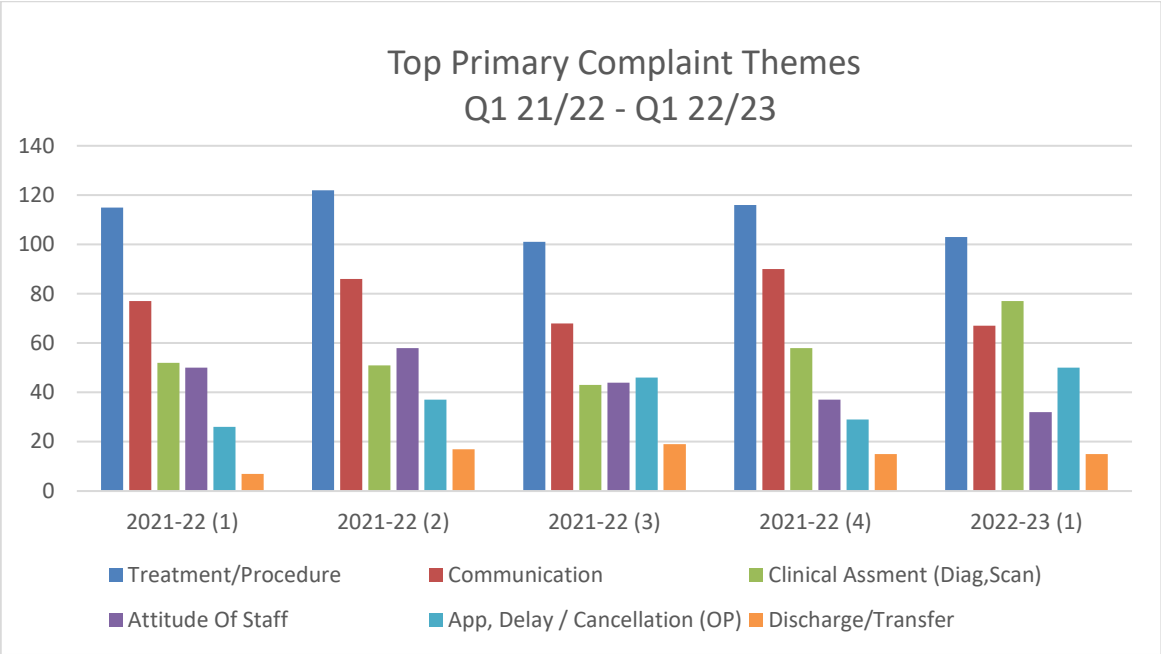


Graph 6: Percentage and number of re-opened complaints, Quarter 1, 2021/22

7.0 Brief thematic overview of complaints

7.1 The opportunity to learn from complaints is an effective way of improving patient care and experience. By applying categorisation and theming to the complaints received, the teams work to improve the quality of care where themes emerge, or where practice is identified as requiring improvement.

7.2 During Q1, the top 5 primary categories remained unchanged with Treatment / Procedure' remaining the top category **(Graph 7)**.

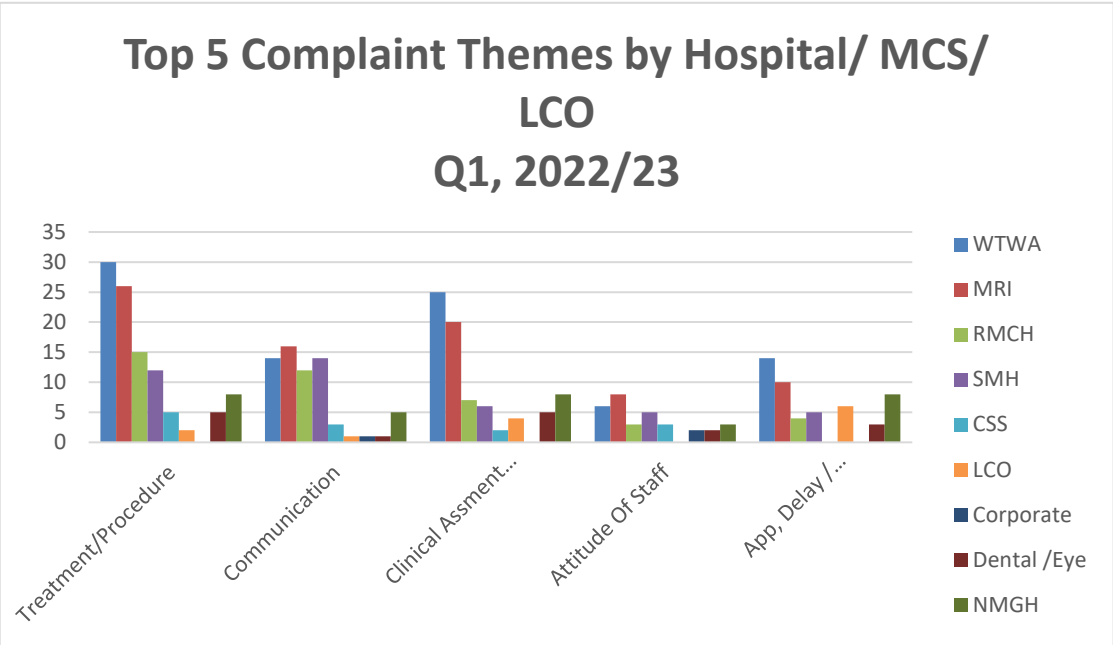


Graph 7: Top Primary Complaint Themes Q1, 2021/22 to Q1, 2022/23

7.3 WTWA received the most complaints relating to 'Treatment/Procedure', some examples include:

- a patient's family experiencing lack of communication regarding the patient's ongoing care and treatment whilst an inpatient
- a patient experiencing a fall on admission and lack of nutrition and hydration
- a patient experiencing delays in receiving hand surgery
- a patient's experiencing delays in receiving cancer surgery

7.4 **Graph 8** below shows the distribution of the top 5 themes by Hospital/MCS/LCO in Q1 2022/23.



Graph 8 Top 5 themes by Hospital/MCS/LCO in Q1 2022/23

8.0 Care Opinion and NHS Website feedback

8.1 The Care Opinion and NHS Websites are independent healthcare feedback websites whose objective is to promote honest and meaningful conversations about the patient experience between patients, and people who provide health services.

8.2 All NHS Website and Care Opinion comments are received by the Patient Experience Team (PET) and shared with the relevant Hospital/MCS/LCO. Responses are required for publication within 5 working days. Designated senior staff within each Hospital/MCS/LCO review the comments and provide a response for publication. **Table 8** below provides examples of the feedback received and the subsequent responses posted on Care Opinion and NHS Website during Q1.

Quarter 1, 2022/23
Manchester Royal Infirmary
"On a busy Friday night, I was seen within the hour after notifying the triage nurse about my difficulty breathing because of sever tonsillitis. I informed them about my sleep apnoea and my worries that waiting until Monday to get medical help was a risk because of a further restriction to my airways because of severe tonsillitis. The nurse tried their best to find immediate space to receive medication so that I could be on my way as well as minimise interference with more urgent cases around me. Definitely felt cared for and was told that coming in was the right thing and should my condition worsen, I should come back. The nurses were very kind and I'm super grateful for them."
Response
Thank you for your wonderful comments regarding the care you received at Manchester Royal Infirmary in the Emergency Department. We were delighted to read that the nurses were kind, caring and put you at ease during a stressful time. It is reassuring to read that on a busy Friday night, the nurses were attentive and that you were able to receive medication quickly to help your condition. We can assure you that we have passed on your comments to the Head of Nursing who will share with the team involved.
Saint Mary's Hospital
"Unhappy with service so far" – 25/5/22 "I saw my midwives at my GP practice. The first appointment I had I was told to go to the hospital for bloods as the midwife was unable to take my blood. Instead of trying my other arm she advised me to go to the hospital. The next time I had my appointment, my blood was taken by a student. Unfortunately, later, I received a call from the midwife advising me to go to the hospital to have my bloods taken again as they had used the wrong vial. At my recent appointment, I was given my Mat B1 Form however my midwife had forgotten to sign it. I asked for this to be posted out to me instead as I did not want to have to take time off work just to go in to pick up a form. It doesn't fill me with great confidence when they can't even get the simple things right. Also, they don't tell you anything without you asking."
Response
We were very sorry to receive your comments and concerns via the NHS website about your experiences within the Antenatal Services at The Manchester University Hospital Trust. It is very difficult to respond to the specific concerns you have raised without being able to

investigate your concerns in more detail. We take all issues surrounding patient care very seriously and would very much like to hear from you directly about your experience. If you contact our Patient Advice and Liaison Service on 0161 276 8686 or by e-mailing pals@mft.nhs.uk they will be able to discuss this with you.

Manchester Royal Infirmary – Hathersage Centre

"Great Practice" – 19/5/22
"The online booking system was awful but that's independent from the practice itself. As soon as I got the telephone consultation, I felt respected and listened to. The lady I spoke to was really nice, warm and helpful. Coming into the practice today to have my implant removed was as safe as positive as the experience could've been. I was greeted by friendly receptionists and the lady who did my procedure was experienced, calm, informative and reassuring. She didn't even just do it and send me on my way, she cared for my well-being and had a joke with me afterward. This was my first time here, and I couldn't have asked for more. Thank you"

Response

Thank you for your comments which we welcome as an opportunity to learn, reflect and evaluate our services.
We are very pleased to hear of your largely positive experience following your appointment, which affirms the hard work and commitment of our staff.
I am however sorry to hear about your experience using our online booking system.
We are aware of issues associated with demand and system overload and are continually looking at ways to improve our access.
If you would like to discuss your experience with us in more detail, please do not hesitate to contact our Patient Advice and Liaison Service (PALS) on 0161 276 8686 or by e-mailing pals@mft.nhs.uk.

North Manchester General Hospital

"Time wasters" - 13/4/22
"The Maxillofacial Department is a joke. I travelled half an hour for my appointment just so they can tell me that it was cancelled but nobody let me know. Receptionist blamed "Booking Centre" saying "I can see the letter was produced", receptionist basically wasn't even able to tell if the letter was actually sent but only "produced" absolute time wasters, the wound is not healing great and seems there is a little infection, but they postponed the appointment by another one month because doctor is on annual leave. Shocking. Anonymous"

Response

Thank you for sharing your experience when you attend the Maxillofacial Department at North Manchester General Hospital. We are very sorry that you do not feel you were treated politely and courteously by the staff who were working at the reception desk. I am sorry that you had not been given prior notification that your appointment had been cancelled and for any inconvenience that this caused to you. You comment that you are concerned that you may have an infection. In order to assist you further or if you would like the opportunity to discuss with a member of the clinical team, please do not hesitate to contact our Patient Advice and Liaison Service (PALS) on 0161 276 8686 or by e-mailing pals@mft.nhs.uk and they will liaise with the clinical team on your behalf. The importance of greeting and welcoming visitors and patients to our departments will be emphasised to colleagues in order to improve our patient service.

Wythenshawe Hospital
“Amazing care” – 16/6/22 “From visiting the Nightingale, having my pre op, being admitted to the admissions lounge, being taken to theatre and then aftercare on Ward F4 I could not have asked for better care. The staff, nursing and medical have all been so compassionate and caring. I would highly recommend this hospital to anyone. Thank you for everything, you are all amazing”
Response
Thank you for your comments following your treatment at Wythenshawe Hospital. It is great to hear that throughout your surgical journey numerous teams provided you with compassion and high levels of care. Your positive comments will be passed on to the teams involved. We wish you a speedy recovery.
Trafford General Hospital
“Fantastic experience” – 9/6/22 “I attended today for major dental surgery. Throughout the entire process, the staff were impeccable. I was made to feel at ease, the atmosphere was relaxed, friendly and professional. From start to finish I was kept abreast of each step of the way. I was asked numerous times about who I was, which clearly limits any mistakes. My vital signs were constantly monitored prior to my surgery. The dentist and anaesthetist explained in full what I was going to have. They answered my queries with ease and with total dignity. The nurses who looked after me; pre & post-surgery were phenomenal. They were witty, friendly, kind natured and thoroughly professional. I was initially scared about my surgery as I have a real fear of all things medical. Within seconds, my anxiety was relinquished as I was met by friendly people at reception. I was led to the ward and from the very start I was welcomed, put at ease and I felt relaxed.”
Response
Thank you for taking the time to provide us with positive feedback. We are delighted to hear that all staff supported you throughout your surgery and kept you well informed, taking the time to offer detailed advice when needed. It is also reassuring to hear that all safety checks were completed thoroughly, highlighting our high standards for pre surgery checks. We are very happy to know that all members of staff including, porters, nurses and surgeons made a positive impact upon your hospital experience. Your appreciative comments will be passed onto the head of department, who will share with the staff involved. We wish you all the best with your post-surgery recovery.

Table 8: Examples of Care Opinion/ NHS Website Postings and Reponses Q1 2021/22

8.3 This quarter a total of 42 comments were received via the websites, of which 18 (43.0%) were positive, 18 were negative (43.0%) and 6 were mixed (14.0%). The number of Care Opinion and NHS Website comments by category; positive, negative, and mixed, are detailed in**, Appendix 1**. **Table 9**

9.0 Learning from Complaints

9.1 This section of the report provides examples of improvements made in response to feedback from complaints. Further detail is provided in Section 6, which outlines the opportunities being explored to support learning and transformation through shared vision, and positive change through open dialogue and reflection.

9.2 Patient complaints offer intelligence that can be used to change practice and improve patient experience and outcomes. Whilst the focus on the performance of managing and responding to complaints is key it is also important that there is a clear intent to ensure that learning from the outcomes of complaints is shared, and improvements are acted upon and disseminated widely to improve patient experience.

9.3 During Q1 2022/23 MFT's Complaints Review Scrutiny Group (CRSG) panel met twice with the management teams from MREH and UDHM each presenting a case in May 2022 and CSS and NMGH each presenting a case in June 2022. Learning and associate actions identified from the 4 cases were discussed and provided assurance that complaints are investigated, and appropriate action taken when needed. Outcomes from the 4 cases discussed are provided in **Table 10** below. Please also refer to Section 11 with regards to proposed changes/improvements to the CRSG.

Hospital / MCS / LCO	Learning	Actions
MREH	We learnt that: • A patient was lost to follow up resulting in a delay in them receiving their treatment. • There was room for improvement regarding the content and quality of the complaint response letter. • An incident had not been registered on the system at the time of the incident occurring.	• Complaint to be shared anonymously at MREH's next ACE Day meeting. • Review patient information leaflets, heightening information around the importance of patients expediting their follow-up appointments should they experience a deterioration in their condition, or they do not hear from the hospital within the designated timeframe. • Increase awareness around the 'Macular Passport'. • Corporate Complaints Team Leader to arrange and facilitate bespoke Complaint Letter Writing Training workshops for all MREH staff involved in complaint response writing. • Establish as to why an incident had not been registered in a timely manner. • Staff to be reminded of the importance of timely reporting of incidents on the Trust's Incident Reporting system.
UDHM	We learnt that: • Dental Students telephone calls/conversations with patients are not documented. • Complaints are not fed back to the dental students or their tutors.	• Process to be developed and implemented to ensure all dental students clearly document all conversations with patients. • All pertinent complaints to be shared with the dental students and tutor and the students supported in reflecting on the

	• Dental Students do not receive PALS and Complaints training.	events leading up to the complaint. • Introduction of PALS and Complaints Training Programme to all dental students.
CSS	We learnt that: • Poor Communication had been experienced by the patient and that the patient's Pre-Appointment Information Leaflet had not been sent to the patient prior to attending outpatients. • A patient had not been offered a chaperone in clinic. • A dignity sheet had not been offered to the patient. • The complaint response letter was signed on behalf of the MCSs CEO and the signature indicating signing under authority was illegible.	• Pre-appointment process reviewed. - Current leaflets to be sent out to all patients with immediate effect until leaflets have been updated accordingly. • Consideration to be given to the introduction of a Chaperone Service. • Staff member to be supported in reflecting on the events leading up to the complaint and an understanding to be gained why a dignity sheet was not offered/provided to the patient. • All staff to be reminded of the importance of clear communication with patients via a de-briefing session with the wider team. • When signing under procuration on CEO complaint response letters 'Name and title' of signature to include the phrase 'for and on behalf of' and their 'printed name', as well as their signature.
NMGH	We learnt that: • A patient's diet was modified without input being sought from Pharmacy resulting in the patient's increased risk of aspiration.	• In-conjunction with Pharmacy colleagues, develop and implement a process for the assessment and safe administration of oral medication for patients with a modified diet.

		• Potential risk to be placed and tracked on the Trust's Risk Register.
	• Poor communication was experienced by the patient's family regarding regular updates from the staff.	• All staff to be reminded regularly at daily huddles of the importance of providing patient's relatives with regular updates and where appropriate, alternative visiting options.
	• Lack of consideration was shown by the staff to the patient's family regarding alternative visiting arrangements.	
	• Lack of early recognition was given in relation to the patient's presenting end of life symptoms.	• Complaint to be discussed at the next NMGH's Medicine Mortality Meeting for General and Specialist Medicine.
	• The complaint response did not answer all the complaint questions thoroughly.	• Corporate Complaints team to facilitate bespoke Complaint Response Letter Writing Training to all staff at NMGH involved in the complaint response writing process.
	• The CEO complaint response did not detail the 'outcome statuses for each of the points raised within the complaint.	• In line with the draft PHSO Complaints Standards Framework: Complaint responses across MFT to clearly highlight which aspects of the complaint have been Upheld/Partially Upheld/Not Upheld. - change in working practice to be communicated to all Hospitals/MCSs/LCO. - All CEO Complaint Response templates to be amended accordingly.
	• As part of the complaint investigation statements had not been gained from the staff members who had been named/complained about within the complaint.	• Bespoke Complaint Investigation Training to be provided to all staff involved in complaint investigations.

Table 10: Actions identified at the Trust Complaints Scrutiny Group during Q1 2022/23

10.0 Hospital /MCS/ LCO Learning from complaints

10.1 Each Hospital/ MCS/ LCO holds regular forums where themes, trends relating to complaints are discussed with focused actions agreed for improvement.

10.2 Detailed below, in **Table 11**, are some examples of how learning from complaints has led to changes that have been applied in practice.

Hospital / MCS / LCO	Reason for complaint	Action Taken
MREH	Concerns received regarding: - a plastic cup being provided to a patient who was experiencing nausea and sickness whilst waiting to be seen in clinic. - lack of communication experienced by the patient's registered carer in relation to the patient's care plan. - a student nurse wishing to complete an eye test, despite the patient not being able to see. - the patient's medical records not being available at the patient's follow-up appointment.	All staff reminded of the expected levels of care to be provided to all patients when attending the Emergency Eye Department. The importance of clearly communicating the reasoning for undertaking Visual Acuity tests with patients discussed with staff Complaint shared with the team and all staff reminded of the importance of adhering to the Escalation Policy when patient's records are identified as not being available for the patient's appointment.
UDHM	Concerns regarding post-surgery aftercare and lack of alliance between specialities involved in patient's care.	Patient post-operative instructions to be reviewed ensuring all emergency contact information is clear, correct and up to date. Concerns shared and nurse supported in reflecting on the events leading up to the complaint and reminded of the importance of communicating professionally and clearly with patients. All staff reminded of the importance of forwarding patient information to the nursing team. Concerns shared and the Nursing Sister supported in reflecting on the

		events leading up to the complaint and reminded of the standards expected when communicating with patients over the phone.
WTWA	Concerns regarding the care and treatment received in A&E, a misdiagnosis and the staff's attitude whilst questioning the misdiagnosis which resulted in a correct diagnosis being made on the patient's third attendance.	All clinical staff reminded of the importance of ensuring all patients who are non-weight bearing/absence of fracture or other identifiable cause for non-weight bearing are reviewed by a senior doctor. All clinicians reminded of the importance of ensuring all young children who have a lower leg injury with no definite fracture are reviewed in the Emergency Department Review Clinic 10 days post injury. As a direct result of the complaint all consultants will ensure the x-rays of the patients with multiple attendances are reviewed. Consultant supported in reflecting on the events leading up to the complaint and reminded of the standard practice for caring for toddlers with a fracture and the importance of providing clear communication to parents.
CSS **(Critical Care)**	Concerns raised regarding poor communication experienced by the daughter resulting in conflicting updates on the patient's status, and staff members attitude whilst seeking support and guidance affecting the decision of the patient's end of life treatment.	Improvement project to be undertaken via Education and Learning Programmes to support enhancing communication and to ensure the provision of compassionate and dignified care is always provided to patients.

NMGH	Concerns received regarding poor communication and lack of nutrition and hydration afforded to the patient.	Complaint shared with all staff in the Emergency Department. All staff reminded of the importance and their responsibilities of undertaking and completing intentional rounding. Implementation of a Patient Liaison Officer in the department between the hours of 10:00 - 22:00 to provide patients/relatives/carers with appropriate support with concerns or enquiries.
RMCH	Difficulties in arranging a viewing time with the Bereavement Team and Mortuary for the family of a deceased patient during a Bank Holiday period.	Revision of Mortuary Standard Operating Procedure to support and ensure appropriate and clear guidance on viewings. Implementation of a structured weekend handover to support family contact arrangements. Reinstatement of the Family Support & Bereavement departments telephone log-book. Viewing arrangements communicated to all relevant staff.
LCO	Concerns regarding the length of time waiting to be assessed by Trafford Autism and Social Communication (TASC).	Private provider commissioned to support with the undertaking of the assessments. Implementation of an Improvement Task and Finish Group to support streamlining the pathway. Business Case developed to support the need for investment in this pathway.

Table 11: Examples of the application of learning from complaints to improve services, Q1 2022/23

11.0 Quality Improvements during Q1 2022/23 included:

11.1 PHSO'S NHS Complaint Standards Framework 2021-22

11.1.1 Ahead of the NHS Complaint Standards Framework being introduced across the NHS and following the implementation of the Trusts Complaints teams 'Immediate Results Improvement Plan' in the previous quarter, during Q1 work continued and will continue

throughout 2022/23 ensuring MFT is responsive to the Expectations within the Framework.

11.1.2 A copy of the 'Long Term Improvement Plan' included in the preceding report will be presented at Professional Board during Q2, 22/23.

11.2 **Complaints Review Scrutiny Group (CRSG)**

11.2.1 In response to the discussions with the newly appointed NED and to improve the existing CRSG standards in the latter part of Q4, 21/22, work commenced during this quarter looking at the current agenda and purpose of the CRSG. The need to improve the way information arising from complaints is reviewed regularly, and how it is using learning from feedback to improve services and patient experience was identified.

11.2.2 A briefing paper providing an overview of the proposed improvement changes to working practices of the CRSG has been written. This will be presented at Professional Board in Q2, 22/23.

11.3 **In house E-Learning Customer Service – Module 2, PALS, and Complaint's package**

11.3.1 Completion and initial quality assurance checks on Module 2 were undertaken in Q1. Launch of the advanced e-learning education package on the MFT Learning Hub is planned for Q2, 2022/23.

11.4 **Advanced Telephone System**

11.4.1 It is always our aim to achieve a high level of customer satisfaction and communication and call handling is one of our primary objectives. Following feedback from services users in which they reported difficulties in contacting the PALS and Complaints teams work commenced during this quarter putting plans in place to enhance the current PALS and Complaints answering system. It is anticipated the newly purchased quality system will be installed and up and running during Q2, 2022/23.

11.5 **Delivery of a North Manchester General Hospital Corporate PALS and Complaints Service**

Given the expansion of the PALS team at NMGH and the absence of a meeting room for patients to meet confidentially with a PALS Case Worker during Q1 building work commenced and relocation of the PALS team and hand over of the Swan Suite is anticipated during Q2, 2022/23.

11.6 **Staff Support - Bespoke Supervisory Sessions**

11.6.1 **Health and Wellbeing Support**

In order to ensure the PALS and Complaints staff were aware of all the support available to them as employees, during Q1, the teams were introduced to the Wellbeing Advocate for Corporate. Further sessions are planned throughout 2022/23.

#TeamMFT
Caring for you, as you care for others

11.6.2 **Safeguarding**

During Q1, the Modern Matrons from the Adult and Children's Safeguarding teams facilitated its first Safeguarding Supervisory Session as part of the PALS and Complaints ongoing development. Further sessions are planned throughout 2022/23.

11.6.3 **Psychological Wellbeing and Mental Health Team Reflective Sessions**

Given the nature of the PALS and Complaints roles, which can be highly stressful, emotive and negatively charged, during Q1 psychological wellbeing and mental health reflective sessions were secured for all PALS and Complaints staff. The sessions will be a bespoke set of group sessions, enabling colleagues to safely share any personal stressors and an opportunity for them to receive appropriate support and coping techniques. The sessions are voluntary and there is no expectation or pressure for staff to attend.

11.7 **Complaints and Incidents pathways**

To improve the process by which complaints and incidents concurrently run in parallel, during Q1 the Head of Customer Services met with the Lead for Governance and Patient Experience at SMH. Work will continue during Q2, 22/23 working with the Hospitals/MCSs/LCO to evaluate and make the necessary changes, in line with due processes and national recommendations.

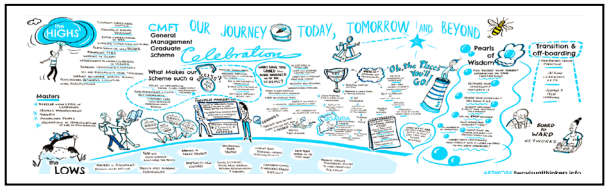
12.0 Education

12.1 **PALS and Complaints Training**

12.1.1 During Q1, the PALS and Complaints team facilitated an educational session as part of the Band 7 Team Leader Senior Clinician Leadership and Management Programme.

MFT CPD
CPD at Manchester University NHS Foundation Trust

12.1.2 During Q1 the PALS Manager also facilitated an educational session as part of the MFT Graduate Development Scheme.



12.2 In Q1, 22/23 PALS and Complaints were pleased to announce the launch of its 2022/23 Training Programme with training sessions on MFT's Learning Hub. Training sessions include Complaint Response Letter Writing training for those who need to improve their

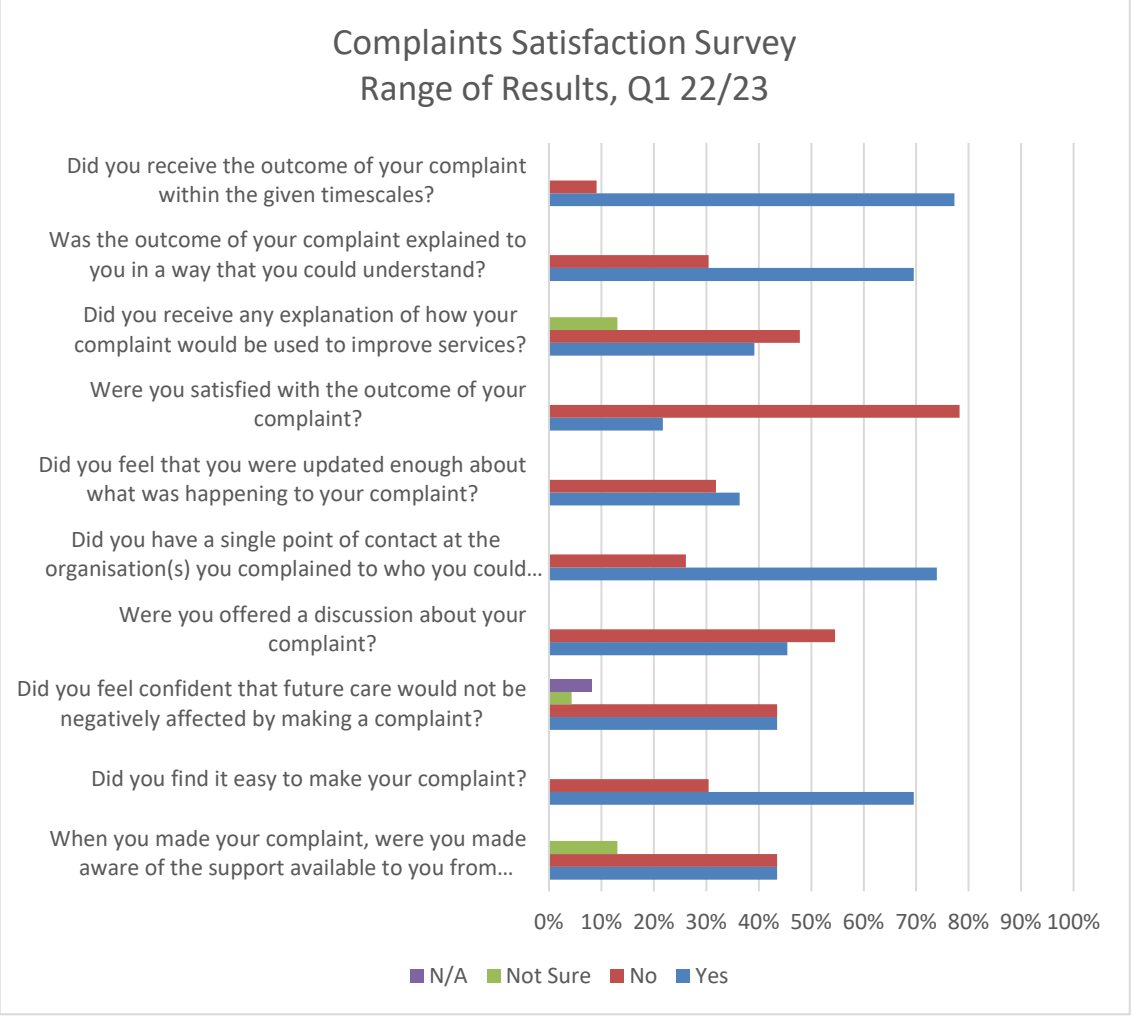
response writing skills and PALS and Complaints training for those keen to find out more about the working practices of PALS and Complaints.

13.0 Complainant's Satisfaction Survey

13.1 Understanding the experience of the complainant during and after a complaint investigation is considered good practice. By asking the complainant about their experiences about the quality of the services they have received, the Trust can use this feedback to make changes and improve our processes and procedures.

13.2 In Q1, 349 surveys, based on the 'My Expectations'[3] paper, was distributed to complainants across all MFT Hospital's/MCS's/LCO at the closure of complaint. As in previous quarters, collection of these surveys remains inconsistent and extremely low, with only 14 questionnaires being returned; the results are shown in **Graph 9** below. It is hoped that with the implementation of the online approach during this quarter that an increase in returns will be seen over the coming months.

13.3 There is a continued increase in the number of complainants reporting they received the outcome of their complaint within the given timescales, which correlates with the slight increase noted in complaints closed within the agreed timescale.



[3] https://www.ombudsman.org.uk/sites/default/files/Report_My_expectations_for_raising_concerns_and_complaints.pdf

Graph 9: Complaints Satisfaction Survey results for Q1 2021/22

13.4 The following are examples of feedback from complainants. Comments received during Q1 2022/23 include the following:

14.0 Planned Improvements

14.1 Continued areas for improvement and development during Q2, 22/23 and throughout 2022/2023, including:

- PHSO'S NHS Complaint Standards Framework – 'Immediate Results Improvement Plan'
- Completion and launch of the PALS and Complaints Customer Service Advanced e-learning package
- Ask, Listen, Do commitment - Improving the experiences of people with a learning disability, autism or both when using the Trust's PALS and Complaints service

- Heightening of PALS and Complaints training across Hospitals/MCSs/LCO
- Optimising learning from Complaints via Quality and Patient Experience Forum
- Optimising learning from Complaints via Education
- Actively sharing learning and communicating Complainant Satisfaction Survey feedback
- Exploration of the introduction of a PHSO/complaints 'upheld' Learning Sub-Group'
- Development of dedicated PALS Volunteer role
- Enhancement of collection of Equality and Diversity data
- Relocation of the PALS office and Reception to a new, more visible location within NMGH
- PALS and Complaints team working and objective setting through the Affina Team Journey

15.0 Equality and Diversity Monitoring Information

15.1 The collection of equality and diversity data is shown in **Appendix 1, Table 15**. As in previous quarters, collection of this information remains inconsistent.

15.2 A continued improvement in collection was found in relation to 'gender' and sexual orientation data, however continued evidence of the ongoing need to improve reporting on 'disability', 'religion' and 'ethnicity' was identified.

15.3 Ways of improving the collection of this data will continue to be explored in Q2 and throughout 2022/23.

16.0 Conclusion and recommendations

16.1 This report provides a concise review of matters relating to Complaints and PALS during Q1. Opportunities for learning and service improvement have continued to be identified, and this report has provided highlights of where this has and will take place.

16.2 The Board of Directors are asked to note the content of this Q1 Complaints Report and the on-going work of the Corporate and Hospital/MCS/LCO teams, to ensure that MFT is responsive to concerns and complaints raised and learns from patient feedback to continuously improve the patient's experience.

Appendix 1 – Supporting information

Table 1: Overview of cases open at the PHSO as at 31st June 2022

Hospital/ MCS/ LCO	Cases/s	PHSO Investigation Progress
MRI (7)		
Rheumatology Specialist Medicine	1	Awaiting Provisional Report
Cardiovascular Specialty	1	Awaiting Final Report
GI Medicine & Surgery	1	Awaiting Provisional Report
In-Patient Medical Specialties	1	Awaiting Provisional Report
Emergency Assessment & Access	1	Scoping
Cardiovascular Specialty	2	Scoping
WTWA (4)		
Surgery (Orthopaedics)	1	Awaiting Provisional Report
Heart & Lung (Cardiology)	1	Awaiting PHSO to re-issue Provision Views
Medicine (Urgent Care)	1	Awaiting Provisional Report
Surgery (Burns, Breast & Plastics)	1	Scoping
RMCH (2)		
CAMHS	1	Awaiting PHSO – case with Review and Feedback Team for consideration
CAMHS	1	Awaiting Provisional Report
SMH (3)		
Obstetrics	2	Scoping
Gynaecology	1	Scoping
CSS (1)		
Allied Health Professions	1	Scoping
UDHM (1)		
Dental	1	Scoping
TOTAL	**18**	

Table 2: Number of PALS concerns received by Hospital/ MCS / LCO Q1 2021/22 – Q1 2022/23

	Q1,21/22	Q2, 21/22	Q3, 21/22	Q4, 21/22	Q1,22/23
WTWA	486	519	489	539	547
MRI	379	451	439	435	461
RMCH	172	149	175	177	146
UDHM/MREH	130	156	122	161	162
SMH	254	254	262	365	272
CSS	124	153	138	133	128
Corporate	62	46	40	32	43
LCO	25	35	20	28	41
Research & Innovation	0	1	6	5	1
NMGH	202	193	175	191	201
Grand Total	**1834**	**1957**	**1866**	**2066**	**2002**

Table 3: Number of Complaints received by Hospital/ MCS / LCO Q1 2021/22 – Q1 2022/23

	Q1,20/21	Q2,21/22	Q3,21/22	Q4,21/22	Q1,22/23
WTWA	94	112	89	111	104
MRI	106	80	94	76	108
SMH	58	65	56	64	50
RMCH	43	48	32	43	49
CSS	16	28	19	33	19
UDHM/MREH	22	24	25	32	20
Corporate	17	20	7	10	19
LCO	14	16	16	10	19
NMGH	42	48	46	48	46
Grand Total	**412**	**441**	**384**	**427**	**434**

Table 4: Complaints Acknowledgement Performance

3 Day Target	Q1, 21/22	Q2, 21/22	Q3, 21/22	Q4, 21/22	Q1, 22/23
100% acknowledgement	100%	100%	100%	100%	100%

Table 5: Comparison of complaints resolved by timeframe: Q1 2021/22 – Q1 2022/23

	Q1,21/22	Q2,21/22	Q3,21/22	Q4,21/22	Q1,22/23
Resolved in 0-25 days	282	294	331	287	297
Resolved in 26-40 days	24	55	50	35	44
Resolved in 41+ days	39	75	105	57	82
Total resolved	**345**	**424**	**486**	**379**	**423**
Total resolved in timescale	**321**	**370**	437	341	383
% Resolved in agreed timescale	**93.0%**	**87.3%**	**89.8%**	**90.0%**	**90.5%**

Table 6: Outcome of Complaints, Q1 2021/22 – Q1 2022/23

Number of Closed Complaints		Upheld	Partially Upheld	Not Upheld	Information Request	Consent Not Received	Complaint Withdrawn	Out of Time
Q1,21/22	345	34	240	61	3	5	1	1
Q2,21/22	424	47	273	84	8	9	2	1
Q3,21/22	486	54	337	74	9	10	1	1
Q4,21/22	379	43	243	73	12	5	2	1
Q1,22/23	423	44	285	76	10	5	1	2

Table 7: Re-opened Complaints by Hospital/MCS/LCO Q1 2022/23

	Request for local resolution meeting	New questions raised as a result of information provided	Response did not address all issues	Dissatisfied with response	TOTAL
WTWA	2	1	5	7	15
MRI	2	2	6	12	22
SMH	0	3	3	4	10
CSS	0	1	1	3	5
RMCH	0	0	0	4	4
UDHM/MREH	0	0	0	4	4
Corporate	0	0	1	2	3
LCO	0	1	0	2	3
NMGH	0	0	0	6	6
Grand Total	**4**	**8**	**16**	**44**	**72**

Table 9: Care Opinion/NHS website postings by Hospital/ MCS / LCO in Q1 2022/23

Number of Postings received by Hospital/MCS/LCO/Corporate Service Q1 22/23			
Hospital/ MCS /LCO	**Positive**	**Negative**	**Mixed**
MRI	2	7	4
WTWA	8	4	0
CSS	1	0	1
Corporate	0	0	0
UHDM/MREH	1	1	0
LCO	0	1	0
RMCH	0	0	0
SMH	4	2	0
NMGH	2	3	1
Grand Total	**18 (43%)**	**18 (43%)**	**6 (14%)**

Table 12: Closure of PALS concerns within timeframe Q1 2021/22 – Q1, 2022/23

	Q1,20/21	Q2,20/21	Q3,21/22	Q4,21/22	Q1,22/23
Resolved in 0-10 days	1595	1711	1710	1790	1906
Resolved in 11+ days	184	249	213	179	202
% Resolved in 10 working days	**89.7%**	**87.3%**	**88.9%**	**90.9%**	**90.4%**

Table 13: Number of PALS concerns taking longer than 10 days to close by Hospital/MCS/LCO Q1 2021/22 – Q1, 2022/23

	Q1,20/21	Q2,21/22	Q3,21/22	Q4,21/22	Q1,22/23
WTWA	35	57	44	36	56
MRI	35	67	75	44	53
RMCH	20	17	32	25	13
UDHM/MREH	15	12	2	0	8
SMH	31	40	23	39	30
CSS	10	15	11	16	16
Corporate	21	11	10	8	14
LCO	2	6	3	6	1
R&I	0	0	0	0	0
NNW	0	0	0	0	0
NMGH	15	24	13	5	11
Grand Total	**184**	**249**	**213**	**179**	**202**

Table 14: Number of PALS concerns escalated to formal investigation Q1 2021/22 – Q1 2022/23

	Q1,20/21	Q2,21/22	Q3,21/22	Q4,21/22	Q1,22/23
No of cases escalated	20	26	22	12	10

Table 15: Equality and Diversity Monitoring Information

Disability	Q1,21/22	Q2,21/22	Q3,21/22	Q4,21/22	Q1,22/23
Yes	26	28	24	34	27
No	8	12	15	16	14
Not Disclosed	378	400	344	377	393
Total	**412**	**441**	**384**	**427**	**434**
Disability Type					
Learning Difficulty/Disability	0	1	0	2	1
Long-Standing Illness or Health Condition	16	19	10	28	11
Mental Health Condition	6	5	6	9	4
No Disability	0	0	0	0	0
Other Disability	5	4	4	2	0
Physical Disability	1	5	1	8	5
Sensory Impairment	2	2	1	2	0
Not Disclosed	382	405	362	376	413
Total	**412**	**441**	**384**	**427**	**434**
Gender					
Man (Inc Trans Man)	147	169	151	175	185
Woman (Inc Trans Woman)	255	269	229	246	248

Non-Binary	0	0	0	0	0
Other Gender	0	1	0	0	0
Not Specified	9	2	4	6	1
Not Disclosed	1	0	0	0	0
Total	**412**	**441**	**384**	**427**	**434**
Sexual Orientation					
Heterosexual	75	96	63	92	51
Lesbian / Gay/Bi-sexual	4	4	1	3	10
Other	0	0	0	0	2
Do not wish to answer	3	3	4	9	8
Not disclosed	330	338	316	323	363
Total	**412**	**441**	**384**	**427**	**434**
Religion/Belief					
Buddhist	0	0	0	0	
Christianity (All Denominations)	48	51	44	64	42
Do Not Wish to Answer	0	4	4	12	5
Muslim	5	8	10	8	5
No Religion	25	38	20	40	40
Other	0	1	0	4	2
Sikh	1	0	0	0	0
Jewish	3	1	3	0	0
Hindu	0	0	1	0	3
Not disclosed	330	337	301	298	337
Humanism	0	0	1	1	0
Paganism	0	1	0	0	0
Total	**412**	**441**	**384**	**427**	**434**
Ethnic Group					
Asian Or Asian British - Bangladeshi	1	1	3	1	1
Asian Or Asian British - Indian	6	2	3	1	4
Asian Or Asian British - Other Asian	3	7	3	3	5
Asian Or Asian British - Pakistani	3	10	7	6	7
Black or Black British – Black African	6	3	7	4	9
Black or Black British – Black Caribbean	0	2	6	6	10
Black or Black British – other Black	1	0	3	3	4
Chinese Or Other Ethnic Group - Chinese	0	1	1	1	0
Mixed - Other Mixed	0	2	2	4	2
Mixed - White & Asian	2	0	0	2	0
Mixed - White and Black African	0	1	1	3	0
Mixed - White and Black Caribbean	1	1	1	0	0
Not Stated	79	92	98	93	86
Other Ethnic Category - Other Ethnic	5	2	0	10	5
White - British	160	145	104	148	139

White - Irish	5	9	4	9	2
White - Other White	2	4	12	7	8
Not disclosed	138	159	129	126	152
Total	**412**	**441**	**384**	**427**	**434**

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Dr Sarah Vause Medical Director Saint Mary's MCS Mrs Kathryn Murphy, Director of Nursing and Midwifery, Saint Mary's MCS
Date of paper:	September 2022
Subject:	Maternity Services Assurance Report, incorporating the Ockenden Report assurance framework and Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Safety Action 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:	Excels in quality, safety, patient experience, research, innovation, and teaching To improve patient safety, clinical quality, and outcomes To improve the experience of patients, carers, and their families
Recommendations:	The Board of Directors are asked to note: • The Immediate and Essential Actions from the independent review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust – the Ockenden Reports • The work in place to ensure the safety of women and babies in Saint Mary's Managed Clinical Service (MCS) The Board of Directors are asked to approve: • The recommendations within Saint Mary's MCS Report in relation to Maternity Continuity of Carer.
Contact:	Name: Alison Haughton, Acting CEO, Saint Mary's MCS Tel: 0161 276 6124

1. Executive Summary

1.1. In line with current reporting framework this paper provides:

- An update on progress of actions identified to be compliant with the Final Report of the Ockenden Review[1] published on 30th March 2022, and
- Assurance to the Board of Directors on matters relating to patient safety within maternity services, compliance with the recently updated Year 4 Maternity Incentive Scheme[2], themes identified from clinical incidents, shared learning and monitoring of actions.

1.2. As reported to the Board of Directors in July 2022, the second and final Ockenden Report identified a further 15 Immediate and Essential Actions (IEAs) which all providers must implement and report their compliance. A date by which compliance must be achieved is yet to be set by NHS England.

1.3. Saint Mary's Managed Clinical Service (SM MCS) continue to monitor progress against the 15 IEAs each month and report this to Saint Mary's Quality and Safety Committee (SM QSC) and Group Quality and Safety Committee. Currently compliance with the IEAs is 70%, which is an increase of 5% since reporting to the Board of Directors in July 2022. It is expected that all provider actions will be completed by December 2022.

1.4. Regional Assurance visits regarding actions taken from the IEAs of the Ockenden report[3] take place during August and September 2022.

1.5. Between 1st June 2022 and 31st July 2022 there were 2751 births across Saint Mary's MCS.

1.6. Saint Mary's MCS Maternity Division reported 1333 incidents between 1st June 2022 to 31st July 2022. All incidents were reviewed through robust governance processes

- 95% (1265) were validated as no harm
- 4.5% (61) were validated as slight harm
- <0.5% (7) were validated as moderate harm or above

1.7. Of the 7 moderate harm or above, 5 cases did not highlight any themes and there were no similar incidents within the preceding 12 months. Incident data shows recurrent themes with 2 cases which have occurred previously in the last 12 months There is an ongoing programme of work to support education on Antenatal CTG interpretation, including recognition of deterioration and escalation to senior members of the maternity team. The progress of these actions is being monitored via divisional Site Obstetric Quality and Safety (SOQS) monthly meetings which will be shared with SM QSC.

1.8. Since the pause of Maternity Incentive Scheme (MIS) Year 4 reporting in December 2021, Saint Mary's MCS have continued to work through the 10 Safety Actions and are currently compliant with 7 and will be fully compliant with all 10 by end of October 2022.

1.9. Challenges remain in achieving compliance with Safety Action 8 of the Maternity Incentive Scheme (MIS) Year 4. MDT training compliance weekly monitoring meetings have been organised by the maternity division to address this.

[1] https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf
[2] https://resolution.nhs.uk/wp-content/uploads/2022/05/MIS-year-4-relaunch-guidance-May-2022-converted.pdf
[3] https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf

1.10. Evidence of compliance is required to be submitted for approval to the Board of Directors in November 2022 against all Year 4 MIS Safety Actions.

1.11. As previously reported to the Board of Directors in July 2022, a review of the governance and reporting arrangements has been commissioned by the SMH MCS leadership team in recognition of the volume of reporting required to assure the Board of Directors on maternity safety. An initial SM MCS Governance statement has been provided in appendix 4 regarding what the review aims to achieve.

1.12. The Board of Directors are asked to note the work ongoing to ensure the safety of women and babies across Saint Mary's MCS and to approve the following recommendations:

- The recommendations within Saint Mary's MCS Report in relation to Maternity Continuity of Carer by supporting the decision to suspend a further 1 MCoC team until such a time that recruitment to vacancies has been achieved to safely support 24/7 MCoC provision.

1. Ockenden Reports Update

1.1. The Board of Directors have received updates relating to Donna Ockenden's first report covering emerging themes [4], on four occasions during 2021 along with updates in January, March, May and July 2022.

1.2. As reported to the Board of Directors in July 2022, Northwest Regional Assurance visits on behalf of NHS England were in planned for the end of August 2022. In preparation for the visits Saint Mary's MCS provided evidence on specified metrics within the 7 IEAs and uploaded these onto the NHS Futures online platform which each document quality assured through Saint Mary's MCS governance team prior to uploading.

1.3. The assurance visits by the Northwest Regional Maternity Team (inclusive of GMEC LMNS, Health Innovation Manchester, service users and North West Regional Maternity Office) are planned for 24th – 26th August across the 3 maternity sites of SM MCS. The purpose of the visits is to review progress against the actions taken from the IEAs of the Ockenden report[5].

1.4. The Final Ockenden report[6], published in March 2022 identified 15 IEAs which were in addition to the previous 7 IEAs from the initial report.

1.5. Saint Mary's MCS have identified areas of compliance, areas which require additional action to be compliant, and areas where external bodies (such as NHS England & Improvement, Royal Colleges, Health Education England, Local Maternity and Neonatal Systems) are required to address.

1.6. Of the 15 IEAs there are 97 separate elements against which maternity providers must achieve compliance. An action plan has been created to address areas of non-compliance for SM MCS, with all provider led actions on target to be completed by December 2022. .

1.7. Of these 97 elements, as of 11th August 2022, 68 elements are compliant, which is an increase of 4 since reporting to the Board of Directors in July 2022. There remain 12 elements which require external input and 1 related to neonatal medical staffing which remains non-compliant. Overall compliance is 70%.

1.8. Saint Mary's MCS are fully compliant with IEAs 4, 8 and 13 and partially compliant for the other 12 IEA's. Areas of focus for include:

- Recruitment and Retention – working to address current vacancies within both maternity and neonatal workforce
- Training - ensuring that all relevant staff receive maternity specific training and remain in date.
- Learning from incidents – sharing and learning regarding triage pathways
- Listening – Both to workforce by undertaking a new culture survey, and to women through commencing '15 steps walkarounds' across all 3 sites with families, commissioners, Non-Executive Director and Maternity Safety Champions

[4] https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf

[5] https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf

[6] https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf

1.9. As per Saint Mary's MCS extended governance framework, the progress of the detailed action plan is monitored via the Maternity Divisional Quality and Safety Committee, with onward reporting to both Saint Mary's MCS Quality and Safety Committee, Group Quality and Safety Board and the Board of Directors bi-monthly via the Maternity Assurance report. The action plan will also be shared with Greater Manchester and Eastern Cheshire Local Maternity and Neonatal System (GMEC LMNS) as part of the wider perinatal quality surveillance framework.

2. Maternity Self-Assessment Tool (MSAT)

2.1. Saint Mary's MCS shared the completed maternity safety self-assessment tool (MSAT) review with the Board of Directors in May 2022, where it was noted that the MSAT is also part of an IEA within the final Ockenden Report[7]

2.2. As of 11th August 2022, of the 168 elements for Saint Mary's MCS:

- 155 elements are compliant with all evidence collated. This is an increase of 3 since reporting to the Board of Directors in July 2022.
- 11 elements are in progress and awaiting evidence: an action plan is in place to monitor progress
- 2 elements require evidence from GMEC LMNS: no further update has been provided.

2.3. The action plan is being monitored through the Saint Mary's MCS governance process as described in 1.10.

3. Patient Safety

3.1. During the period of this report, 1st June 2022 to 31st July 2022, there were 2751 births across Saint Mary's MCS.

3.2. The following section of this report relates to incident management, aligned to the Saint Mary's MCS Assurance Oversight Framework (AOF), with particular focus on those where harm has been caused and includes details relating to maternal deaths and neonatal brain injuries.

3.3. As previously reported to the Board of Directors, governance processes are in place within Saint Mary's MCS where assurance in respect of patient safety is obtained. This includes external reviews of all incidents classified as moderate and above that are reported to GMEC LMNS Patient Safety Special Interest Group.

3.4. As previously reported to the Board of Directors in July 2022, Saint Mary's MCS completes a quarterly Perinatal Mortality Review (PMR) Report which provides a full review of stillbirths and neonatal deaths and includes identified themes, areas for learning and monitoring of actions. The Q1 2022/2023 PMR report has been completed and did not identify any themes but did identify areas for learning with actions being monitored within Saint Mary's MCS Maternity Division. The report will be presented in September 2022 to the Board of Directors meeting held in private to maintain confidentiality where sensitive details may be identifiable.

3.5. Table 1 illustrates incidents reported in June and July 2022. In line with the perinatal surveillance model, Saint Mary's MCS Maternity Division monitor maternity data monthly via

[7] https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf

the Maternity Score Card (see Appendix 1) which tracks incident reporting data throughout the year.

Incidents	June 2022		July 2022	
	Number	%	Number	%
No harm	595	94.4	670	95.3
Slight harm	31	4.9	30	4.3
Moderate	2	0.32	2	0.29
Major	2	0.32	1	0.14
Catastrophic	0	0	0	0
Total Incidents	**630**		**703**	

Table 1 Reported incidents June and July 2022

3.6. In June and July 2022, a total of 7 cases were reported in the moderate, major, or catastrophic harm category:

- 3 cases were referred to the Healthcare Safety Investigation Branch (HSIB). Please see 3.8 below for further details.

- Of the remaining 4 clinical incidents:
  - 1 case was related to delayed recognition of a maternal bowel injury requiring surgery – major harm
  - 1 case related to delayed recognition of a deteriorating condition following admission with a secondary postpartum haemorrhage – moderate harm
  - 1 case was related to delayed recognition and management of an abnormal antenatal CTG – moderate harm
  - 1 case related to a baby with jaundice who was readmitted from home and required an exchange transfusion[8] – major harm

3.7. Of the 7 moderate harm or above, 5 cases did not highlight any themes and there were no similar incidents within the preceding 12 months. Incident data shows recurrent themes with the following 2 cases which have occurred previously in the last 12 months:

3.7.1. One case related to delayed recognition of abnormal antenatal CTGs. There is an ongoing programme of work to support education, recognition and escalation to senior members of the maternity team. The progress of these actions is being monitored via divisional Site Obstetric Quality and Safety (SOQS) monthly meetings.

3.7.2. One case related to the delayed recognition of a deteriorating patient. The lack of recognition and management of the deteriorating patient has been identified in incidents previously and additional education has been provided to all staff across the MCS with monthly audits being undertaken by the Ward Managers. Audits are monitored via matrons and updates of compliance provided to SOQS.

3.8. Other learning identified included the recognition and management of jaundice for babies with all skin tones. The clinical team have provided educational updates to staff which included the need to obtain a blood sample when an error reading is noted when using a bilirubinometer.

3.9. During June and July 2022, a total of 5 cases were referred to the Healthcare Safety Investigation Branch (HSIB) in line with national reporting, due to suspected hypoxic ischaemic

[8] Exchange transfusion (ET) is the removal of an infant's blood with high bilirubin levels and/or antibody-coated red blood cells (RBCs) and replacement with fresh donor blood.

encephalopathy, 2 cases were considered no harm, care was provided appropriately with no identified learning and 3 cases were reported in the moderate, major, or catastrophic harm category:

- 1 case related to a woman who was admitted to Delivery Suite with an abnormal CTG. The woman's membranes were artificially ruptured and the CTG deteriorated further. She was promptly transferred to theatre where her baby was born by category 1[9] caesarean section. The learning identified the need for further education for the management of antenatal CTG's and considering the full clinical picture (major harm)

- 1 case related to a woman who had chosen vaginal birth after a previous caesarean section. There was a lack of recognition of maternal risk factors (previous pre-term caesarean section) for a uterine rupture. The learning identified the importance of senior obstetric input for women choosing a vaginal birth after a previous caesarean section (moderate harm)

- 1 case related to a woman who was admitted for induction of labour due to raised blood pressure. There was a delay in escalating concerns with her clinical observations leading to a delay in transfer to Labour Ward. There is a programme of work supporting early identification and management of abnormal observations to ensure timely escalation and transfer to Labour Ward (moderate harm)

- 1 case related to a woman in labour who experienced a cord prolapse. The registrar responded to the emergency call bell due to a fetal bradycardia and the baby was born 14 minutes later by category 1 caesarean section. All care was appropriate, and no learning identified (no harm)

- 1 case related to a woman who attended the maternity unit with vaginal bleeding. Observations and fetal monitoring were commenced. The fetal heart rate reduced to 70bpm and fresh blood loss was noted. The Consultant Obstetrician attended, and the woman was transferred to theatre where her baby was born 15 minutes later by category 1 caesarean section was performed. All care was appropriate, and no learning identified (no harm)

3.10. From April 2023, HSIB will separate into two different organisations. The Health Services Safety Investigations Body (HSSIB) and the Maternity and Newborn Safety Investigations Special Health Authority (MNSI). MNSI will carry on the work of the HSIB maternity programme conducting safety investigations into maternity incidents across England. It has been reported that the processes will remain the same and anticipate very little disruption to providers or families.

3.11. No maternal deaths occurred within Saint Mary's MCS in June or July 2022.

4. Maternity Incentive Scheme (MIS) Year 4

4.1. As previously reported in July 2022 to the Board of Directors, MIS Year 4 was relaunched on 6th May with a new submission date of 5th January 2023. To ensure timely Board of Directors approval, Saint Mary's MCS will submit evidence of compliance in November 2022.

4.2. Table 2 provides an overview of the Saint Mary's MCS current Year 4 MIS compliance.

[9] Category 1 caesarean birth is when there is immediate threat to the life of the woman or fetus and birth should occur within 30 minutes,

Safety Action	Indicator/ standard	Current position Aug 2022	Expected at submission
1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	Compliant	Compliant
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Working Towards	Compliant
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	Compliant	Compliant
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Compliant	Compliant
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Compliant	Compliant
6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?	Working towards	Compliant
7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?	Compliant	Compliant
8	Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multiprofessional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?	Working towards	Compliant
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Compliant	Compliant
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?	Compliant	Compliant

Table 2 Year 4 MIS compliance

4.3. Saint Mary's MCS currently meet all required standards for 7 of the 10 Safety Actions and as such request the Board of Directors to note and approve the detail shared in the appendices as part of ongoing external reporting.

4.4. It was reported to the Board of Directors in July 2022 that Saint Mary's MCS were compliant with 8 of the 10 Safety Actions. This reduction relates to a standalone maternity digital strategy being required and is an amendment to the MIS Year 4 Safety Action 2 criteria.

4.5. At this point in the reporting cycle set out for Year 4 MIS, Saint Mary's MCS are required to submit actions and updates to the Board of Directors for the following Safety Actions:

- Safety Action 2 – Maternity Services Dataset

- Safety Action 5 – Maternity bi-annual safe staffing paper
- Safety Action 6 – Compliance with the 5 elements of Saving Babies' Lives Care Bundle version 2
- Safety Action 8 – Training
- Safety Action 9 – Safety Champions and Midwifery Continuity of Carer

5. Safety Action 2 – Maternity Services Dataset

5.1. Currently SM MCS are submitting data to the Maternity Services Data Set (MSDS) to the required standard.

5.2. In June 2022, further clarity was sought from NHS Resolution following a new request within the relaunched MIS Year 4 guidance regarding a maternity digital strategy. It was expected that the maternity digital strategy would be part of the overall group digital strategy and awaited confirmation.

5.3. In July 2022, NHS Resolution confirmed that the expectation of the strategy was to be standalone and align with the Trust strategy but not be within it. As such, SM MCS are not currently compliant with the overall standards within Safety Action 2.

5.4. Work is now underway with support from Group Informatics to ensure that the maternity digital strategy is aligned with the proposed Group Digital Strategy.

5.5. It is expected that this will be completed by September and ratified at SM MCS Management Board in October 2022.

5.6. Compliance with the digital maternity strategy within Safety Action 2 of the Maternity Incentive Scheme Year 4 is expected to be achieved by the end of October and included within the November MIS Year 4 compliance report to the Board of Directors.

6. Safety Action 5 – Midwifery Staffing

6.1. In July 2022, Saint Mary's MCS midwifery vacancy was **75 WTE** across 3 maternity sites. There are **97.5 WTE** posts in offer which are expected to be in post between September and November 2022.

6.2. A review of the midwifery workforce is submitted to the Board of Directors every six months as an embedded process to provide assurance on midwifery staffing. The last submission was in March 2022.

6.3. Work remains ongoing to increase recruitment and address vacancies, details of which are provided in the September 2022 bi-annual Nursing and Midwifery workforce report (Appendix 3).

7. Safety Action 6 – Saving Babies Lives Care Bundle version 2

7.1. Saint Mary's MCS, as part of 2020/2021 standard contract, and in line with best available evidence to reduce perinatal mortality, has fully implemented each of the 5 elements within version 2 of the Saving Babies Lives Care Bundle (SBLCB)[10].

[10] https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf

7.2. It is expected that Saint Mary's MCS will achieve compliance at the time of submission and will continue to provide an update to Saint Mary's MCS Quality and Safety Committee and the Board of Directors

7.3. **Element 1 - Smoking Cessation and CO measurement**

7.3.1. To meet year 4 MIS Safety Action 6 element 1, it is required for at least 80% of women to have a Carbon Monoxide (CO) measurement recorded at their booking appointment and again when they attend their appointment at 36 weeks gestation. Compliance has been monitored monthly at site specific quality and safety meetings.

7.3.2. Table 3 provides quarterly progress of CO measurement at the woman's booking appointment.

	Overall
Quarter 1 21/22	72%
Quarter 2 21/22	85.8%
Quarter 3 21/22	90.7%
Quarter 4 21/22	94%
Quarter 1 22/23	93%

Table 3 CO Booking compliance

7.3.3. SM MCS continue to meet the required standard for CO measurement at booking and continues to monitor compliance monthly via Maternity Services Divisional Quality and Safety Committee.

7.3.4. Table 4 provides quarterly compliance of CO measurement at 36 weeks.

	Overall
Quarter 1 21/22	20.8%
Quarter 2 21/22	36.5%
Quarter 3 21/22	59.4%
Quarter 4 21/22	76%
Quarter 1 22/23	80%

Table 4 CO 36/40 compliance

7.3.5. SM MCS now meet the expected standard for Element 1.

7.3.6. Further monitoring and scrutiny of monthly progress continues to be applied at the Maternity Services Divisional Quality and Safety Committee.

7.4. **Element 2 – Fetal Growth Restriction (FGR)**

7.4.1. To reduce the risk of stillbirth and meet year 4 MIS Safety Action 6 element 2, Saint Mary's MCS are required to identify and record each woman's risk status for having a growth restricted fetus at booking.

7.4.2. Saint Mary's MCS meet the expected standard with over 90% across all three maternity sites.

7.5. Element 3 – Reduced Fetal Movements

7.5.1. As previously reported to the Board of Directors, Saint Mary's MCS are compliant with both requirements for this element.

7.6. Element 4 – Fetal Monitoring

7.6.1. To improve fetal outcomes by providing training in fetal monitoring and to meet Year 4 MIS Safety Action 6 element 4, Saint Mary's MCS are required to have a dedicated lead Midwife for Fetal Monitoring and lead Obstetrician for Fetal Monitoring per maternity site. Saint Mary's MCS 3 maternity sites are compliant with this element.

7.6.2. In addition, in line with Safety Action 8, Saint Mary's MCS are required to have 90% of eligible staff attend multi-professional fetal monitoring training annually.

7.6.3. Saint Mary's MCS currently do not meet the required standard for element 4. Further information on training compliance and actions are provided in section 8.

7.7. Element 5 – Preterm Birth

7.7.1. To improve neonatal outcomes and meet year 4 MIS Safety Action 6 element 5, Saint Mary's MCS must ensure that women who birth before 34 weeks gestation receive a full course of antenatal corticosteroids within 7 days of birth.

7.7.2. In addition, magnesium sulphate which improves neonatal neurological outcome must be given within 24 hours prior to birth for women who birth before 30 weeks gestation.

7.7.3. Saint Mary's MCS continue to be compliant with this element.

7.7.4. It is expected that Saint Mary's MCS will be compliant at time of submission and will continue to provide a quarterly update to Saint Mary's MCS Quality and Safety Committee and the Board of Directors.

8. Safety Action 8 – Training

8.1. Safety Action 8 expects that 90% of all relevant staff groups (identified in Table 5-8) must have received maternity specific training prior to submission of Year 4 MIS.

Staff Group	Oxford Road	North Manchester	Wythenshawe
Anaesthetic Consultants	91%	78%	93%
Anaesthetic Trainees	75%	55%	100%
Obstetric Consultants	79.3%	94%	93.75%
Obstetric Trainees	81.25%	12%	93.94%
Midwives	93.5%	91%	92.92%
Maternity Support Workers	85.96%	93%	90.32%

Table 5 Multidisciplinary Emergency Training (%) at 18th Aug 2022.

Staff Group	Oxford Road	North Manchester	Wythenshawe
Midwives	96%	95%	97.17%
Obstetric Consultants	86%	94%	93.75%
Obstetric Trainees	85%	92%	51.52%

Table 6 Fetal Monitoring Compliance (%) (either face to face or virtual training) at 18th Aug 2022

Staff Group	Oxford Road	North Manchester	Wythenshawe
Midwives	90%	90%	94%
Neonatal or Paediatric Consultants*	94%	73%	100%
Neonatal junior doctors/trainees**	100%	13%	57%
ANNP's	92%	100%	95%
Neonatal Nurses	99%	100%	95%

*Neonatal or Paediatric Consultants covering Neonatal units **Table 7** Neonatal Resuscitation (%) at the end of July 2022

**Neonatal junior doctors who attend births

Staff Group	Oxford Road	North Manchester	Wythenshawe
Midwives	97%	87%	88.68%

Table 8 CTG Machine Training at the end of July 2022

8.2. Saint Mary's MCS acknowledges that current training compliance for some staff groups remains below the required standard. Whilst areas of lower compliance were escalated to relevant divisional leads significant improvement in certain staff groups is yet to be seen.

8.3. A weekly meeting to monitor training compliance with relevant staff group representatives will commence from 15th August 2022. Leads for Obstetrics, Maternity, Neonates and Anaesthetics have all been made aware of the current compliance and action required.

8.4. Training compliance concerns have been escalated to Saint Mary's MCS Maternity Services Divisional Quality and Safety Committee to support appropriate scrutiny and ensure that training remains a focus for all relevant staff groups.

9. Safety Action 9

9.1. Safety Champions

9.1.1. To achieve compliance with Year 4 MIS safety action 9, Saint Mary's MCS are required to have robust processes which provide assurance to the Board of Directors on maternity and neonatal quality and safety issues.

9.1.2. As reported to the Board of Directors previously, Saint Mary's MCS met the required standard and have site based frontline maternity, neonatal and obstetric safety champions who undertake monthly 'feedback/staff walkaround sessions' with executive and non-executive safety champions.

9.1.3. Staff feedback regarding safety concerns are addressed promptly and progress is communicated to the teams bi-monthly using safety huddles and safety notice boards. (please see Appendix 2).

9.1.4. Site based frontline maternity, neonatal and obstetric safety champions have supported the clinical team across maternity and neonates to attend the MatNeoSiP quality improvement work stream, which for 2022 is focused on optimisation of the pre-term infant. A report on the project, along progress, timescales and expected outcomes will be provided to Divisional Quality and Safety Committee in August 2022. An update on this work will be included in the November bi-monthly Maternity Assurance report to the Board of Directors.

9.1.5. Following the relaunch of MIS Year 4 there was an amendment to the requirements for Board Level Safety Champions. It is required that bi-monthly engagement sessions are undertaken by a member of the board across each of the 3 maternity sites.

9.1.6. In June, engagement sessions by SM MCS Board members took place on both North Manchester and Oxford Road sites. Unfortunately, due to sickness an engagement session by a member of the board did not take place on the Wythenshawe site.

9.1.7. To ensure feedback is heard from ward to board, engagement sessions with the non-executive director maternity safety champion across all 3 maternity sites are planned to take place throughout August 2022 and every 2 months going forwards. On these engagement sessions, discussions will be documented and actions along with progress will be captured within the bi-monthly Maternity Assurance report from November 2022 onwards.

9.1.8. As required by MIS Year 4 safety action 9, this assurance paper is presented to the Board of Directors by the Board Safety Champion and highlights incidents reported as serious harm (Section 3); staff feedback (9.1.3); maternity staffing (section 6); and staff training compliance (section 8).

9.2. **Midwifery Continuity of Carer**

9.2.1. In line with Year 4 MIS Safety Action 9 requirements, Saint Mary's MCS provided assurance to the Board of Directors on the progress and plans relating to the national ambition to achieve Midwifery Continuity of Carer (MCoC)[11] as the default maternity offer by March 2023.

9.2.2. In July 2022, Saint Mary's MCS reported to the Board of Directors that progress on the current MCoC action plan has been paused and following risk assessment of the existing MCoC teams, 5 of the 7 teams would be suspended until such a time that midwifery staffing could safely support the reinstatement and continuation of the MCoC action plan. The risk assessment would be reviewed every 3 months.

[11] NHS England and NHS Improvement, (2021). Delivering Midwifery Continuity of Carer at Full Scale: Guidance on planning, implementation and monitoring 2021/22

9.2.3. The Saint Mary's MCS submitted to the Board of Directors a phased approach MCoC action plan which is projected to be achieved by Q3 2027/2028. This approach aims to ensure safety and stability of the maternity service during a period of transformational change in delivering maternity care however will not meet the current NHS England ambition to offer MCoC as a default model of care by March 2024.

9.2.4. An updated staffing risk assessment for MCoC teams has been completed in August 2022 and has indicated an increased risk to sustain 1 of the current 2 MCoC teams in place within Saint Mary's MCS. This is due to midwifery vacancies in the team making 24/7 MCoC provision not possible. The risk assessment has been approved within SM MCS Maternity Division. The risk assessment will be reviewed again in 3 months.

9.2.5. As reported in July 2022 maternity assurance report, it is the expectation from NHS England that decisions to suspend any MCoC teams must be approved by the Board of Directors.

9.2.6. Saint Mary's MCS request the Board of Directors approve the recommendation to suspend 1 MCoC team until such a time that vacancies within Saint Mary's MCS current midwifery establishment have been recruited to. This is expected to be in Quarter 3 2022/2023.

10. Recommendations

10.1. It is recommended that the Board of Directors:

- note the information provided in this report in relation to:
  - The Immediate and Essential Actions from the independent review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust – the Ockenden Reports
  - the work in place to ensure the safety of women and babies in Saint Mary's Managed Clinical Service (MCS)
- approve:
  - The recommendations within Saint Mary's MCS Report in relation to Maternity Continuity of Carer. Supporting the decision to suspend a further 1 MCoC team
- Note the work in progress to strengthen compliance and support learning and assurance in relation to maternity safety

Appendix 1 : SM MCS inhouse scorecard for perinatal clinical quality

CQC Maternity Ratings March 2019	Overall	Safe	Effective	Caring	Responsive	Well Led
	Good	Good	Good	Outstanding	Good	Good

Staff survey	
Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment (reported annually)	79.1
Proportion of specialty trainees in O&G with 'excellent' or 'good' on how they would rate the quality of clinical supervision out of hours (reported annually)	83.7

Summary

- The data is validated each month and shared via the Q&SC process; this report contains the data for June
- Maternity incidents are reported separately via the governance reports presented at Q&SC
- Exception report details are below
- All HSIB referrals are reviewed by MDT to identify lessons learnt and mitigate any risks

Major PPH > 2.5litres	Term admissions to NNU	Stillbirths
• Incidents monitored monthly • Major PPH quality improvement work undertaken • Lessons learnt shared across the MCS	• All term admissions reviewed to identify if the admission was avoidable and identify lessons learnt • MatNeo quality improvement programme in progress to reduce term admissions	• Perinatal Mortality Review Tool used to complete MDT review for all stillbirths • All stillbirths are incident reported and reviewed by the MDT to identify lessons learnt

							GMEC monthly average (Jun 22)	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sept-22	Jan-22	Feb-22	Mar-22
Perinatal	1:1 care in labour						Percent	93.66	99.22	98.75	96.80	97.04	94.7	98.89						

	3rd/4th degree tears	Percent	2.87	1.91	1.44	1.54	1.87	1.32	1.37					
	Obstetric haemorrhage > 2.5L	Rate per 1000	3.31	0.38	5.6	5.16	0.74	0.44	0.53					
	Term admissions to NNU	Rate per 1000	41.67	63.38	57.79	53.23	54.52	49.15	53.48					
	Apgar score<7 at 5 minutes (term babies)	Rate per 1000	11.37	8.61	11.38	9.68	4.88	12.89	9.34					
	Stillbirth number	Rate per 1000	3.02	4.96	4.96	3.64	5.18	2.16	5.26					
	Neonatal Deaths	Rate per 1000	2.52	2.13	2.13	2.19	1.48	5.05	2.25					
Patient Experience	Number of formal compliments	Number	3	2	1	5	1	11						
	Number of formal complaints	Number	11	6	15	8	9	7						
	Complaint response on time	Percent	-	-	-	-	-							
	Maternity Unit diverts	Number	0	0	0	0	0	0	0					
Training	Emergency skills and drills	Percent of staff trained	73.5	79.4	74.18	79.52	79.79	83.25	83.99					
	CTG training	Percent of staff trained	90.7	85.8	81.6	85.4	85.26	93.56	92.66					
	CTG competency assessment	Percent of staff assessed	87.4	67.2	66.05	62.1	60.3	59.72	58.66					
Coroner Reg 28 made directly to the Trust			No	No	No	No	No	No	No					
HSIB/ CQC concern or request for action			No	No	No	No	No	No	No					
StEIS reported incidents			1	5	3	5	5	3	4					
Incidents with moderate harm or above			1	3	2	3	3	4	3					
HSIB referrals			1	4	2	4	4	2	3					

Appendix 2
Staff Feedback

Feedback from Safety Walkarounds across Saint Mary's MCS
August 2022

NHS Manchester University NHS Foundation Trust

Key Themes

Staff safety drop-in sessions have been provided monthly since March 2019. These sessions provide the opportunity for staff to raise any safety concerns that they have with Clinical Leads

These sessions are now provided across the MCS. Below are some of the responses to concerns raised on all three sites.

Since January 2022 we have had a total of 117 concerns raised at the drop-in sessions. Of these, 78 have been resolved, which is 66.6%.

The concerns raised cover a variety of subjects; however key themes that have emerged relate to Equipment (48%), Staffing (37%) and Clinical concerns (12%).

Who are your safety champions?

- Clinical Head of Division Professor Ed Johnstone
- Head of Midwifery Wythenshawe Sarah Owen
- Head of Midwifery Oxford Road Bev O Connor
- Head of Midwifery North Manchester Esme Booth
- Director of Nursing and Midwifery Kathy Murphy
- Medical Director Sarah Vause
- Non-Executive Director/Maternity Safety Board Champion Chris McLoughlin
- Chief Nurse/Maternity Executive Board Safety Champion Cheryl Lenney

In the absence of a safety champion, either the site-based lead or deputy will attend.

YOU SAID	WE DID
There is concern in all areas at North Manchester about midwifery staffing issues.	A poster is produced on a bi-monthly basis to provide an update on the work being done to support staffing.
There is a shortage of breast pumps on ward 66 at Oxford Road campus.	Small Change, Big Difference form completed.
Limited pulse oximeters on the Dawes Redman machines in Triage at Wythenshawe.	These have been ordered and we are awaiting delivery.

Safety walkarounds occur every month across each maternity site for anyone to raise concerns. Please note, should you wish to raise a concern you can email staffsafetydrop-in@mft.nhs.uk at any time. The safety champions look forward to seeing you on the next walkaround.

Appendix 3 – Bi-Annual Nursing and Midwifery Staffing Report

Report of:	Kathryn Murphy, Director of Nursing and Midwifery
Paper prepared by:	Rachael Schollar, Head of Nursing Gynaecology Beverley O'Connor, Head of Midwifery, Oxford Road Esme Booth, Head of Midwifery North Manchester Kath Eaton, Head of Nursing, Newborn Services
Date of paper:	July 2022
Subject:	Safer Staffing
Purpose of Report:	Indicate which by ✓ Information to note ✓ Support Accept ✓ Resolution Approval ✓ Ratify
Purpose of Report:	To provide Saint Marys Hospital Management Board with the bi-annual Nursing and Midwifery Safer Staffing report
Consideration against the Trust's Vision & Values and Key Strategic Aims:	To improve patient safety, clinical quality and outcome Improve the experience of patients, carers and families To support productivity & Efficiency
Recommendations:	The SM HMB is requested to accept the report and approve Board declaration of compliance with MIS Safety Actions 4 & 5
Contact:	Name: Mrs Kathryn Murphy, Director of Nursing and Midwifery Tel: 0161 276 6623

1. Introduction

1.1 This bi-annual nursing and midwifery staffing report is provided to the Saint Mary's (SM) Hospital Management Board covering the period December 2021 to May 2022. The paper sets out the position of the Saint Mary's Managed Clinical Services (MCS), against the context of national professional staffing standards and the national nursing and midwifery challenges.

1.2. The impact of coronavirus (COVID-19) on the Nursing and Midwifery workforce continues to be a challenge with significant impact on staff health and wellbeing and on recruitment and retention.

1.3. SM MCS continues to attract and recruit staff across all the Divisions, recruiting nurses and midwives who are both newly qualified along with those who have experience. Nurses from both adult and child branches are recruited and typically 90% of recruits each year are newly qualified. Similarly, midwifery students from the pre and post registration pathways form the bulk of the midwifery recruitment. As such, the months January to September characteristically reflect the most difficult time for nursing and midwifery recruitment. Whilst June to September historically demonstrate the highest number of vacancies in the calendar year as newly qualified nurses and midwives graduate in September and take up their first posts throughout September to December.

1.4. Across all divisions 2022 has brought change to senior Nursing and Midwifery leadership which has been well supported by the continued commitment to development and growth of our potential leaders and rising stars.

1.5. 2022 has also seen the final stages of the integration of the Women and Children's division into the Managed Clinical Service model, following the overarching acquisition of North Manchester General Hospital which has required a focus to align on nursing and midwifery staffing .

1.6. In line with the NHS Long Term Plan, which promises five-year job guarantees for every nurse or midwife graduating in the region where they qualify, SM MCS, as part of the wider MFT offer, has supported job offers to all qualifying students in 2022 and intends to support this initiative moving forwards.

1.7. The strategic directions for strengthening nursing and midwifery across SM MCS builds on the attraction recruitment and retention work already commenced and continues to be driven in collaboration with SM MCS HR team.

1.8. This paper will inform the current position of staff in post across all Divisions as well as the SM nursing and midwifery forecast for all qualified staff to the end of December 2022.

2. Midwifery Service Workforce Position

2.1. In line with NHS Long term plan, Safe Maternity care is a key component with actions to achieve:

- 50% reduction in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025.

- full implementation of Saving Babies Lives Care Bundle
- implementation of Better Births recommendations

2.2. SM MCS Maternity division is committed to achieving the recommendations, acknowledging that this can only be achieved with a suitably trained, experienced and supported workforce.

2.3. To achieve this SM MCS Maternity division will focus on ensuring:

- The appropriate midwifery establishment for the current midwifery service using a national recognised staffing model
- Recruitment and Retention
- Monitoring of Red Flags for staffing and appropriate escalation, including evidence of supernumerary midwifery workforce compliance in accordance with Maternity Incentive Scheme Year 4.

Recommended midwifery establishment using recognised staffing model

2.4. With support from Greater Manchester and Eastern Cheshire Local Maternity System (GMEC LMS) Saint Mary's Managed Clinical Service workforce establishment was reviewed by Birth Rate plus (a recommended methodology for midwifery workforce planning) in March 2021.

2.5. This review identified a staffing gap of 17 WTE midwives against the current funded establishment and 24 WTE Maternity Support Workers (MSWs) (Table 1)

Table 1

Site	Birth Rate Plus March 2021	Gap against funded establishment RMs WTE March 2021	Gap against funded establishment MSWs WTE March 2021
North Manchester	172.07	0	0.52
Oxford Road	385.69	-16.15	-24.55
Wythenshawe	189.29	-0.67	0
Total	**747.05**	**-16.82**	**-24.03**

2.6. The establishment gap for 17 WTE midwives was addressed following support received from Ockenden NHS England funding in July 2021, however funding for MSW's was not available.

2.7. Table 2 provides the current maternity workforce establishments at the end of May 2022 for SM MCS.

Table 2

Site	Birth Rate	Current Establishment (WTE)	Gap between BR	Gap between BR

	Plus March 2021	May 2022	Plus and Current Establishment RMs	Plus and Current Establishment MSWs
North Manchester	172.07	180.32	8.25	0
Oxford Road	385.69	360.83	0.8	-24.06
Wythenshawe	189.29	214.31	25.02	0
Total	**747.05**	**755.46**	**34.07**	**-24.06**

2.8. Saint Mary's MCS has addressed the midwifery gaps identified in March 2021 and further skill mixing has supported an increase in midwifery posts across the 3 maternity sites. The majority of these posts sit within either non-clinical specialist or non-clinical leadership roles (such as Maternity Bleep Holders, Ward Managers, Matrons and Deputy Heads of Midwifery).

2.9. SM MCS acknowledge that there remains a staffing gap of 24 WTE MSW's which has yet to be closed.

2.10. In 2021 Manchester Foundation Trust (MFT) undertook a review the current roles of band 2 and 3 support workers to reflect appropriate renumeration of the work undertaken, and this included MSW's. The outcome of the review has led to a development package for current band 2 MSW's and new MSW's to complete which will support them in working at band 3 level.

2.11. It has not been possible to address the known band 3 MSW gap until the MFT review was completed in March 2022. Work is now underway within the division to review the band 3 MSW workforce gap and identify funding to support recruitment.

Changes in Birth Rate Plus modelling

2.12. Following the publication of the Final Ockenden Report on 31st March 2022 one of the Immediate and Essential Actions concerning workforce stipulates that each maternity provider should have their midwifery establishment calculated utilising Birth Rate Plus. A further review has been commissioned by Greater Manchester and Eastern Cheshire (GMEC) Local Maternity System (LMS) and is expected to commence Q3 2022/2023.

2.13. This new Birth Rate Plus review will now consider the increased activity on the Wythenshawe site following support of East Cheshire Trust who have been unable to facilitate an inpatient service since March 2020.In addition, the review will also focus on the increased midwifery workforce required to implement Midwifery Continuity of Carer as a default model. Current Workforce modelling, using a nationally recommended tool, has indicated that for SM MCS an additional 77 WTE midwives are required over the next 6 years.

2.14. The review will also provide an updated calculation of specialist midwives required on each maternity site, considering the increasing leadership roles now required as part of Ockenden

Immediate and Essential Actions and the impact on increasing specialist midwifery workforce to successfully sustain Saving Babies Lives Care Bundle version 2.

Midwifery Recruitment December 2021 – May 2022

2.15. Historically, SM MCS recruit to a predicted turnover which is calculated from local workforce intelligence and reflects 8.5 WTE midwives leaving, across the MCS, per month based on a 12-month average.

2.16. The midwifery vacancy at the end of May 2022 was 55 WTE. This is higher than in May 2021 and reflects the increase in midwifery establishment and challenges within midwifery recruitment nationally.

2.17. SM MCS maternity teams have utilised a number of strategies to support recruitment over the last 6 months. These include:

- Working with the corporate team supporting targeted recruitment campaigns
- Rolling job advertisements for both inpatient and community services
- Guaranteed job offers for all final year midwifery learners
- Representation at the site specific MFT open days
- SM MCS specific open day in May 2022
- A team of Band 7 Recruitment and Retention Specialist midwives with a particular focus on reducing attrition funded by NHS England/Improvement.
- Participation in a national International Midwifery Recruitment Campaign which remains in progress
- Working with Greater Manchester Higher Education Institutes to increase the capacity of future learning cohorts
- Attraction campaigns for experienced midwives and nurses demonstrating multiple career pathways including research fellows, Enhanced Clinical Practitioners and Advanced Clinical Practitioners.

2.18. Work commenced in Q1 to address these vacancies. This recruitment work is ongoing throughout 2022 and include:

- 58 Guaranteed Job Offers (GJO) made to final year midwifery learners.
- a projected pipeline of 25 domestic midwifery recruits
- a confirmed domestic pipeline of 2 domestic midwifery recruits

2.19. It is always aimed that the September recruitment of newly qualified midwives will fill both the actual vacancy factor and the expected turnover from September to the end of February. As such, the anticipated midwifery vacancy by September 2022 is 74.35 WTE.

2.20. Internal domestic recruitment this year is estimated to be 70 WTE midwives by Quarter 3 SM MCS, which does not enable recruitment to turn over across the MCS to February 2023.

2.21. Saint Mary's MCS, as part of wider GMEC LMS, continue to support international recruitment and expect 11 International Midwives in post by late 2022 which will help address the gap and support recruitment to turnover.

2.22. SM MCS, as part of a wider GM workstream, have increased midwifery training places each year over the last 3 years, however it is nationally acknowledged that the current number of students in training is insufficient to support the expanding requirements of the midwifery workforce and further work is required.

2.23. The Director of Nursing and Midwifery from SM MCS chairs the GM Education work stream for midwifery and Saint Mary's continues to work in partnership with the Greater Manchester Higher Education Institute's (GM HEI) to look at innovative ways to increase midwifery training capacity and attract students to train in GM and commence programmes of education in 2022/23.

Midwifery Retention

2.24. Over the last 6 months the reasons for midwives leaving, whilst similar to previous themes, have seen an increase related to midwives retiring due to changes in the NHS pension and moving closer to home post COVID19. There has also been an increase in midwives looking to move to smaller, less complex units and those who have requested career break to facilitate travelling abroad post pandemic.

2.25. In January 2022, following receipt of 6 months funding from NHS E/I, SM MCS commenced 3 recruitment and retention midwives in post. SM MCS were successful in securing additional funding, which will support this team to remain in post until April 2023 and address the reasons why midwives are leaving and aim to improve the retention rate within midwifery.

2.26. Saint Mary's MCS consists of a diverse workforce of multiple nationalities and cultures. Some of whom have been significantly affected by travel restrictions which has impacted on their health and wellbeing. They have been supported to travel with extended annual leave which clearly demonstrates our commitment to the 'Caring for You' campaign.

2.27. The Professional Midwifery Advocates have facilitated restorative supervision sessions for the midwifery workforce which have been rostered to support staff attending. RCS sessions have also continued to be offered to the student midwives in partnership with Manchester and Salford Universities.

2.28. Saint Mary's MCS have listened to staff and engaged with them through staff surveys, mentimeters and listening events. Feedback has been provided through the "You said We did" initiative which has focussed on equipment to support staff in their everyday work. Saint Mary's MCS has also been supported by Organisation, Training and Development team to gain further feedback from staff and formulate an action plan to support staff health and wellbeing.

2.29. New midwives have been supported before commencement of employment with keeping in touch sessions, meeting the teams and networking with other new employees both face to face and virtually.

2.30. SM MCS continue to experience challenges in recruiting to community midwifery teams and work is underway, supported by SM MCS Consultant Midwife, to understand the current issues and solutions to improve this

Maternity Escalation and monitoring of staffing

2.31. Within the Final Ockenden Report on 31st March 2022 there is an Immediate and Essential Action relating to appropriate escalation. Across the MCS there is a supernumerary Bleep Holder on duty 24 hours a day, 7 days a week who monitors and reviews unit status, acuity and flow, escalating as required in accordance with policy.

2.32. A midwifery staffing meeting is held twice weekly to address unexpected staffing absences, with staffing levels reported 3 times a day by the maternity bleep holder on all 3 sites. This report is circulated to managers, matrons, Heads of Midwifery and both Hospital and Board Level Maternity Safety champions. Activity and staffing is also reported to GMEC LMS once a day.

2.33. Out of hours, the Bleep Holder is supported by a senior midwife (Band 8a) on call and also a second-tier escalation on call rota of Band 8b and above. The on-call rota has been integrated across the MCS and the Bleep holder policy has been updated to include a standard operating procedure for all 3 maternity sites to follow should there be an issue which requires escalation. It is expected that this will be ratified in August 2022.

2.34. Where there are increases in demand and/or acuity, there is an SM MCS escalation policy in place which aligns to the Greater Manchester and East Cheshire Maternity Escalation Policy leading to a temporary closure of the unit and divert of activity to alternate providers.

Maternity 'Red Flags Events'

2.35. The midwifery Red Flag events are a combination of the NICE guidance NG4 recommended events and locally derived measures identified from serious incident investigations and are reported via the incident reporting system and these are reviewed in line with the MFT process for incident management.

2.36. A monthly workforce dashboard is maintained which reflects the maternity staffing and is reported each month via the SM MCS obstetric governance meetings.

2.37. During the 6-month period December 2021 to May 2022 there were 264 reported Red Flag Events reported. This was a decrease from 461 Red Flag Event incidents reported over the previous 6 months. This is consistent with previous years with historical data demonstrating lower incidence of red flags between December and May when compared to April to November.

2.38. Specific Reg Flag reports related to midwifery staffing are

- Redeployment of Midwifery Co-ordinator
- Unable to provide one-to-one care to women in active labour

2.39. During December 2021 to May 2022 there were no occasions when the designated supernumerary midwifery labour ward coordinator was redeployed to provide clinical care.

2.40. In the same time period, there were 7 Red Flag Events reported for inability to provide one-to-one care in active labour. 5 were appropriately escalated and resulted in the bleep holder being redeployed into clinical workforce, supported by on call matron attendance. The remaining 2 events relate to a delay in transfer from maternity triage to labour ward which were not appropriately escalated. These 2 incidents have been thoroughly reviewed and

work remains ongoing to support prompt transfer to labour ward and timely escalation when not possible.

2.41. All 7 Red Flag Events were reviewed and did not have any adverse clinical outcomes for the mothers and babies involved, however birth experience was negatively affected.

NHSP and Agency Workforce

2.42. To support the current workforce gap, enhanced NHSP rates, agency and overtime pay continue to be monitored on a weekly basis by the Heads of Midwifery and NHS Professionals.

2.43. NHSP in Saint Mary's MCS is staffed by Saint Mary's midwives and uptake of shifts has been between 25-30% despite support to maintain enhanced NHSP rates for midwives and overtime payment for full time staff.

2.44. Due to the ongoing staffing pressures felt both locally and nationally across maternity services Saint Mary's MCS have been supported to utilise Midwifery Agency Services supported by the Corporate Workforce team. The benefits have been limited and the main source of workforce cover remains NHSP. The senior midwifery team continue to meet with the MFT Trust workforce leads weekly exploring attraction strategies and monitoring the fill rates.

Summary

2.45. SM MCS Maternity Division has seen increased vacancy numbers during December 2021 to May 2022 and plans to address this however the challenge remains to ensure that we retain the staff recruited with the measures discussed within this paper.

2.46. SM MCS Maternity Division will monitor and prioritise midwifery workforce to ensure the maternity care is of the highest standard.

2.47. There remain challenges nationally in recruitment of the expanding future midwifery workforce and SM MCS will continue to work closely with both education and NHS England to support ongoing work to improve this.

3. Gynaecology Nursing Service Workforce Position

3.1. Since the pandemic the division of Gynaecology has undergone fundamental large-scale transformation and undertaken a huge recruitment drive to fill the nursing vacancy gaps as a result of the transformation programme which has included international recruited nurses and newly qualified students this work has been sustained throughout 2022

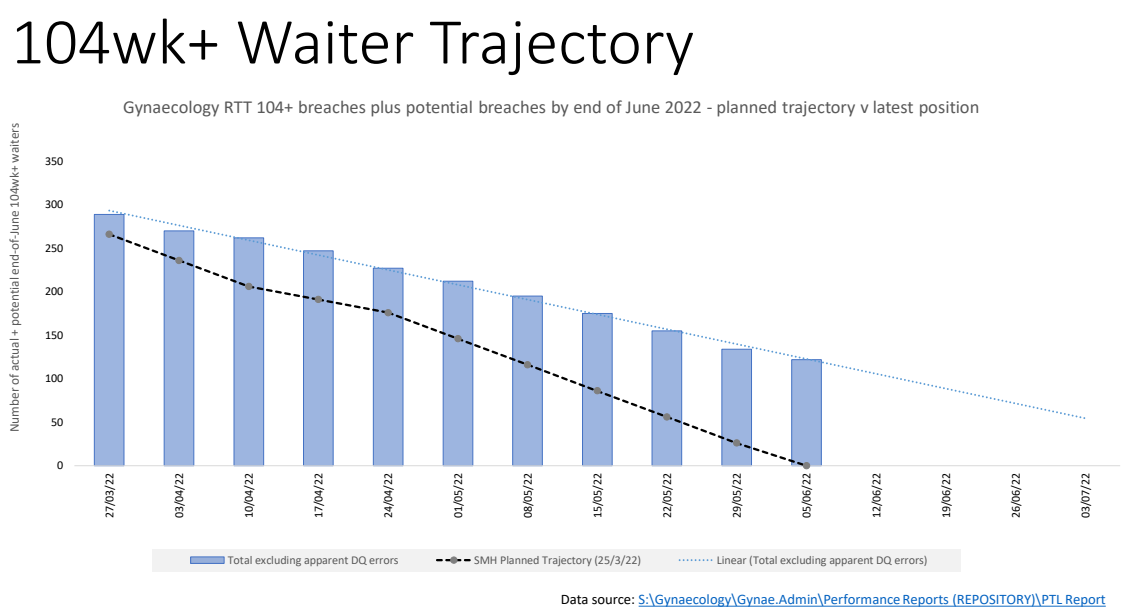
3.2. The Gynaecology 2022/23 strategic strategy document outline the divisions commitment to Develop Divisions \ Directorates and individual services with its purpose in mind.

- Actively engage patients to seek their views and have patient care at the centre of decision making.
- Provide equitable access to services for the community it serves
- Provide a safe and rewarding environment for staff to work in.

- Utilise NHS resources effectively to provide sustainable service that deliver the most benefit to patients.
- Have a continued focus on research and innovation in order to improve patient care.
- Aim to become nationally and internationally recognised for clinical excellence.

3.3. Gynaecology intends to achieve this through

- Ensuring every part of the managed clinical service remains focussed on delivering its purpose.
- Make every member of staff across every site feel a valued part of the managed clinical service.
- Support Divisions\Directorates in developing and delivering medium- and long-term service strategies.
- Strive to secure the resources required to deliver those strategies.



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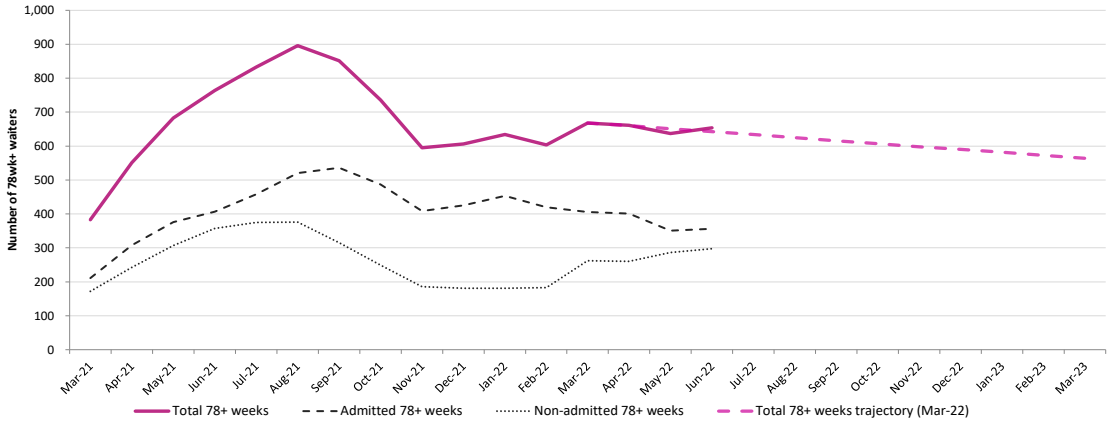
78wk Trajectory to March 2023



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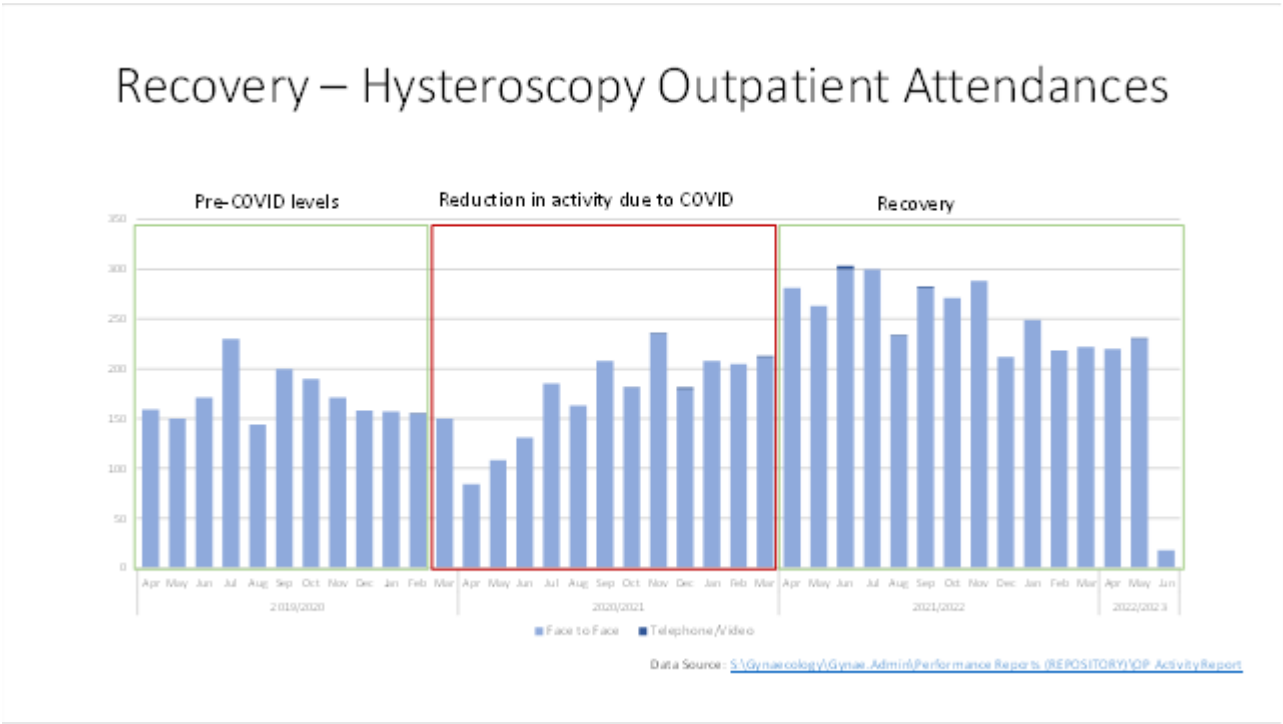
3.4. Gynaecology currently face enormous challenges in tackling the elective recovery backlog attributed to the COVID 19 pandemic. Government set targets to achieve 104 week and 78 weeks trajectory and 2-week cancer pathway waits remain a central focus of the work that is being delivered. The data shown above illustrates the progress that has been made in achieving this and that a downward trend is evident.

3.5. To date Gynaecology remain on track in achieving reviewing patients to Pre COVID levels, data demonstrates that there has been increase in the number of patients that are being seen within our specialist Hysteroscopy services overtaking Pre COVID levels. The data below highlight the increase in patients that we have been treating post COVID, and as such the impact on nursing workforce establishment requires it to match this increase to prevent delays, cancellations, and stress within the workforce. Challenges still remain within Urogynaecology and Cancer Exclusion to achieve our targets of which recruitment, resource is currently being reviewed among the divisional team.



3.6. A nursing workforce review is currently underway to establish the requirement of nursing budget against the current service provision. Figures illustrate no change in the baseline budget in the last 12 months, the number of vacancies has reduced in the 12 months through successful recruitment, and acquisition of 8 guaranteed job offer students and 12 international recruitment nurses over the preceding 12 months.

Site	Current RN Establishment (WTE)	Current Vacancy end May 2022 (WTE)
North Manchester	7.02	0
Ward 62	29.49	6.0
EGU	44.39	2.18
F16	17.36	2.94
Outpatients	12.06	1.0
Theatres	67.07	4.79
Total	**177.39**	**14.91**

3.7. The current nursing workforce review identified that a further 2WTE RN are required within the Womens Outpatient department due to the increase in outpatient activity and no change in baseline. Ward 62 remain compliant, and the outstanding areas are currently being evaluated. A divisional business case will then be submitted to the Senior Leadership Team for consideration.

3.8. Ward 62 work on the nurse patient ratio of 1:8, although staff work across the MCS and staff will be redeployed to other areas if staffing required. There is an escalation process in place which is followed in the event of staffing shortfall. Daily staffing sheets are completed and reviewed by the escalation bleep holder.

3.9. From the nursing workforce review within budget and supplemented by new income from MESH monies, posts have been created such as clinical nurse specialist lead posts within Colposcopy and Urogynaecology in order to provide the senior leadership overview within those areas so to ensure compliance with our external moderators' objectives and have oversight and assurance that we are achieving our wait targets and providing high quality safe care to our patients who are awaiting dates for treatment.

3.10. Gynaecology is focused on developing nurse led services and as such have recently appointed a senior nurse to lead on the set up of a nurse led pathway for Menopause, as this is currently not nurse led and will contribute to tackling the backlog of patients on this pathway.

3.11. Theatres are also nearing completion of a workforce consultation which will ensure greater utilisation of staff due to the change in working patterns to be in alignment with that of theatre scheduling, improve the flexibility of lists and reduce the necessity for NHSp usage.

3.12. Gynaecology have also developed mini triumvirates whereby the divisional management team will meet with each specialist area and the leads attached to discuss the strategic and operational targets and discuss areas of concern and develop solutions. This will serve to ensure that there is a good oversight from a senior level on all specialist areas, and that support is provided to staff within these areas.

Site	Leavers (last 12 months) WTE	Recruitment (last 12 months) WTE
North Manchester	5	4
Oxford Road	32	30
Wythenshawe	19	21
Total	**56**	**55**

3.13. It is predicated that Gynaecology have approximately between 1-3 staff leaving across all departments across the MCS each month. As a result, we have secured from a recruit to turnover perspective we have secured 8 Guaranteed job offer students to commence in September 2022, and a further 3 to commence in January 2023.

3.14. Gynaecology have reviewed qualitative date and undertaken a thematic review to establish the reason for staff leaving the organisation in conjunction with the Staff Survey results of 2021 and identified three main themes

- Improvements required regarding Education and training for new starters 37%
- Workplace Stress 45%
- Staff not feeling involved in delivering changes that affect the department 29%

3.15. As a result of this data, we have:

- Introduced quarterly "Big Conversation" with senior leaders to examine what is working well, what we need to improve and gain assurance.
- Senior leaders have recently devised their own Gynaecology Nursing Charter in which they developed the Gynaecology nursing Vision along with 3 elements of team culture

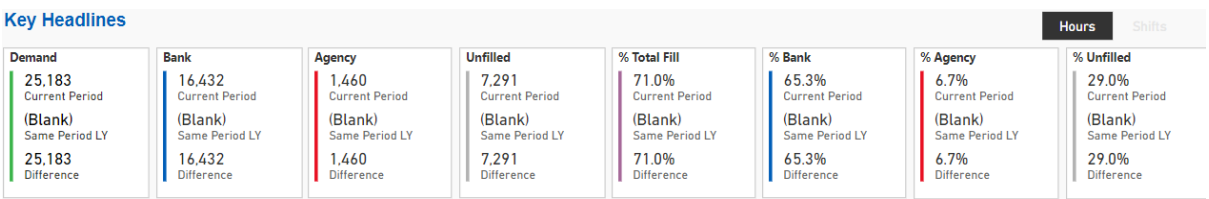
which is required, this will be used as a platform for all future recruitment campaigns and be part of all our departmental papers so to formulate conversations and embed this into practice.

- Developed a Workplace Stress training session for senior staff to provide education and resource how they can better support staff in the workplace.
- Quarterly “Gynae Road trips” are held by Head of Nursing and the Lead Nurse whereby departments are visited, and staff are given the opportunity to discuss any concerns, and to promote recent campaigns such as “Civility Matters”.
- Gynaecology is also introducing Professional Nurse Advocates to provide restorative supervision to staff and the skills to improve staff wellbeing and thus improving retention and patient outcomes.
- “Time for Coffee” walkabouts by Head of Nursing and Lead Nurse to speak to patients and staff on day-to-day departmental issues.
- Developed a buddy system for IR nurses to ensure that they remain support from recruitment and beyond and are currently reviewing our induction programme for all new starters to ensure it is robust programme which supports new starters and provides the diversity and knowledge required.
- Gynaecology will also be introducing a new role in that of an Education and Quality Matron whose focus will be on improving the educational resource available and retention of staff, enhance the training provision and ensure that there is a successful recruitment campaign template within Gynaecology, whilst also developing an Educational Agenda which will be the blueprint for the future.

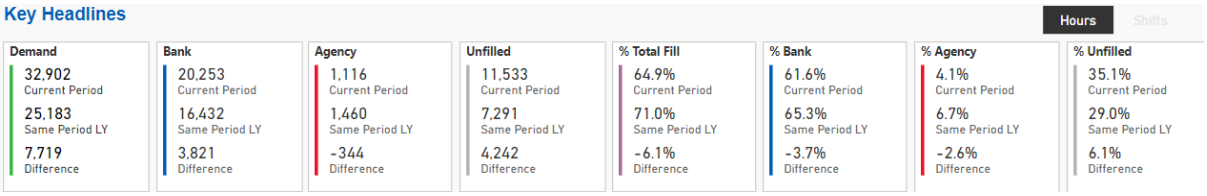
3.16. NHSP Usage is monitored by Head of Nursing and Lead Nurse weekly, and leaders are held to account for their data at monthly workforce meetings. The challenges currently within the Operational team has meant that nursing are using additional NHSP to cover administrative shifts within the Emergency Gynaecology Department, which has increased our usage over the previous month. The Theatre consultation which is currently ongoing has led to a high demand of NHSP shifts due to the alignment issues with theatre scheduling, which it is anticipated that this consultation will resolve.

3.17. In addition, Gynaecology has also had unprecedented sickness at over 10% in months of January and February 2022, which again effected the NHSP demand.

May 2021



May 2022



3.18. As part of a recent Gynaecology away day for senior leaders, staff developed a Gynaecology Nursing Charter in which they designed their "vision" slogan for Gynaecology nursing in conjunction with identifying three elements that the culture of the team must encompass. This charter will now be the platform in which we reference on our local papers, will be used within our recruitment campaigns and become the underpinning of conversations with each other so that we are aligned in our vision.

3.19. As part of the Long Term Plan objectives Gynaecology will:

- Ensure 2 week wait Cancer pathway is met, whilst increasing our capacity for diagnostic clinics.
- Gynaecology is looking at ways in which we can support patients "while they Wait" a NHS backed campaign to ensure patients wellbeing whilst they are awaiting treatment. This is an initiative that is discussed at our Quality meeting and taken forward into Outpatients department.
- Consider the provision of more "See and Treat" availability through scoping of resource and capacity within the department.
- Invest in the workforce to develop their skills, ensure succession planning is in place with an overview of the ageing workforce, so to reflect the needs and priorities of the future of Gynaecology services as a whole

3.20. Despite the challenges Gynaecology have taken great strides in improving serve provision and patient experience. Staff have demonstrated incredible resilience, teamwork and determination to continue striving to provide the care we aspire to for our patients.

3.21. There is a continued focus on workforce development with an emphasis on a skilled nursing Infrastructure capable of supporting a sustainable, timely, qualitative service. Creation of new roles within Gynaecology to deliver advanced clinical skills is paramount to provide another layer of advanced clinical skills and expertise to our client group and to ensure we maintain and develop our provision of nationally accredited specialist services.

3.22. The emergency gynaecology unit has developed much more robust care pathways, the implementation of a triage model similar to that of maternity has been successful and seen a huge improvement in triage waiting times to treatment. Staff engagement has improved, and all the vacancies filled. Development of a strong cohesive leadership team is now evident, and work is currently underway to introduce a rotation staffing model across the MCS to provide flexibility of staffing, update staff skill set and provide opportunities to develop new skills.

3.23. Working with the final stages of the full integration of North Manchester Women and Children's division gynaecology services as part SM MCS aims to deliver harmonising of pathways including cancer exclusion and Emergency Gynaecology to enable women to be

directed to their local service. Establishing Nurse Led roles e.g pessary clinics and expanding the clinical nursing roles on EGU are part of the transformation being considered.

3.24. As the Division continues in the recovery phase, there has is a huge focus on theatre staffing and utilisation with the submission of a theatre staffing and consultation paper to align both maternity and gynaecology theatre services to ensure flexibility across the division and flow of staff. The theatre consultation also allows for increase in additional theatre lists and so reducing the backlog of our P1-P4 patients.

3.25. Gynaecology services are very proud to be launching in 2022 our Gynaecology Voices patient forum, in which to capture patients' feedback to aid service provision. Whilst it has been a challenging year, the pressure, anxiety, level of change and uncertain environment has undoubtedly impacted on the wellbeing of staff within the Gynaecology Division at all levels and understandably people feel tired, and morale has reduced. The gynaecology division have completed the EQIA of the service and have sought staff feedback from the relocation of services and the impact this has had upon their overall wellbeing. It is important therefore that we support our teams with their Health and Well-being to enable them to rise to the challenges presented to them. The plan is also to introduce Professional Nurse Advocates within Gynaecology to further support staff during these challenging periods

3.26. 2022 focus will be the alignment of services across the MCS, the provision and development of nurse led services and ensuring a nurse staffing model which meets the requirements of the gynaecology recovery plan, whilst also focusing on succession planning, workforce development and staff retention.

Challenges

3.27. It remains a challenge to ensure that our trajectories are met with the requirement to still strengthen staffing in certain areas within Gynaecology. The governance department remains a concern with the lean staffing structure resulting in the inability to lead on several projects, provide support to the recent acquired North Manchester Hospital and provide the assurance and oversight required across the MCS as a whole. A business case has been developed and produced to the Senior Leadership Team to consider further investment, as it is acutely aware of the findings from the Ockenden Report (2022) which demonstrated the importance of ensuring that robust governance process is in place, which allow for lessons to be learnt and for these lessons to be continually audited to ensure that they are embedded into practice.

3.28. Elective recovery will continue to be a challenge and developing new innovative ways in order to see patients and reduce the backlog of waiting patients. The workforce review will be crucial in ensuring there is adequate staffing to accommodate additional activity.

3.29. Workforce vacancies within the operational team have impacted upon the nursing staffing and contributed to delays and fragmented streaming of patients due to the lack of fully trained staff. The Divisional Director is fully abreast of the challenges and the impact of this, and recruitment is ongoing and training resource is being implemented.

3.30. The disaggregation of North Manchester Hospital now requires a full workforce review how we can harmonise our services and utilise the space and staffing to achieve our strategic

and operational ambition. The nursing provision within North Manchester will undertake a review, as will the governance provision there once staffing resource and the nursing structure are aligned to ensure adequate resource. The development of the services will also be considered and how this will be taken forward, and the vision outlined.

Summary

3.31. Gynaecology remains under immense pressure post COVID-19 pandemic, and the potential for further staffing challenges. To mitigate these risks work will continue around all aspects of recruitment and retention, and focus upon the development and succession planning of the workforce as a whole.

3.32. The Gynaecology workforce was in year 20/21 a serious challenge with large vacancy numbers, this year 21/22 we have managed to fill these recruitment gaps and the challenge remains to ensure that we retain the staff recruited with the measures discussed within this paper.

3.33. Elective recovery will continue to be a focus going forward into 22/23, and the achievement of the Long Term Plan objectives.

3.34. Ensuring qualitative and quantitative data is used to drive forward service improvement and ensure that the basics of nursing are being met through senior leadership overview.

3.35. Assurance that the workforce meets the needs of the service and that provisions are put into place to safeguard the wellbeing of both staff and patients.

4. Newborn Services Nursing Workforce

4.1. Newborn Services are committed to delivering on the NHS People Plan. The Divisional People Plan outlines our approach and priorities to ensure our workforce have a positive and supported experience at work and there are clear links between the service strategy.

4.2. The key workforce challenges faced by the Division are recruitment of experience staff to vacancies, meeting National standards for Qualified in Speciality (QIS), and retention of new starters particularly on the Newborn Intensive Care Unit (NICU). Through feedback from staff surveys we have identified a number of key themes which need addressing in order to create a healthy, inclusive and compassionate culture across the Managed Clinical service (MCS).

4.3. We will continue to develop transform our workforce with the integration of Allied health professionals, Physicians Associates, Nurse associates and other members of the MDT.

4.4. Newborn Service's aspiration is to be the neonatal employer of choice within the North West and wider. We will achieve this by showcasing the great development and fulfilling careers on offer across all disciplines within the MCS. We are committed to ensuring that staff feel empowered, are listened to, and have influence over how the service functions.

- Safety of patients requires nursing and medical staff in the right place at the right time and work is ongoing to ensure this.
- MatNeo collaboration ongoing for optimisation and stabilisation of newborn infants.

- Neonatal CNST standards met – ongoing work to ensure QIS meet national standards.
- Monthly review of risk register – lessons learned discussed at Divisional and Hospital meetings. Lessons learned disseminated to staff at core huddle/unit forum.
- NNAP data is shared with NWNODN and benchmarked against other comparable units. CQC response submitted in view of ORC being outlier for normothermia for babies born less than 32 weeks.

4.5. Progress in the last 6 months within Newborn Services

- Integration of North Manchester Neonatal Unit into NBS MCS
- Ward Accreditation – NICU @ ORC and the Neonatal Unit @ Wythenshawe attained
- Gold award and the Neonatal Unit @ North attained Silver in their first ever ward accreditation.
- Surgical Nurse Specialist role now implemented enabling patients to return to local hospital/RMCH in a timely manner as staff trained to manage surgical problems.
- Activity is under plan at ORC due to high percentage of vacancies, sickness absence (including COVID) and maternity leave. This has been compounded by the recent Klebsiella infection outbreak where activity has been reduced as a result of working to BAPM where previously this may have been flexed
- Successful pilot of Special Care Coordinator Role demonstrated reduction in Length of Stay, improved discharge processes and fewer babies attracting HRG5.

4.6. The Division has begun work on introducing a 'kindness collaborative' using the Civility Saves Lives campaign along with adopting a Safety 2 approach to incident management focusing on 'What went well'.

4.7. The Division has continued to hold regular Unit Forums to deliver key messages and obtain feedback.

4.8. To support the North Manchester Integration the HoN and Lead Nurse held face to face and virtual engagement events to provide staff with an opportunity to share their concerns regarding the integration. WMTM feedback forms are available to staff at North Manchester to provide ongoing feedback on any changes.

4.9. The Divisions to support staff at all levels to be involved in Quality Improvement work and are supporting key staff to undertake Quality Improvement training to support their work.

4.10. The nursing establishments across SM MCS are agreed as follows for each site in Table 1.

Table 1

Site	Current Establishment (WTE)	Current Vacancy end May 2022 (WTE)
North Manchester	39.82	4.62*
Oxford Road	266.67	56.83**
Wythenshawe	46.21	5.84 ***
Total	**352.7**	**67.29**

* Recruited to band 5 vacancies with IR and GJO
** Recruited to turnover in band 5 establishment reducing vacancy gap by 35.88WTE by September 2022 with IR and GJO plus band 6 and band 7 recruited to vacancies awaiting start dates

*** Band 4 NA vacancies now recruited to from GJO to start September 2022

4.11. The Neonatal Critical Care Transformation Review (NCCR) submission were very successful during the latest round of submissions in November 2021 for allocation by April 2022. A total of £1,221,379 was allocated to Newborn services MCS in order to increase cot side care provision. NHSE request frequent updates and any underspend is to be recalled by the national team.

4.12. Saint Mary's Oxford Road have seen an increase in baseline establishment in 2022 with an additional 18.5 WTE bands 5,6 and 7 posts (£1.13million) from the Neonatal Critical Care Review (NCCR) NHSE funding allocation.

4.13. SM Wythenshawe have also seen an increase in baseline establishments with an additional 0.5 WTE band 5 post (£25,042K) from the (NCCR) NHSE funding allocation.

4.14. SM North Manchester have also seen an increase in baseline establishments with an additional 1.3 WTE band 5 posts (£61,718K) from the (NCCR) NHSE funding allocation

4.15. Recruitment progress is good with appointment of 6.54 WTE to the Band 7 establishment with a further 2.71WTE at interview stage. The latest recruitment to Band 6 saw appointment of 9.28 WTE, again no external applicants stepped forward, so candidates appointed were all internal staff. Although positive recruitment the successful band 7 recruitment has created additional vacancy at Band 6 as the majority were internal candidates. This still leaves a vacancy factor of 12.8 WTE. In view of the large vacancy factor, we have advertised for Band 5-6 development post and several quality roles with an aim to attract external candidates.

4.16. SM MCS have been successful in recruiting to the increase in Newborn Services MCS establishment:

- 25 Guaranteed Job Offers (GJO) made to final year nursing learners and were accepted due to start in September/October 2022
- There is a confirmed domestic pipeline of 18 domestic nursing recruits with 2 still to start and 3 withdrawals.
- 23 international recruits have taken up posts within Newborn Services
- A further 38 international nurses are in the pipeline to start over the next few months
- In total there will be 66 nursing recruits in offer, with an anticipated withdrawal rate of 30% for the domestic nursing recruits, it is expected that approximately 60 newly qualified nurses will take up their post in quarter 3.

4.17. The overall number of nursing vacancies is predicted year on year based on historic evidence collated from the leavers. The reasons for leaving are similar across SM MCS as in previous years and is related to nurses retiring, moving closer to home, moving to a smaller unit or recently travelling abroad. There have also seen movement to sister sites across the MCS as base sites, along with promotion to alternative roles within NBS such as

trainee Advance Clinical Practitioner (ACP), Connect North West transport team and High Dependency Team.

4.18. There has been a decrease in overall the nursing attrition rate across the MCS seeing 32.85WTE leavers. This falls within the usual pattern of the nursing turnover. This now includes the North Manchester site from November 2021.

4.19. Predicted turnover is calculated from local workforce intelligence and reflects 2.7WTE nurses leaving per month based on a 12-month average.

4.20. It is always aimed that the September recruitment of newly qualified nurses will fill both the actual vacancy factor and the expected turnover from September to the end of February. The anticipated position by September 2022 is that the Newborn Services will be at full establishment for band 5 nurses.

4.21. NBS has mitigation to recruit to turnover to March 2023 with the current pipeline supporting a continued replacement of those nurses that leave, supporting the attrition rate described above.

4.22. In recognition of the national shortage of neonatal nurses the Newborn Services Division continues to review alternative roles and strategies to support the nursing cohort. All new band 5 starters to Newborn Services are supported to rotate between the level 3 and level 2 sites during the induction period. This model has been used following the transaction of the North Manchester site into the MCS.

4.23. In order to meet demands of the service the operational matron reviews the staffing needs and looks at where mutual aid is possible. The Lead Nurse, matron team, along with the Directorate Manager and HoN review the staffing across the MCS formally to review the pressures and look to support individual sites where able in order to support staffing over the weekend with mutual aid. Alongside this the service has taken the following steps;

- The division has a proactive recruitment strategy including some success in attracting experienced nurses.
- The Division continues to promote the diversity of roles within the service via social media campaigns to attract external candidates.
- Developing a Band 5-6 development programme to support staff development and support recruitment into Band 6 posts
- The Division has rotational opportunities between sites for all staff groups to support retention and support a mobile workforce

4.24. NHSP usage continues to be monitored on a weekly basis by the Lead Nurse and Head of Nursing. As the vacancy gap starts to reduce at the end of September 2022, it is anticipated that enhanced NHSP rates. NHSP usage has not historically seen an immediate reduction in spend when the nursing team come into post. This is due to the complexity of the service and the supernumerary time allocated to staff in order they are able to work within the neonatal environment and competently care for babies with all needs. NBS is working with the NWNODN who are supporting a shortened induction pathway for international nurses recognising their existing experience within neonatal care. This will support the international nurses to access the qualified in speciality (QIS) course sooner, further increasing their

knowledge and skills, and support earlier promotion. As part of the NCCR funds, any underspend can be used to backfill NHSP staff filling gaps of staff who undertake the QIS course to support a reduction in the impact of care at the cot side.

4.25. The NHS Long Term Plan focuses on a number of areas in Neonatal Care which now form part of the Newborn Services work plan and five-year strategy.

- These include:

- Improve the safety and effectiveness of services
- Develop our expert neonatal nursing workforce
- Extra neonatal nurses
- Expanded roles for some AHP's
- Enhance experience of families
- From 2021/22, care coordinators in each clinical neonatal network
- Invest in improved parental accommodation

4.26. The NHS Long Term Plan has committed to new investment in neonatal services until March 2024 to support delivery of the Neonatal Critical Care Transformation Review (NCCR). As discussed previously Newborn Services made a return to the NWNODN demonstrating that SM Newborn Services MCS require funding for 41.26WTE cot side staff further to the current funded establishment across the MCS to be fully compliant with NHSE workforce tool calculations.

4.27. With the integration with the North Manchester site, it was established that the Neonatal Unit was staffed to 80% occupancy. This has resulted in staffing challenges when the unit is busy or has occupancy greater than 80%. The unit currently routinely runs on 5 staff giving direct patient, however if the capacity is at 100% the staffing requirement is 7 plus a supernumerary coordinator to meet national standards. The unit's total nursing establishment should be calculated on the basis of an average 80% cot occupancy (DoH, 2009).

4.28. The Neonatal Unit team also provides support at the delivery of unwell babies - 5 staff on duty can be depleted to 3 if emergency assistance is needed on the hospitals Delivery Suite. North Manchester General Hospital does not currently have a Transitional Care Unit as similar hospitals in the Network do, which results in an increased admission rate of babies who could be cared for by their mother if Transitional Care was provided by the midwifery team.

4.29. Added to the current staffing situation is the workforce projection which estimates that the need for Neonatal services will increase in each coming year along with the birth rate. This is estimated to equate to a requirement for up to 9+1 direct care givers per shift.

4.30. The calculation for the BAPM recommends field is based on recommendations that IC babies should be cared for on a 1:1 basis, HD babies on a 1:2 basis and SC on a 1:4 basis. The recommendation also says a supernumerary Team Leader should be present on all shifts, so one is added to the total for the recommended staff. It is recognised that NBS does not consistently achieve BAPM standards on every shift. To mitigate this staff are redeployed to the cot side from quality roles and mutual aid is supported across sites to the area of greater risk. In view of not meeting the service specification requirement for nursing

workforce NBS has developed an action plan which has been signed off by the Trust board. This action plan is to be reviewed and updated and presented at the next Trust Board Meeting

4.31. The Toolkit recommends care for IC and HD babies should be provided by 'Qualified in Speciality' nurses or nurses training for QIS while supervised by a nurse who is QIS. This recommendation is calculated based on the IC 1:1 basis and HD 1:2 basis

4.32. Across the MCS there is a supernumerary shift coordinator/team lead on duty 24 hours a day, 7 days a week who monitors and reviews unit status, acuity and flow, escalating as required in accordance with policy

4.33. The matrons, Lead Nurse and Head of Nursing support an on-call rota which has been integrated across the MCS.

4.34. The shift coordinator on each site documents the unit status in the daily status report but reviews staffing requirements at least 3 times per 24 hours across the MCS; this report is circulated to all Senior Nursing, Midwifery and Management staff to enable close monitoring of the activity and staffing levels across the MCS.

4.35. Wythenshawe Newborn Services continue to support East Cheshire Trust who have been unable to facilitate an inpatient service since March 2020

4.36. Newborn services has supported its' first Professional Nurse Advocate within the service with the intention to follow the pathway used by maternity services in facilitating restorative supervision sessions for the nursing workforce.

4.37. Newborn Services MCS have listened to staff and engaged with them through staff surveys, mentimeters and listening events. Feedback has been provided through the "You said We did" initiative which has focussed on staff recruitment and support for staff in their everyday work. As a division, Saint Mary's MCS has also been supported by Organisation, Training and Development team to gain further feedback from staff and formulate an action plan to support staff health and wellbeing.

4.38. New nurses have been supported before commencement of employment with keeping in touch sessions, meeting the teams and networking with other new employees both face to face and virtually.

4.39. Due to the COVID-19 pandemic Newborn services faced many challenges which have enforced some workforce transformation initiatives: These include

- Enhanced communication and efficiency through introduction of IT solutions
- Introduction of V-Create enabling parents to be inclusive in their babies' care when not able to visit.
- Microsoft Teams linking with video conferencing
- Maximise use of capacity and optimise resources across the MCS including Integration with NMGH
- Work ongoing with Obstetrics re: elective C –section list at Wythenshawe,
- Ongoing discussion re: redesign of estates at NMGH
- Provide licensed Numeta parenteral nutrition across the MCS

- Development of MDTs to improve outcomes, strengthen cross site working, provide resilience and professional leadership
- Drug Monograph Project
- Ongoing task and finish group
- Delivery suite stabilisation of preterm infants
- Lifestart Trollies
- Outpatient capacity and alignment
- Use of Attend Anywhere

4.40. The NHSP uptake in Newborn Services remains lower than the start of the pandemic. To support the delivery of cot side care, staff within quality roles are redeployed to the cot side and mutual aid from the Wythenshawe site staff, have supported patient flow to continue in the main. Face to face mandatory training has also been cancelled to support cot side care as required, although all staff were supported to complete their online learning and compliance maintained. Despite this Newborn Services MCS has maintained a positive position. The area that has been most affected is the non-medical appraisals in the period July to December 2021. There is a recovery plan in place and has already made an improvement to compliance in December 2021

4.41. Newborn Services have developed different ways of working to enhance communication and efficiency with parents across the MCS, with the introduction of some virtual clinics within the Neonatal Outreach and Bereavement Teams and the counselling support service. The neonatal counsellors implemented an alternative strategy in order to reach out to all families and staff during the pandemic, who have continued to receive face to face, socially distanced, support sessions, as well as telephone sessions where appropriate...

4.42. The Newborn life Support course was halted during the first two waves of the pandemic. The courses restarted in March 2021, although due to government guidelines and restrictions regarding distancing, the numbers of people able to attend have been reduced. This has impacted on the number of staff required to undertake the NLS course and those who require renewing their certificate. In order to maintain a safe standard of practice, team members required to be involved in immediate resuscitation of the Newborn and management of the deteriorating Newborn infant have undertaken in-house neonatal resuscitation training, in line with CNST standards. This demonstrates 95% compliance.

4.43. In terms of NLS, compliance is diluted in the band 5 workforce due to a predominantly junior workforce with no existing neonatal experience.

Band	MCS	ORC	WNNU
B8 ANNP	94%	88%	100%
B8	83%	80%	100%
B7	87%	86%	100%
B6	76%	77%	60%
B5	14%	8%	46%

4.44. Qualified in neonatal Speciality course (QIS) moved to online sessions in April 2020, and the as such the Division is pleased to confirm that the number of staff supported successfully through these courses has not fallen during the pandemic.

4.45. COVID-19 has brought new and unprecedented challenges in clinical care, including the delivery of Family Integrated Care (FiCare) where parents are at the heart of delivery their

baby's day to day care. Strict infection control measures have created new barriers to family involvement in care, restricting the duration of visits and the number of family members who can visit safely. Innovative solutions are required to mitigate family separation. Newborn services has seen the introduction of a virtual Realtime platform called vCreate which supports family involvement in care and parental well-being and strengthens positive relationships with staff. Parents can share in their baby's progress by using live films and picture updates. This can be shared with the whole family and important people in their lives of the parents' choice. Key information about neonatal conditions and developmental milestones are a special feature of this virtual communication platform. This platform has been critical during wave 3 of the pandemic where parents have had to isolate as tested positive for COVID-19

5.0. Summary

5.1. It is recognised that there are nursing and midwifery staffing challenges nationally. The Saint Mary's Managed Clinical Service is working to reduce vacancies, improve retention and become an employer of choice focusing on opportunities for career development and maximising recruitment opportunities.

5.2. Workforce pressures are expected to continue although with a reduced impact due to recruitment of a newly qualified workforce. Work is on-going to mitigate the impact of the staffing pressures on the SM workforce across the MCS and support health and wellbeing.

5.3. Innovative ways of working and the delivery of clinical pathways across all services will continue to be developed ensuring effective compassionate care can be delivered to patients safely whilst maintaining compliance to Infection control standards.

6.0. Conclusion

6.1. Saint Mary's Hospital Management Board are asked to receive this report and approve the declaration of compliance with MIS Safety Actions 4 & 5 in respect of midwifery and neonatal nurse staffing

Appendix 4 - Saint Mary's Managed Clinical Service Governance Statement

Scope of responsibility

The Saint Mary's Managed Clinical Service (SM MCS) senior leadership team, led by the Chief Executive Officer, have responsibility for maintaining a sound system of internal control that supports the achievement of SM MCS aims and objectives.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

• Identify and prioritise the risks to the achievement of the successful embedding of policies, aims and objectives of SM MCS
• Evaluate the likelihood of those risks being realised and the impact should they be realised and
• Manage them efficiently, effectively, and economically.

Governance Structure

SM MCS operates a committee structure to oversee Quality and Safety (including audit, and health and safety), Risk, Finance, Workforce Leadership and Development, Operational Performance, Infection Prevention & Control / Harm Free Care, Safeguarding, Research and Innovation and Hive/Informatics. These committees report into SM MCS Management Board which reports up to Manchester University NHS Foundation Trust Board and associated sub-committees and ultimately the Board of Directors.

Governance Team

The SM MCS has a functioning governance team who work closely with clinical and managerial colleagues throughout the service to ensure that pathways of reporting to the committees are sound and of high quality.

Indictors

A range of indicators are used to monitor quality, safety and performance. SM MCS are confident about the range used, as this is based on internal risk assessments and external recommendations[1234]

SM MCS operate a risk register that informs and is informed by these indicators.

Focus in 2022/23

SM MCS governance focus in 2022/2023 is to:
1. Strengthen existing governance structures to promote clear lines of communication and assurance

2. Aligned with the implementation of Hive, continue to Improve accuracy and interrogation of quality, safety and performance indicators