MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING
(PUBLIC AGENDA)

TO BE HELD ON MONDAY 11TH SEPTEMBER 2023
At 2:00pm – 5.00pm

Main Boardroom
Cobbett House

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 10th July 2023	*(enclosed)*
4.	Patient Story	*(Film)*
5.	Matters Arising	
6.	Chairman's Report	*(Verbal report of the Group Chairman)*
7.	Chief Executive's Report	*(Report of the Group Chief Executive enclosed)*
8.	Report from the Board of Directors' Scrutiny Committees • Workforce Scrutiny Committee – 29th August 2023 • Quality and Performance Scrutiny Committee – 29th August 2023 • Finance and Digital Scrutiny Committee – 5th September 2023 (verbal)	*(Reports of the Group Non-Executive Directors)*
9.	**Operational Performance**	
	9.1 To receive the Integrated Performance Report	*(Report of the Group Executive Directors enclosed)*
	9.2 To receive the Group Chief Finance Officer's Report M4	*(Report of the Group Chief Finance Officer enclosed)*
	9.3 To provide an update on the Hive Programme	*(Report of the Deputy Group Chief Executive, SRO for Hive Programme enclosed)*
	9.4 To receive the 2023/2024 Emergency Preparedness Resilience and Response (EPRR) core standards	*(Report of the Deputy Group Chief Executive, SRO for Hive Programme enclosed)*

10. Strategic Review

10.1 To receive an update on strategic developments	*(Report of the Group Executive Director of Strategy enclosed)*
10.2 To receive a report on the Annual Planning process for 2024/25	*(Report of the Group Executive Director of Strategy enclosed)*
10.3 To receive a report on NHS Long-term Workforce Plan	*(Report of the Group Executive Director of Workforce and Corporate Business enclosed)*

11. Governance

11.1 To receive a report on NHS England's revised Fit and Proper Test Framework for board members (August 2023)	*(Report of the Group Executive Director of Workforce and Corporate Business enclosed)*
11.2 To receive the Annual Patient Experience report	*(Report of the Group Chief Nurse enclosed)*
11.3 To receive the Annual Complaints report	*(Report of the Group Chief Nurse enclosed)*
11.4 To receive the Q1 Complaints and Patient Experience report	*(Report of the Group Chief Nurse enclosed)*
11.5 To receive the Group patient safety incident response policy	*(Report of the Joint Group Medical Director enclosed)*
11.6 To receive the Group patient safety incident response plan	*(Report of the Joint Group Medical Director enclosed)*
11.7 To receive a report on the management of Never Events	*(Report of the Joint Group Medical Director enclosed)*
11.8 To receive the Annual Medical Revalidation Report and Annual Statement of Compliance	*(Report of the Joint Group Medical Director enclosed)*
11.9 To receive the Remuneration and Nominations Committee Terms of Reference	*(Report of the Group Executive Director of Workforce and Corporate Business enclosed)*

12. Date and Time of Next Meeting

The next meeting will be held on Monday 13th November 2023 at 2:00pm

13. Any Other Business

NHS Manchester University NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS' MEETING

Meeting Date: 10th July 2023

(PUBLIC)

Main Boardroom, Cobbett House

Present:	Kathy Cowell (Chair) (KC)	Group Chairman
	Mark Cubbon (MC)	Group Chief Executive
	Trevor Rees (TR)	Deputy Group Chairman
	Peter Blythin (PB)	Group Director of Workforce & Corporate Business
	Julia Bridgewater (JB)	Group Deputy Chief Executive
	Jenny Ehrhardt (JEh)	Group Chief Finance Officer
	Nic Gower (NG)	Group Non-Executive Director
	Luke Georghiou (LG)	Group Non-Executive Director
	Cheryl Lenney (CL)	Group Chief Nurse
	Toli Onon (TO)	Joint Group Medical Director
	Damian Riley (DR)	Group Non-Executive Director
	Mark Gifford (MG)	Group Non-Executive Director
	Tom Rafferty (TRa)	Director of Strategy
In attendance:	Nick Gomm (NGo)	Director of Corporate Business/ Trust Board Secretary

92/23 Apologies for Absence

Apologies were received from Chris McLoughlin, David Furnival, Jane Eddleston, Darren Banks, Angela Adimora and Gaurav Batra.

93/23 Declarations of Interest

No specific interests were declared for the meeting.

94/23 Minutes of the Board of Director's meeting held on 13th March 2023

The minutes of the Board of Directors' (Board) meeting held on the 13th March 2023 were approved with the following amendments:

- Nic Gower was not in attendance.
- Mark Gifford presented the verbal report from the Audit Committee, not Nic Gower.

Board Decision:	Action	Responsible officer	Completion date
The Board approved the minutes.	n/a	n/a	n/a

95/23 Patient Story

CL introduced a filmed patient story regarding a patient who had spent 3 ½ weeks on a ward awaiting an operation on a broken ankle.

KC summed up the themes and lessons learnt from the patient's experience and asked CL to thank the patient for sharing their story.

Board Decision:	Action	Responsible officer	Completion date
The Board noted the patient story.	None	n/a	n/a

96/23 Matters Arising

There were no matters arising.

97/23 Group Chairman's Report

KC provided the Board with an overview of the activity undertaken across MFT to celebrate the 75th anniversary of the NHS.

Board Decision:	Action	Responsible officer	Completion date
The Board noted the Group Chairman's verbal report.	None	n/a	n/a

98/23 Group Chief Executive's Report

MC presented his report which described:

- The visit of the Chief Executive of NHS England
- Current operational performance
- Recent industrial action
- The CQC inspection of MFT's maternity services
- The external clinical governance stocktake and well-led developmental review
- Plans for an overarching strategy for MFT
- Latest news on the North Manchester General Hospital (NMGH) redevelopment with MFT receiving confirmation of funding
- The 2 year pilot for a Sickle Cell Hyper Acute Unit
- NHSE England's Equality, Diversity and Inclusion Improvement plan
- The NHS Long-Term Workforce Plan with PB looking to strengthen working with local schools and universities to support delivery

He summarised his three main concerns as the elective backlog, MFT's financial position, and the conclusions from the CQC inspection of maternity services. All issues are reflected in the principal risks within the Trust's Board Assurance Framework.

MG described positive feedback he had received from local MPs regarding MFT's plans for NMGH and welcomed the sickle cell pilot as an opportunity to further MFT's community engagement activity. KC reminded the Board of the work undertaken already by the LCO with the local sickle cell community group and PB advised the Board that a sickle cell staff group had been established.

Board Decision:	Action	Responsible officer	Completion date
The Board noted the Group Chief Executive's verbal report.	None	n/a	n/a

99/23 Reports from the Board of Directors' Scrutiny Committees

The Non-Executive Director (NED) Chairs of the Board of Directors' Scrutiny Committees presented their reports which described matters discussed in the last meetings of them.

EPR Scrutiny Committee held on 26th April 2023

In GB's absence, KC highlighted:

- the Hive upgrade
- the positive assurance received from Deloitte with regard to the delivery of the programme
- the fact that no patient safety incidents had occurred as a result of Hive since go-live

Audit Committee held on 20th June 2023

NG highlighted:

- the positive assurance from external audit on the annual report and annual accounts
- the positive value for money assessment from external audit
- recent internal audit reports

Quality and Performance Scrutiny Committee held on 20th June 2023

DR highlighted:

- how the committee used the new Integrated Performance Report
- improvements to the urgent care pathway
- the deep dive into never events which occurred during 2022/23
- the development of a new 'red' pathway in maternity services following lessons learned from a patient's complaint
- the implementation of PSIRF

Workforce Scrutiny Committee held on 20th June 2023

In AA's absence, KC highlighted**:**

- the latest reports from the Freedom to Speak Up Guardian and the Guardian of Safe Working
- the progress in delivering MFT's People Plan
- the LIME arts 50 year anniversary event in July

Finance and Digital Scrutiny Committee held on 27th June 2023

TR highlighted:

- the challenging financial position in M2
- progress in delivery of the Waste Reduction Programme (WRP)
- the results from the National cost collection exercise
- updates from the Chief Information Officer

Board Decision:	Action	Responsible officer	Completion date
The Board noted the reports	None	n/a	n/a

100/23 Integrated Performance Report

CL introduced the new Integrated Performance Report (IPR) and explained that each lead Executive Director would present their relevant section.

TO presented the Safety section. The Trust has a Safety Oversight System that operates daily throughout the Trust, providing contemporaneous scrutiny and contextualisation of quality and safety intelligence. This enables immediate action in relation to emergent risk, for instance through the issuing of Trust wide patient safety alerts, but also the identification of high impact and

transferable learning.

In April 2023, the Group Quality and Safety Committee approved the Trust's Patient Safety Plan, designed to provide the infrastructure for the implementation of the Patient Safety Incident Response Framework and describing the clear focus for patient safety improvement that will be included in the Trust-wide Patient Safety Incident Response Plan when published in September 2023.

The key areas of focused improvement and assurance in relation to patient safety are aligned to the patient safety insight, involvement and improvement priorities identified for 2022-23 in the Patient Safety Plan. They include the controls associated with the safety of invasive procedures, medicines safety, effective management of patient risk, patients waiting for access to care, diagnostics and/or treatment, maternity safety and understanding the impact of inequality. All of these areas are subject to exception reporting for additional scrutiny through the Quality Governance infrastructure of the Trust.

Using historic Trust data as a benchmark, the Trust's rolling 12 month never event profile continues to give rise to concern: with a particular area of focus on invasive procedures. The QPSC received an exception report in relation to the focus of safety improvement work and the issue was also described at GROC in relation to the strategic risk exposure.

The Board of Directors receives routine reports relating to Maternity services, and the QPSC has held an extra-ordinary meeting to scrutinize the Saint Mary's Managed Clinical Service (SMMCS) response to the CQC warning notice. The areas of escalation from the dashboard are currently under detailed review.

The Trust has two overdue National Patient Safety Alerts and one alert where compliance was changed following the implementation of Hive. All the alerts are medicines-related. The alerts are subject to a risk assessment and progress with compliance is being managed through the Medicines Safety Committee.

The Group Infection Control Committee oversees the performance associated with attributable reportable organism performance, with a key focus on screening compliance, timeliness of decolonisation therapy, anti-microbial stewardship, ability to isolate (environmental factors), and adherence to IPC pathways.

The Trust was issued with a PFD relating to the role and responsibilities of Physician Associates, specifically in relation to discharge. The Trust will be providing the necessary assurance in response. Further areas of focus where there were opportunities to strengthen patient safety controls include governance associated with safety critical procedural documents, patient safety culture, and the effective governance of the management of risk.

The Quality and Safety Strategy 2022-25 is enabling the Trust to review its performance within the Effectiveness domain with a different lens than previously. The focus on insight has led to the initiation of a programme of work to identify the correct, proportionate, and relevant metrics to measure progress to achieving the objectives identified in the Effectiveness plan. The metrics presented in the current version of the IPR are traditional and focus on mortality, the management of external recommendations, the key controls in place (clinical policies and guidance), performance in national audit, and the national CQUIN scheme. Utilising data from Hive and the Healthcare Evaluation Data (HED), the indicators are currently under review to support a more integrated approach to outcome data, with a clear focus on understanding and eliminating unwarranted variation.

Several important areas for escalation were highlighted by TO:

There is a continued risk that assurance in relation to implementation of NICE guidance across the Trust has been sub-optimal. A revised process has now been put in place to provide ongoing assurance in relation to newly published or revised NICE guidance. There is a requirement to complete an assurance exercise in relation to previously published guidance, which has now been commenced. This is being monitored through the Clinical Effectiveness Committee with escalations

to the Clinical Practice Oversight Committee.

There is evidence that there has been sub-optimal compliance with the Trust's High Priority Audit Plan 22/23. There is a potential issue in relation to case ascertainment and data validation within the national audits.

There is also a risk in relation to policy governance across the Trust, with the governance of a significant number of policies sub-optimal. This position has been escalated to the Quality and Safety Committee and is a weakness in control in strategic risks and as such escalated to the Group Risk Oversight Committee. This issue is compounded by a policy management solution that is not easy to navigate. There is an action plan in place to address the policy governance backlog, and a plan to procure a policy management system that better meets the needs of the Trust.

In response to a question from KC regarding Board awareness of adherence with NICE guidance, TO explained that metrics would be developed and reported to QPSC.

CL provided an update on the 'Caring' metrics within the IPR.

During May 2023, MFT has seen a slight increase in the number of complaints that were upheld. An initial review of the themes has identified that communication at the point of care delivery is the main reason that the complaint was upheld. Further analysis is being led by the Patient Experience Team to identify specific learning and inform action planning, which will be monitored through the Patient Experience Forum.

There has been a slight increase in the number of formal complaints received, the themes in May are concerns raised about Treatment / Procedure and further analysis is taking place through June 2023 to drill down further to identify trends and ensure they are aligned to targeted improvement plans.

An improvement has been noted in complaints re-opened, where the rate has decreased from 20.7% in April to 15.59% in May. A complainant may be dissatisfied with the response for a number of reasons with a key theme noted in May that the Trust did not respond or resolve all the concerns they raised through our complaint response letter. The Patient Experience Team are leading focused training (quality of response and investigation) to further reduce the rate at which complaints are re-opened, but more importantly to ensure that when concerns are raised there is good resolution and learning that can be spread across all sites.

The Family and Friends Test response rate is monitored, as is the % of those who would recommend MFT's services. During May, a total of 14,788 responses were received, 92.74% rated our services as good, and 4.42% rated services as poor. Feedback is provided directly to clinical areas, there is no special cause variation noted. Maternity Services utilise Maternity Voices Partnership (MVP) feedback in addition to Friends and Family (where women do not tend to engage with FFT), and during May an improvement has been seen in feedback from patients either through MVP, or through QR codes, introduced in May, which are readily accessible in in-patient areas. In the LCO, FFT is also utilised less due to the nature of services delivered in people's homes. The LCO have introduced QR codes that can be accessed in homes and clinics. Analysis of themes and learning will be monitored through the Patient Experience Forum. What Matters to Me (WMTM) and Quality Care Round (QCR) are also actively monitored.

Mixed Sex accommodation breaches have occurred in critical care areas, where exemptions are in place that support delivery of single sex critical care services in mixed sex environments. At the point of discharge, the exemption is no longer applicable and a 'breach' is said to occur if we have been unable to discharge a patient to a step-down area. The Patient Experience Forum are monitoring this, aiming to work with the critical care teams to identify any earlier drivers of the target not being met. There has been a significant positive increase in the number of What Matters to Me (WMTM) survey completions since October 2022 and March 2023, however, there is a slight decrease in April 2023 with 3507 responses compared to 3954 in March 2023. The Patient Experience and Quality Improvement Teams have identified food provision as a focussed area, which has also been noted through Clinical Accreditation, with a refresh of mealtime processes being undertaken. May data is not available at the time of reporting.

Whilst formal compliments are recorded through our electronic reporting systems, informal compliments are not routinely collected and are being considered for inclusion in future reports.

Special cause variation in complaints related to discharge or transfer from hospital has been identified. A series of focused work is underway including, a high-level learning event held with key stakeholders (pharmacy, palliative care, community and discharge teams) with a mapping exercise taking place to identify workstreams. The LCOs' Resilient Discharge Programme is a key piece of work to ensure the patient voice is understood at the point of discharge, and to assure sustainability of improvements made.

Duty of Candour compliance is an area of significant development aligned to the implementation of the PSIRF, with a revised policy and training opportunities in place. The risk in relation to this area of patient engagement is recognised across the Trust with each Hospital/MCS/LCO proactively mitigating the risk through enhanced monitoring and dedicating specific staff for oversight purposes.

The 2023/24 Clinical Accreditation programme, refreshed in February 2023, commenced in April 2023, with 28 accreditations already undertaken, including reassessment of three areas identified as 'white' (lowest achievement). Improvement was noted in these three areas, with each now accredited as 'bronze'. The Programme has been aligned to outcomes available in the Hive system.

There is special cause variation of access to timely care/assessment and treatment and a series of deep dives in urgent & emergency care, elective care, cancer and diagnostics have taken place in May 2023 to identify remedial actions.

The PLACE outcomes in the IPR are from latest available data (October 2022). Whilst most areas score highly, variation has been noted in three areas at MRI; food, privacy, and dignity. At the MLCO in-patient settings, access has been noted as requiring improvement. The Patient Experience of Care Group are monitoring the actions put in place to address the issues found. A series of PLACE 'light' visits are taking place through May and June when outcomes will be shared in future reports.

Compliance with s132 of the Mental Health Act 1983 has been monitored since January 2023 following an initial review of Mental Health provision undertaken by the Trust Safeguarding Team. The main area of concern relates to bed availability and being able to effectively provide and record the correct information to patients in a timely manner. There were no red complaints or incidents relating to Mental Health Concerns in May 2023.

There is oversight of a range of safeguarding indicators through the Group Safeguarding Committee and the AOF however new indicators, such as compliance with Deprivation of Liberty Standards, and Learning Disability / Autism and Quality Standard Compliance, are under development and will be included in the next IPR.

In response to a question from KC regarding what was being done to improve the food offer highlighted by WMTM data as a key issue, CL explained there had been some issues with menus and lack of clarity over some patients' dietary requirements. Hive is being used now to record dietary requirements, enabling all those involved in an individual's care to be aware. KC asked for a further update to be provided to QPSC in October.

The operational performance section of the IPR included data from up to the end of May 2023. JB provided an update on the position as at the end of June 2023.

The June position for A & E performance has now been confirmed with 75.8% of patients being seen in 4 hours, resulting in an overall 74.2% position for Q1. This ranks MFT as 40th out of 129 Trusts nationally. MRI remains the most challenged site and Greater Manchester (GM) remains in Tier 1 so additional support will be available from the national team, to support improved performance.

At the end of June, there remained 317 patients who had waited more than 78 weeks for their treatment but only 21 were without dates, all of which were corneal graft patients whose treatment is delayed due to a lack of materials available. Q2 will require 10500 patients to be seen in order to maintain delivery of the target.

The cancer position at the end of June saw 358 patients who had waited over 62 days for treatment against a target of 315. Gynaecology remains the speciality which is particularly challenged.

The volumes of patients awaiting diagnostics remains a challenge with 50% patients currently receiving their diagnostics appointment within 6 weeks. The target for the end of March 2024 is for 75% to do so. There has been a focus on long waits and cancers which means routine referrals are experiencing lengthy delays. In addition, there has been an increase in unscheduled demand which is impacting on elective capacity. A deep dive review of diagnostics was held on 26th May between Hospital CE and Group Executives. A set of actions was agreed and will be taken forward through the newly established Diagnostic Improvement Workstream. Recovery plans and trajectories are in place to work towards delivering the 6-week diagnostic standard.

KC thanked everyone for their hard work in reducing the elective backlog and asked JB to continue to bring updates on activity, productivity and efficiency to QPSC on a regular basis.

PB introduced the workforce section of the IPR.

Across GM, workforce metrics are still adversely affected by a challenging operational context. Although absence due to sickness is well below the rates witnessed during the pandemic, they have not returned to pre-Pandemic levels. As of April 2023, the Trust Attendance Rate was 94.32%. The single month Attendance Rate has seen a steady improvement since December 2022 however the Rolling 12 Month Sickness Absence rate has continued to increase into 2023/24 and is currently at 6.33%.

Workforce turnover (12-month average) has seen a small improvement to 13.89% in April 2023, however this remains above target. Stability/Retention Percentage is also showing an improvement on last month at 87.57% but is under achieving against target of 89%. Vacancy Rate is in keeping with turnover and retention trends remaining stubbornly above target throughout the last 12 months, currently at 9.44% against a target of 7.5%.

Mandatory training compliance levels are showing a general improvement over the last 6 months. Level 1 Mandatory Compliance for April 2023 achieved against target at 90.07%. However, further attention is needed in relation to Level 2 & 3 Mandatory Compliance which remain below target at 78.83%.

Appraisal compliance is also showing a general improvement over the last 6 months, although it remains below target. Non-Medical Appraisal Compliance for April 2023 was 81.24% against a 90% target. Medical Appraisal Compliance for April 23 was 88.83%, which is a slight decrease from March 2023 when the Trust achieved against target at 90.02%.

MFT's key metrics in relation to the theme of 'Belonging' show a mixed picture. Key areas to improve on include the Staff Engagement score which is currently 6.4 for April 2023 against a target of 6.8, and % BME staff in Band 8a and Above Roles which is currently 11.0% for April 2023 and is much lower than the BME population of Greater Manchester at 23.6% (reported by Office of National Statistics).

The Workforce agenda remains a strategic priority for the Trust, particularly in relation to staff experience, engagement, and workforce productivity and efficiency. The MFT People Plan was reviewed at the start of the year to reprioritise deliverables aligned to organisational priorities and work continues to deliver against this plan and monitor its impact.

In response to a question from DR regarding the issues with Levels 2 and 3 mandatory training compliance, PB explained that some of the issue was to do with individual members of staff but there were also issues with access to the training, both in terms of time available and the method of provision of the training. He committed to bringing a report to WFC with more detail.

MC emphasised the need to take decisive action on the results of the staff survey and communicate well with staff so they understand what is being done. PB agreed and noted that the internal, more frequent Pulse surveys paint a more positive picture of staff views.

TO noted that the recent industrial action has proven a 'bonding' exercise in many ways for different staff groups, and explained that MFT are working co-operatively with the trade unions to ensure that safe services were delivered during times of industrial action.

JEh presented the finance section of the IPR.

After two months, the year-to-date position for the Trust is a £21.7m deficit against a planned deficit of £16.9m, this is an adverse variance of £4.8m. The main reason for this adverse variance is continued material overspends on pay budgets, in part relating to last month's junior doctors' strike.

Within that YTD position the Trust delivered an in-month position for May 23 of a deficit of £8.8m against a planned deficit of £7.7m, an adverse variance of £1.1m. The key reason for this variance of £1.1m was the net amount included in the month 2 position for the impact of the pay award, moving from 2% assumed in the plan to 5%, impacting as referenced below.

Year to date income is overall £0.9m better than plan. The main drivers of this improvement are additional income relating to the revised pay award (YTD £5.3m) noting this is offset in an overspend on pay (corresponding forecast cost of £6.1m). In part offsetting this are Income for Cost Pass Through (CPT) drugs which is lower than planned (£2.9m), for which there is an offsetting underspend in non-pay and under performance in other operating income (e.g. overseas patients and car parking income).

For Month 2, and impacting on the year-to-date position, NHSE issued reporting guidance advising Trusts to not show any assumption of over or underperformance in relation to income associated with elective activity performance. Therefore all income for the planned elective activity is assumed to be received in these year to date figures. If this wasn't the case, the impact on income would be £12.3m and our therefore MFT's reported position would be £12.3m further adverse to plan.

Year to date pay expenditure is overspent by £15.4m, £6.1m of this relates to the additional cost of the 23/24 AfC pay award (a pressure of £0.8m above expected income). c.£4m relates to the costs of covering industrial action and the remainder relates to mainly to additional medical staffing above planned levels, undelivered WRP and some budget phasing.

Year to date non-pay expenditure is below plan by £9.0m, of which £2.5m relates to CPT drugs. The balance in part relates to budget phasing and reflects the reduction in activity during the industrial action in April.

It is anticipated at this stage in the year that the Trust will deliver the planned breakeven financial position. There are some significant risks to delivery which will require mitigation.

The cash balance at 31st May was £169.5m which is below forecast by £4.1m - this primarily reflects lower than forecast cash outflows on capital (£13m) and lower payments than forecast to trade suppliers (£3m) which are offset by lower than planned income receipt for patient services (£19m). It is anticipated that the income for patient services receipts, and other differences, are timing issues and will be recovered and reversed in future months. Cash is lower than the planned value primarily due to timing differences. It is anticipated that these timing differences will mainly unwind over the next two quarters but work is ongoing to confirm assumptions and profiling.

Capital expenditure year to date against the GM envelope is £5.4m compared to a plan of £4.9m. The total capital spend year to date is £9.1m compared to a plan of £13.6m. The key driver for this underspend relates to delays to approvals for the New Hospital Programme at NMGH.

The financial plan for the first 6 months of the year, against which actual results are being compared, is for a deficit each month. The second 6 months of the year requires delivery of a surplus, reflected in a significant shift between month 6 and 7, and in month 7 and thereafter a surplus of c£5m a month needs to be delivered. Steps are therefore required to curtail the significant overspends in pay, reduce other areas of spend, and increase progress on the identification and delivery of WRP.

In response to KC's request for feedback regarding the format and content of the IPR, MG stated that there is significant value in there being a single version of the truth used in all management and scrutiny committee meetings, and NG noted the importance of the commentary section to provide detail on top of the pass/fail nature of the metrics.

Board Decision:	**Action**	**Responsible officer**	**Completion date**
The Board noted the report	Metrics to monitor adherence with NICE guidance to be developed and reported through QPSC	TO	August 2023
	Cl to provide an update on the work to improve the patients experience of MFT food to QPSC	CL	October 2023
	PB to provide a report to WFC regarding compliance with mandatory training levels 2 and 3	PB	August 2023

101/23 Group Chief Finance Officer's Report

JEh introduced the report, explaining that it was a regulatory requirement to report to the Board an up to date statement of comprehensive income and the Trust's statement of financial position. These items are not included in the finance section of the IPR.

In response to a question from KC regarding compliance of all partners with the GM finance accountability framework, JEh explained that all Trusts were signing it off through their Board meetings. However, there was not yet a GM-wide plan for how they would address the £130m risk which the GMICB are carrying. LG noted that this should be addressed through system-wide initiatives to work more efficiently and effectively. MC added that the fact that it hadn't been reduced during Q1 meant there was more to do in the rest of the year so there is a need to identify system-wide initiatives and implement them swiftly.

TR noted that the year-end projection is to have less than a month's worth of cash and that this is something which FDSC will be monitoring closely.

Board Decision:	**Action**	**Responsible officer**	**Completion date**
The Board noted the Month 2 I&E position against the 23/24 plan and Cash and Capital positions for the Trust. and agreed the GM ICB System Savings	None	n/a	n/a

statement (focusing on cost reduction) and the allocation decisions regarding any future new funding.			

102/23 Update on Hive Programme

JB began her introduction to the report by welcoming an award of £91k from Epic rewarding MFT's successful implementation process. The funds will be spent on further system improvements.

JB highlighted:

- New programme governance introduced as a result of recommendations from Deloitte.
- Improvements to address the number of escalations within the administration workstream.
- The system upgrade which took place on the 22/6/23 to deliver up to date software and functionality and deliver some important clinical pathway developments.
- The implementation of the 3rd party system for blood transfusion will take 12 months and so a review of current workarounds has taken place and recommended actions for implementation will now be taken forward.
- The focus on benefits realisation with £11m realised so far from a target of £19m.
- The value of MyMFT with DNA rates for patients using it at 5.4% compared to a DNA rate of 9.3% for patients not using it.

In response to questions from NG, JB explained that the system had to be taken down for a short time for the upgrade due to its significance but added that smaller upgrades are happening frequently without the need for system downtime. She also described discussions ongoing with the national team regarding the linking of MyMFT with the NHS app.

MC noted the potential of Hive to enhance patient engagement with the Trust including encouraging more healthy behaviours.

MG commented that staff comments about Hive received during Senior Leadership Walkrounds had been positive and LG suggested further external communication regarding the success of the Hive programme.

Board Decision:	**Action**	**Responsible officer**	**Completion date**
The Board noted the progress made since Go Live completion and the significant progress made in the first phase of Stabilisation.	None	n/a	n/a

103/23 NHSE 2023/24 elective priorities' Board checklist

JB introduced the report which included a NHSE checklist for Trust boards to assure themselves of the Trust's plans to deliver elective and cancer recovery objectives. The three key performance deliverables and metrics included are: to virtually eliminate waits of >65w by March 2024; to continue to reduce the number of cancer patients waiting over 62d; and to meet the 75% cancer FDS ambition by March 2024. Key progress has been made in some areas but the report also highlights areas where improvement is required. Hospitals/MCSs/LCOs carried out their own assessments to contribute to the Trust position.

DR explained that the checklist had been scrutinised within QPSC and it will continue to be used there as a benchmark for performance monitoring.

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

104/23 Update on strategic developments

TR introduced the report which provided an update on strategic issues nationally, regionally, and within MFT. He highlighted a number of key areas within the report.

On 15 June 2023, the government published the 2023 mandate to NHS England, setting out the key objectives for the service to deliver this year. It has fewer targets and is a shorter document than in previous years to emphasise the government's commitment to deliver on the key concerns of the public and recognise the importance of allowing integrated care systems the freedom to deliver effectively. The priorities are:

- Cut NHS waiting lists and recover performance
- Support the workforce through training, retention and modernising the way staff work
- Deliver recovery through the use of data and technology.

This mandate is intended to apply from 15 June 2023 and progress will be kept under review until a new mandate is published.

An engagement draft of Greater Manchester's Joint Forward Plan has been shared across the system for review and feedback. The document is based on the six missions in the Integrated Care Strategy; the actions to deliver them; the measures for tracking delivery; and where accountability is held supported by the performance framework and agreed ways of working. The NHS England guidance states that the plan should be continually reviewed and formally updated on at least an annual basis. In line with this, GM ICB intend to further develop the document in particular in relation to the financial sustainability mission and to keep the momentum on system conversations with a focus on making choices that secure long-term sustainability whilst continuing to improve outcomes for the population of GM.

Plans for the North spoke CDC in Harpurhey were developed and submitted to NHSE in May and have received ministerial approval. The plans focus on delivering enhanced diagnostic capacity, as well as reducing health inequalities for people living in and around North Manchester. Confirmation of ministerial approval for the CDC North spoke plan has now been received. The CDC programme team has recently expanded to support delivery of the wider programme, including delivery of the North Spoke.

NHS England has confirmed an accelerated timeline for the roll out of the Targeted Lung Health Check (TLHC) programme. MFT is the lead provider working in collaboration with Greater Manchester Cancer Alliance, The Christie and Northern Care Alliance. The agreed approach is to set up Community-Based One-Stop Clinics utilising risk stratification and immediate ultra-low dose CT scan of the thorax for those eligible (at-risk, ever-smokers aged 55-74yrs). This is a tried and tested approach, developed by MFT in 2016/7 and now adopted nationally. The roll-out will be based on Primary Care Networks stratified by smoking prevalence, lung cancer incidence and mortality, and deprivation.

MC welcomed the update and also highlighted the bid to pilot a new model for the management of sickle cell which has been approved by NHS England. The new pathway will provide patients across GM and the North West with more rapid access to specialist advice and care including admission, if necessary, on a 24/7 basis, wherever they live, and bypassing their local emergency department. MC commented that this initiative, along with the Community Diagnostic spoke in North Manchester and the Targeted Lung Health check programme were good examples of the

work MFT is undertaking to address health inequalities.

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

105/23 Annual Infection Prevention Control (IPC) report

CL introduced the IPC Annual Report which describes how the Trust's Infection Prevention and Control team (IPCT) has engaged in Health Care Associated Infection (HCAI) Prevention and Control during the period 2022-2023. She highlighted:

- The continued impact of the COVID pandemic over the last financial year and the lessons learned which have been kept in place to reduce the chances of other infections in the future.
- The work undertaken on preventing infections such as the vaccination programmes in place across the Trust.
- The contribution of the Trust in managing the outbreak of Mpox (also known as Monkeypox).
- Increases in the prevalence of some infections across the Trust e.g. CPE.
- The establishment of a new Antimicrobial Stewardship Committee, spanning hospital and community, chaired by the Medical Director of NMGH.
- Water sampling for Legionella Remedial with action successfully undertaken on outlets that did not meet the required standard.
- Outbreak management requirements across MFT over the last financial year.

In response to a question from KC regarding C. diff infections, CL explained that it was very contagious and the pressure on ward and side-room capacity during Covid had caused issues with isolating patients quick enough. There is a particular lack of side-room capacity in NMGH.

Due to the increasing levels of some bacterial infections, DR requested a detailed report to be presented at QPSC for further scrutiny.

In response to a question from DR regarding staff vaccination, CL explained that planning had already begun for this year's flu vaccination programme and she was confident uptake would be higher without having to deliver a COVID vaccination programme at the same time.

Board Decision:	Action	Responsible officer	Completion date
The Board noted the report and approved it for publication.	Report on specific HCAI infections which are increasing across the Trust to be presented at QPSC	CL	October 2023

106/23 Annual Safeguarding Report

CL introduced the report which provides assurance to the Board of Directors that Manchester University NHS Foundation Trust (MFT) is fulfilling its statutory safeguarding responsibilities as outlined in Section 11 of the Children Act 20041 and in the Care Act 20142 and regulatory standards. The report:

- details the systems in place to support MFT staff to keep service users safe and protect them from neglect or harm whilst they are in the care of MFT's Hospitals/MCSs/LCOs.
- identifies how patients, service users and their loved ones have a voice, by ensuring that they are actively involved in decision-making regarding their safety and protection, ensuring

that they feel safe.
- informs the Board of Directors of the internal and external safeguarding activity undertaken in 2022-2023 and outlines the key priority areas for 2023-2024.

CL highlighted:
- MFT's responsibilities as a corporate parent when looked after children are under MFT's care
- The increase in children with acute mental health needs requiring care and the work underway to offer support to.
- Compliance with level 2 and 3 safeguarding training.
- MFT's CAMHS including Galaxy House, which is currently seeing more demand than it has capacity to care for.
- A focus on improving care for people with a learning disability or autism including enhanced training for staff.
- The role Hive can play in supporting safe data sharing with partners.
- The fact that 95 safeguarding risk are raised every day across MFT.

In response to a question from TR regarding any issues with continuity of care for children transitioning into adulthood, CL explained that it had been an issue historically but a lot of work had been carried out since then. A consultant nurse is in place at RMCH to address any issues. KC added that, in addition, a youth worker had been funded by the charity for RMCH.

MG welcomed the increase in reporting of safeguarding issues, noted the opportunity to play a greater role in influencing wider safeguarding policy and practice, and sought assurance that there is at least someone on each ward who has the requisite level of safeguarding training. CL explained that she would provide assurance of that through QPSC.

In response to a question from KC, CL confirmed that the Trust wasn't relying on the 2019 CQC report for assurance regarding CAMHS services. RMCH provide assurance on all their services, including CAMHS, through the established Group-level assurance processes.

Board Decision:	**Action**	**Responsible officer**	**Completion date**
The Board noted the report and approved it for publication.	Assurance on ward staff levels 2 & 3 safeguarding training compliance to be provided to QPSC	CL	August 2023

107/23 Update on response to Ockenden Report

CL introduce the report which provided:
- an update on progress and ongoing monitoring of compliance following the Care Quality Commission (CQC) inspections of maternity services and receipt of a Section 29A Warning Notice (24th March 2023)
- assurance of ongoing compliance of Ockenden Immediate and Essential Actions (IEAs)2 received by the Quality and Performance Scrutiny Committee
- an update on the Maternity Self-Assessment Tool (MSAT)
- Maternity Incentive Scheme (MIS) Year 4 Q4 22/23 reports of Avoidable Term Admissions in Neonates (ATAIN) as required within the Maternity Incentive Scheme
- an executive summary of the Maternity and Neonatal Safety Dashboard

CL reminded colleagues that an extraordinary QPSC had been held on the 16/6/23 which was dedicated to an update on the improvement work undertaken within SMMCS since the CQC warning notice. £1.7m had been invested and discussions were ongoing with national and regional colleagues to influence future policy and practice.

CL highlighted that the still birth figures recorded in the maternity dashboard incorrectly stated that the still birth rate at SMMCS was 8 per 100 when in fact it should be 3 per 100. The published Board papers will be amended to correct this.

CL further highlighted:

- a presentation she had given to Manchester's Health Scrutiny Committee
- the maternity self-assessment tool
- NHSE's 3 year delivery plan for maternity services
- the Maternity Incentive Scheme which would be presented at future QPSC meetings to enable detailed scrutiny
- the impact of current vacancies on maternity care and the need to move staff between sites on occasion to manage demand
- the number of diverts which have been required between MFT hospitals for maternity care
- the target to increase training compliance to 90% by September 2023

KC also reminded the Board that CM, the NED Maternity Board Safety Champion, had carried out a number of visits to SMMCS to receive assurance on the safety of services and to talk to the staff.

Board Decision:	Action	Responsible officer	Completion date
The Board noted the report.	Board papers to be amended to reflect the correct still birth rate	NGo	July 2023

108/23 Update report on MFT's Risk Management Framework and Strategy(RMFS)

TO introduced the report and explained that the annual review of the RMFS had been carried out, informed by feedback from the Group Risk Oversight Committee and from the Board of Directors' seminar in June 2023.

MFT's new principal risk infrastructure and changes to the ways in which risks would be escalated and de-escalated were presented for approval.

KC acknowledged the work of the interim Director of Clinical Governance and noted that it was for the Board to approve the RMFS, not ratify it.

Board Decision:	Action	Responsible officer	Completion date
The Board approved the revised Risk Management Framework and Strategy.	None	n/a	n/a

109/23 Group Risk Appetite Statement

TO presented the revised Group Risk Appetite Statement for approval by the Board. Comments from NEDs at the June Board seminar had informed the final version.

Board Decision:	Action	Responsible officer	Completion date
The Board approved the revised Group Risk Appetite Statement.	None	n/a	n/a

110/23 Board Assurance Framework (BAF)

PB introduced the BAF which presents the risks which have the most potential to impede MFT's delivery of its strategic aims. These risks are overseen by the relevant Board Scrutiny Committees. The BAF incorporated the new Risk Appetite Statement and Principal Risk Infrastructure approved at this meeting. It also responded to the recommendations from this year's review of the BAF by MFT's internal auditors.

KC noted that the BAF influences the contents of the agendas at each of the Board's Scrutiny Committees.

Board Decision:	Action	Responsible officer	Completion date
The Board accepted the Board Assurance Framework.	None	n/a	n/a

111/23 Terms of reference for the Strategic Projects Scrutiny Committee

PB introduced the report which proposed the establishment of a new committee of the Board of Directors and presented the terms of reference for approval. The need for a new committee had been identified as part of the Board governance review completed earlier in the year.

JEh gave examples of some of the projects which would be under the purview of the committee including the NMGH redevelopment, the Wythenshawe Masterplan and proposals for a new dental hospital.

In response to a comment from KC regarding the need not to limit the projects in scope by their financial value, JEh explained that the £15m figure in the terms of reference had been included as it reflected NHSE approval levels. LG commented that financial cut-off limits would not always be relevant as lower cost initiatives may still have significant strategic or reputational impact.

Board Decision:	Action	Responsible officer	Completion date
The Board approved the terms of reference for the Strategic Projects Scrutiny Committee.	None	n/a	n/a

112/23 Amendments to MFT's Constitution

PB introduced the report which proposed amendments to MFT's Constitution following a review carried out be external legal advisers. The proposed changes updated the Constitution to ensure it was in line with recent legislative changes and national guidance on governance for NHS organisations. Following approval by the Board, the amendments were being presented to the Council of Governors on the 12/7/23 for their dual approval in line with the provisions within the existing constitution.

Board Decision:	Action	Responsible officer	Completion date
The Board approved the amendments to	None	n/a	n/a

MFT's Constitution.			

113/23 Date and Time of Next Meeting

The next meeting of the Board of Directors will be held on Monday 11th September 2023 at 2:00pm

114/23 Any Other Business

There were no additional items of business.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING (Public)

ACTION TRACKER

Board Meeting Date: 10th July 2023		
Action	Responsibility	Completion date
Metrics to monitor adherence with NICE guidance to be developed and reported through QPSC	TO	Complete. Included in IPR
Cl to provide an update on the work to improve the patients experience of MFT food to QPSC	CL	October 2023
PB to provide a report to WFC regarding compliance with mandatory training levels 2 and 3	PB	Complete. Included in IPR
Report on specific HCAI infections which are increasing across the Trust to be presented at QPSC	CL	October 2023
Assurance on ward staff levels 2 & 3 safeguarding training compliance to be provided to QPSC	CL	October 2023
Board papers to be amended to reflect the correct still birth rate	NGo	Complete

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

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

Agenda Item 7

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Executive
Paper prepared by:	Mark Cubbon, Group Chief Executive
Date of paper:	September 2023
Subject:	Group Chief Executive Report
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	The Group Chief Executive has provided a report which provides an overview of activities at the Trust, the response to current operational pressures, and progress made on strategic objectives. They have outlined issues of current interest to the Board and have shared their top three areas of concern.
Recommendations:	The Board of Directors is asked to note this report.
Contact:	Name: Leo Clifton, Senior Business Manager Tel: 0161 529 0264

The purpose of this report is to provide a general update on matters that the Group Chief Executive Officer (CEO) wishes to highlight to the Board since the last public board meeting. The report is divided into 5 sections:

1. Strategic Updates

There are three key strategic updates I would like to bring to the Board's attention:

North Manchester Redevelopment

On 17th August, Lord Markham CBE and Minister of State for Health, visited North Manchester General Hospital (NMGH) as part of a nationwide tour of hospitals connected to the Government's New Hospital Programme (NHP). Members of the Executive Director Team were in attendance alongside staff from NMGH, local MPs, Integrated Care Board (ICB) colleagues and patients from the local community. This visit provided an opportunity to showcase our plans to build a new hospital on the NMGH site, but also the extent of the plans to deliver additional housing and to support economic growth in the area, in collaboration with Manchester City Council, and other partners.

We continue to work with the NHP team to provide the necessary details to inform the final stages of Outline Business Case, which will enable us to complete the next phase of design and agree a timetable for construction. In the meantime, we continue to prepare the site in readiness for the development and we are set to open the new Multi-Storey Car Park and Cycle Hub on Monday 25th September, marking the successful delivery of the first phase of essential enabling works. This is an important step and provides a much needed, safe and modern facility for staff and visitors to access.

MFT Elective Recovery Plan

We are making good progress with our plans to improve the performance and productivity of our elective services across MFT. We have recently committed to scale up the use of the Trafford Elective Hub with a dedicated leadership team now in place to support the expansion and improvements in utilisation.

An Outpatient Improvement Programme is in place and is leading a range of initiatives to increase clinic utilisation and reduce DNAs. We are working closely with the national Getting It Right First Time (GIRFT) programme, making full use of the guidance and support available to us.

We are also trialling self-scheduling in a small number of specialties through the MyMFT patient portal, which will help to reduce Did Not Attends (DNAs). We now have 250,000 patients signed up to MyMFT and early indications show the DNA rate for all patients using the portal is around half that of the wider patient population. We plan to roll out further over the months ahead.

There are also encouraging trends in our theatre utilisation which has improved by 5% since April, with Trafford showing an increase of 6%. That said, there is still variation in performance and this is an important focus through group led improvement work, and for each hospital leadership team.

Annual Members' Meeting

This year's Annual Members' Meeting takes place on the 20th of September, between 1pm and 5pm, in the Post-Graduate Centre on the Oxford Road Campus. The theme of this year's event is 'Your health matters' with a particular focus on the work underway at MFT to address health inequalities. The event is open to all staff, MFT members, and our local communities.

In addition to hearing presentations from the Chairman, the lead Governor, and members of the Group Executive Team; there will be a range of stalls from services across the whole of MFT presenting the work they are doing to improve health and address health inequalities. In addition, the Local Care Organisation (LCO) will be providing blood pressure and health checks on the day, and the CURE team who support smoking cession will be providing advice and lung health check assessments. Governors will also be on hand to promote our Membership Scheme and to hear feedback about local health care and our services.

Further information can be found on the MFT website.

2. Operational Delivery

This section provides a high-level overview of operational delivery which is reflected in more detail in the Integrated Performance Report in item 9.1 on the agenda.

Performance & Recovery

In Urgent and Emergency care, year to date 4-hour performance across all types is 72.30% against a trajectory of 66.3%. While we continue to make improvements, there is variation in performance across our sites, with the Manchester Royal Infirmary (MRI) experiencing the most acute pressures.

Our focus is on modifying pathways across our acute sites to support a reduction in waiting times within our Emergency Departments, while working with our partners to support earlier discharges and improve flow. Clinical and operational teams across all acute sites are working together to identify opportunities for improvement and to share examples of good practice.

Our year to date performance for ambulance handovers within 15 minutes is 45.80% against a target of 65%. This is against a backdrop of considerable improvements in ambulance handover delays across the Trust.

For Cancer Care the 62-day cancer backlog in July was 346 against a planned trajectory of 305. We are expecting additional capacity to deliver improvements to this position, moving us closer to our trajectory.

July month end performance against the Faster Diagnosis Standard was 70.5% against a submitted trajectory of 68.3%, our year-to-date performance is 71.94% against a March 2024 target of 75%.

In August, we received notification from NHSE that national Cancer Waiting Times standards have been amended with implementation from 1st October. The revisions place a heighted focus on delivering 62-day and 31-day performance while removing the Two Week Wait target. The changes bring together the various 62-day targets into a single standard with the same adaptations being implemented for 31-day standards. Board oversight documentation will be updated to the new reporting format and performance teams have already adopted the new standards for internal tracking and monitoring.

For elective performance, at end of July there were 321 patients waiting over 78 weeks predominantly due to patient choice, patients being medically unwell, or due to the impact of industrial action. At end July, there were 8,748 patients waiting over 65 weeks against a planned trajectory of 8,762.

Our year to date 6-week diagnostic performance at end July was 50% against a planned trajectory of 47.3%. Challenges in this area are significant although MFT remains committed to the target of 25% by 31st of March 2024, through the work of the Diagnostic Improvement workstream.

Elective assurance letter

We received a letter from NHSE on 4th August thanking colleagues across NHS services for their continued efforts to support elective recovery, in particular the reduction in long waits. The letter set out the next steps for protecting and expanding elective capacity. The 23/24 annual planning assumption was to ensure we have no patients waiting greater than 65 weeks by 31st March 2024. Subsequently, the letter outlined a new expectation for all patients in the 65-week wait cohort to have had their first outpatient appointment by 31st October.

We are working across all MFT sites and GM partners to ensure any additional capacity we can create is focussed on the achievement of the national ambition, although continued industrial action presents an obvious and significant risk to delivery. All Trust boards have been asked to confirm actions are in place to achieve the requirements set out in the letter with a deadline for return of 30th September.

Industrial Action (IA)

Since our last Board meeting, we have experienced further periods of industrial action across part of our Junior Doctor and Consultant workforce. We have continued to prioritise access to our urgent services during these times, but we have tried to protect as much planned elective activity as possible. This has been particularly challenging through the peak holiday periods, but I am grateful for the enormous effort from our multidisciplinary teams to prepare for, and safely deliver services throughout each period of IA.

While taking every reasonable step to reduce the impact on our patients, it has been necessary to reschedule thousands of appointments since IA commenced. With each period of IA, there is further risk to delivery of our challenging performance trajectories.

Winter Planning

A programme of work is being undertaken to define comprehensive winter plans at both site and group level to prepare for the increased pressures we are likely to see throughout the winter period. We will be incorporating learning from previous years and are working in close partnership with our locality leads to develop a system-wide plan. A core element of our winter planning is to provide alternatives to admission where possible, with an ongoing focus on effective discharges from our acute hospital beds into safe community settings.

Electronic Bed Capacity Management System

MFT is one of several Trusts working with NHSE on a pilot programme to develop a Electronic Bed and Capacity Management System (eBCMS) as part of The Urgent and Emergency Care (UEC) Recovery Plan. The programme aims to optimise our bed management capabilities in Hive and implement appropriate solutions to improve patient flow. An initial assessment against the eBCMS criteria has been completed and the next steps will be to detail the requirements for Hive optimisation and revised operational procedure to underpin the improvements. The timeline for delivery is in development with NHSE, with a focus on gaining the maximum benefit prior to winter.

3. Quality & Safety

This section provides an overview of recent developments in relation to quality & safety including any external or internal inspections and audits:

Following the outcome of the trial of Lucy Letby, NHS England has written to all Trusts and Integrated Care Boards to reiterate the mechanisms in place to strengthen patient safety monitoring; ensure patients, families and staff are listened to; and to strengthen background checks on Board members.

The letter specifically asks that Boards must ensure proper implementation and oversight of Freedom to Speak up arrangements so that:

- All staff have easy access to information on how to speak up.
- Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
- Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures, where everyone feels safe to speak up, should also be put in place.
- Boards seek assurance that staff can speak up with confidence and whistle-blowers are treated well.
- Boards are regularly reporting, reviewing and acting upon available data.

At today's Board there are a number of reports relevant to this work:

- The Committee report from the Quality and Performance Committee held on the 29th of August notes the presentation at that meeting of the Freedom to Speak Up Annual Report for 2022/23 and the Quarter 1 report for 2023/24.
- The enhanced Patient Safety Incident Response Policy, along with the Patient Safety Incident Response Plans from our hospitals, Managed Clinical Services, and LCOs are presented for Board review in item 11.5 on today's agenda.
- NHS England's new Fit and Proper Person's Framework, and the work underway to fully implement it at MFT, is presented in item 11.1 on today's agenda.

Maternity services: Care Quality Commission (CQC) inspection

On 28 July the CQC formally published their report following an inspection of Maternity services which took place in March 2023. A comprehensive action plan has been in place and has been progressing well, since the time of the inspection. We continue to have enhanced oversight with several distinct workstreams led by members of the St Mary's Hospital (SMH) leadership team which are now moving into the next phase of improvement and stabilisation. Our maternity units have also formed a key focus for leadership walkabouts for executive and non-executive directors, enabling oversight of the improvements taking place and escalation of any identified issues.

RMCH Spinal Safety Review

Last year, the Northern Care Alliance NHS Trust (NCA) notified MFT that they would be undertaking a safety look back in relation to the care provided by a spinal surgical consultant who had previously been in their employment and who had performed surgery at Royal Manchester Childrens Hospital until 2012. Concerns had been raised by patients and families focusing on identification of any patient harm and safety concerns, and the professional practice of the consultant.

RMCH initiated a review of patients who were operated on by the surgeon between 1st January 2006 and 31st December 2012. All patients who are having their case notes reviewed were sent an initial advisory letter and those who have since been excluded from the review, or where there were no concerns identified, have been sent a letter of reassurance. Designated contact points for patients or families were provided in the letters to ensure they have the information and support they need.

Primary reviews are being undertaken by consultant spinal surgeons and an additional spinal surgeon will carry out secondary reviews. The Quality and Performance Scrutiny Committee received a progress report on this matter at their meeting on the 28th of August and will continue to monitor progress.

4. Workforce & Organisational Development

Recruitment to Senior Leadership Roles

We are currently recruiting to a number of key leadership positions and I will provide a verbal update on the posts and timeline for recruitment at the board meeting.

Consultant Appointments

Since July of this year, 16 consultants have been appointed to roles within the following specialties: Anaesthetics, Burns and Plastics, Dental Surgery, Diabetes, Gynaecology, Infectious Diseases, Ophthalmology, Orthopaedics, Paediatric Gastroenterology, Paediatric Surgery, Radiology, Thoracic and Trauma & Orthopaedics.

We continue to attract a high calibre of candidates and provide a development programme for newly appointed consultants.

Listening Well Programme

Throughout July and August, I have hosted a series of ‘Listening Well’ events spanning all Hospitals and Managed Clinical Services (MCS). These one-hour events supported by Organisational Development and local hospital Chief Executives, provide an opportunity for ongoing dialogue between frontline teams, local leadership, and group executive teams.

Around 750 colleagues have participated in these informal engagement sessions to hear about priorities, ask open questions and participate in Menti conversations around views on our future strategic priorities. The events will continue until the end of September when priority themes will be consolidated to support follow-up sessions in the Autumn with a focus on the development of our workforce culture and our organisational strategy.

5. Top concerns

The current top concerns I would like to highlight to the Board are:

Financial Position

Our financial position is under increasing pressure as evident in our reported position at Month 4. We continue to take appropriate action to deliver improvements to our run-rate through the application of enhanced controls, delivering improvements in productivity, and through the delivery of cost improvements. We are on track to deliver £112m of cost improvements and we have a plan to deliver £136m by the end of the financial year. We remain committed to the delivery of our plan, but there are significant risks to our position, as noted in the Chief Financial Officer update on the agenda.

Impact of Industrial Action

The ongoing episodes of Industrial Action present significant operational challenges, disruption for our patients, and pose additional risks to delivery of our already challenging performance trajectories. There is a financial consequence to each period of action which contributes to the in-year financial challenge described above.

The above concerns are reflected in the principal risks within the Trust Board Assurance Framework.

Agenda Item 8(I)

NHS Manchester University NHS Foundation Trust

Workforce Scrutiny Committee
Highlight Report

This report includes the key escalations and discussion points from the last Committee meeting of the Workforce Scrutiny Committee for consideration by the Board of Directors. The agenda for the meeting is included.

Committee meeting date	29th August 2023
Committee Chair	Angela Adimora

KEY ESCALATION AND DISCUSSION POINTS

ALERT

Although reducing staff absence is reducing the rate remains at 5.5% with an aim to reduce to pre-pandemic levels. Still some areas / departments which are above 10%.1/3 of staff absent for over 28 days are absent due to mental health reasons.130 people were absent from work as a result of COVID on 25/8.

ASSURE

Staff absence is tracked regularly and reported through relevant Committees and Group Recovery Board. A 'heat map' is in place to highlight any particularly 'under pressure' areas.

Patient safety was maintained throughout recent period of industrial action but delays to elective treatment have occurred. Good relations are being maintained with staff and their representative bodies.

Employee Health and Wellbeing Services are evaluating well.

Work continues to be undertaken to enhance the staff experience. A progress report was considered by the Committee which included reference to the Group Chief Executive lead staff engagement programme.

The national Perinatal Culture and Leadership Development Programme is being embedded within Saint Mary's and Listening Events are continuing for all staff there. Saint Mary's recruitment and retention work is showing signs of success but there remain 60 midwifery vacancies at end of July and this is monitored closely. Due to new starters arriving, this gap should be reduced to under 10 by the end of the year.

Work is on track to deliver the actions required to address the recommendations of the internal audit report on job planning for doctors.

MFT is meeting the relevant standards with regard to medical revalidation.

The GMC training survey results (2023) have been analysed. Internal reviews and monitoring has been established, including visits to areas and specialties where issues have been flagged in survey results.

WSC received the Guardian of Safe Working quarterly report, data from which is triangulated with other sources to better understand the junior doctor experience. There has been a drop this quarter in exception reports to the Guardian. Staffing levels and rota gaps are the issues highlighted most frequently within exception reports.

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The Q1 report of the FTSU Guardian was received. The FTSU Guardian, NED lead, and Exec lead will be undertaking a 'reflection' to assess how FTSU is functioning within MFT, including ensuring that staff do not feel that they will be disadvantaged by raising issues.

Work is underway to address issues raised in the last NHS staff survey. Staff incentives are in place to increase survey completion this year.

ADVISE

NHS Long Term Workforce plan has been launched. Detail of funding is yet to be provided to Trusts and it will be distributed via GM ICB. Discussions underway with external colleagues to ensure funding streams are fairly allocated. The potential for medical apprenticeships is being explored with the University of Manchester.

National legislation regarding support for carers is expected next year. This will require an amendment to flexible working and carer support policies at MFT.

MFT is considering the North West the Black, Asian and Minority Ethnic Assembly anti-racist framework as part of its work on inclusion and diversity. . As part of this the Diversity Matters Strategy is being reviewed and a refreshed version will be presented to the Board of Directors for approval..

The FTSU annual report and Quarter one reports were received.

RISKS

The principal and strategic risks which are relevant to WSC were presented. Strategic risks related to workforce are being reviewed and new ones will be approved at Group Risk Oversight Committee and reported to future WSCs.

ACTIONS (actions required of the Board/Committee receiving this report

To receive the recommendation from WSC to approve the annual submission for appraisal, revalidation and medical governance.

LEARNING

Learning from exercises to gather staff experience data is informing a range of improvement actions identified in reports presented to the meeting.

Meeting agenda

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

Workforce Scrutiny Committee

Tuesday, 29th August 2023 at 9.30am – 12.00noon

A G E N D A

Main Boardroom, near Cobbett House Reception, ORC

1.	Apologies		
2.	Staff Story		
3.	Declarations of Interest		
4.	Minutes of the Workforce Scrutiny Committee held on 20th June 2023	*(enclosed)*	*All*
5.	Matters Arising (if not included on the Main Agenda)		*All*
	Items for Scrutiny and Assurance		
6.	Report of the Group Executive Director of Workforce and Corporate Business	*(enclosed)*	*Peter Blythin*
7.	To receive the NHS Long Term Workforce Plan	*(enclosed)*	*Peter Blythin*
8.	MFT performance against workforce metrics included in the Integrated Performance Report	*(enclosed)*	*Peter Blythin*
9.	Update on strategic risks relevant to workforce including escalations from Group Risk Oversight Committee	*(enclosed)*	*Peter Blythin*
10.	To receive a progress report on cultural work at St Mary's Managed Clinical Service following CQC report	*(enclosed)*	*Alison Haughton/ Vicki Hall*
11.	To receive a position statement against MFT's Equality, Diversity and Inclusion Improvement Plans	*(enclosed)*	*Nick Bailey*
12.	To receive a progress report against actions from the Job Planning Internal Audit	*(enclosed)*	*Toli Onon*
13.	To receive the Annual Medical Revalidation Report and Annual Statement of Compliance	*(enclosed)*	*Toli Onon*
14.	To receive the 2023 GMC Survey	*(enclosed)*	*Toli Onon/ Peter Blythin*
	Work Programme Governance Items		
15.	Guardian of Safe Working Quarterly Report (Q1)	*(enclosed)*	*Karen Fentem*

16.	To receive the Annual Report of the Freedom to Speak-Up Guardian (including Q1 data)	*(enclosed)*	*Andrew Lloyd*
17.	To receive a progress report on staff survey improvement plans / initiatives (including trend analysis)	*(enclosed)*	*Peter Blythin/ Yvon Poland*

Items for Noting

18.	To receive the Workforce Scrutiny Committee Work Programme	*(enclosed)*	*Committee Chair (Angela Adimora)*
19.	To note the following meetings held:		
19.1	Workforce & Education Committee meeting held on 23rd June and 28th July 2023	*(enclosed)*	*Committee Chair (Angela Adimora)*
19.2	Medical Directors' Workforce Board meetings held on 29th June and 27th July 2023	*(enclosed)*	*Committee Chair (Angela Adimora)*

Any Other Items

20.	Any Other Business	*All*

Date of Next Meeting

21. The next meeting is to be held on
Tuesday, 24th October 2023 at 10:00am
in the Main Boardroom, ORC

Agenda Item 8(ii)

Manchester University NHS Foundation Trust

Quality and Performance Scrutiny Committee
Highlight Report

This report includes the key escalations and discussion points from the last meeting of the Quality and Performance Scrutiny Committee for consideration by the Board. The agenda for the meeting is included.

Committee meeting date	29th August 2023
Committee Chair	Damian Riley

KEY ESCALATION AND DISCUSSION POINTS

ALERT

The waiting list for diagnostics has risen from 30,000 in September 2022 to 42,000 in July 2023 – a range of improvement actions are in place to address this. There are workforce issues in key modalities which is affecting delivery.

The time waiting for those with mental health needs in MFT's Emergency Departments is a concern and discussions are taking place with local mental health providers to improve the situation.

ASSURE

The Committee considered a number of elements of quality and safety performance, including the implications of a recent never event, maternity safety and assurance in relation to the actions taken in response to learning. The continued requirement for improvement in the governance associated with the effectiveness domain was subject to scrutiny by the Committee, with a detailed review scheduled for October.

Diagnostic performance was considered in depth by the Committee. It is being managed as a strategic risk, supporting the focused scrutiny of actions being taken in mitigation, and achievement of the performance target remains a significant challenge. Compliance with the trajectory set by NHSE for improvement in Emergency Department 4-hour wait target was discussed with assurance received regarding agreed derogation from the national target.

A new set of improvement actions to improve operational performance have been agreed and are reported through Group Recovery Board.

The June data from the Accountability Oversight Framework (AOF) was received with assurance received that any site specific concerns were being addressed. A refresh of the AOF is currently being undertaken to ensure it meets the needs of the Trust.

Assurance was received that services were safe during the recent periods of industrial action but they have affected the delivery of the elective recovery programme and will lead to some longer waiting times for patients.

Two issues identified in colorectal and urology services resulting from disaggregation of services have been identified and managed effectively. There is no evidence to date of any patient harm.

There has been a cohort of '12 hour trolley wait' patients admitted to hospitals outside of MFT who were excluded from initial performance reporting. All had been treated appropriately and there are no safety issues. The matter has been discussed with NHSE and agreement has been reached as to how the data will be reported.

The Statement of Compliance against EPRR standards was discussed prior to approval at the Board of Directors. There are no areas of non-compliance.

The role of Quality Impact Assessments within the waste Reduction Programme was noted and supported.

The Annual Complaints report was reviewed by the QPSC. Complaints had gone up during the year with the largest number being about waiting times for treatments. PALS number have increased as well. The turnaround times for responding to complaints has improved.

There was a temporary suspension of Saint Mary's andrology laboratory following an inspection by UKAS. A further inspections took place on 25/8 and the service will now be re-accredited. The issues leading to the suspension have been identified and are being resolved.

The Q1 Perinatal Mortality scheme report was received along with lessons learnt from Q2 2022/23. The reporting requirements for year 5 of the Maternity Incentive Scheme were presented by Saint Mary's and noted.

The Patient Safety policy and Patient Safety plans from hospitals/MCSs/LCOs were discussed and supported prior to approval at the Board of Directors in September.

ADVISE

An ACE day in September is taking place and all sites are being asked to focus on their contribution to the national clinical audit programme.

A report will come to a future Committee meeting following a review of systems after the recent Letby case. Quality Impact Assessment tool.

It was agreed to postpone the item on Learning from Deaths to the October QPSC to ensure there was sufficient time to discuss it in full.

RISKS

The relevant sections of the Strategic Risk Exposure Report were discussed at the meeting.

ACTIONS (actions required of the Board)

To note the support for the Patient Safety policy and associated Patient Safety plans.

LEARNING

Learning featured in a number or reports to the Committee, including the Annual Complaints report, and underpins the new Patient Safety policy and associated plans.

Committee agenda

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

Quality & Performance Scrutiny Committee

Tuesday 29th August 2023 at 1.00pm – 4:00pm

MAIN BOARDOOM
COBBETT HOUSE

A G E N D A

1.	Apologies		
2.	Declarations of Interest		
3.	Minutes of the Extraordinary Quality & Performance Scrutiny Committee held on 16th June 2023 and the Quality and Performance Scrutiny Committee held on Tuesday 20th June 2023	*(enclosed)*	*All*
4.	Matters Arising if not on the main agenda		*All*
5.	To note the Performance quality and safety strategic risk exposure report	*(presentation)*	*Toli Onon / Tanya Claridge*
6.	**Performance Items for Scrutiny and Assurance:**		
	6.1 MFT performance against operational performance metrics within the Integrated Performance Report and the AOF	*(enclosed)*	*David Furnival*
	6.1.1 To receive a report on any patient safety Impact of Industrial Action	*(verbal)*	*Toli Onon/ Cheryl Lenney*
	6.1.2 To receive a report on Emergent Disaggregation Risk (including an update on urology/colorectal issues	*(enclosed)*	*David Furnival*
	6.2 To receive a report on the 12-hour trolley waits data issues	*(enclosed)*	*David Furnival*
	6.3 To receive the Annual EPRR Core Standards Submission	*(enclosed)*	*David Furnival*
7.	**Quality Items for Scrutiny and Assurance:**		

	7.1 MFT performance against Quality and Safety metrics within the Integrated Performance Report	*(enclosed)*	*Toli Onon / Tanya Claridge*
	7.2 To receive the annual Complaints Report	*(enclosed)*	*Cheryl Lenney*
	7.3 To receive the Quality Impact Assessment Tool	*(enclosed)*	*Cheryl Lenney*
	7.4 To receive a report on the Spinal Surgery lookback exercise	*(enclosed)*	*Stephen Dickson/ Rachael Barber*
	7.5 Update on UKAS Inspection of andrology laboratory	*(enclosed)*	*Alison Haughton/ Sarah Vause*
8.	To receive the Perinatal Mortality Review Summary (PMRT) report	*(enclosed)*	*Cheryl Lenney*
9.	To receive the Group Patient Safety Incident Response policy and plan	*(enclosed)*	*Toli Onon*
10.	Learning from Greater Manchester Mental Health (GMMH) external review	*(enclosed)*	*Cheryl Lenney*
11.	To receive a report on Learning from Deaths	*(enclosed)*	*Toli Onon*
12.	To review the QPSC Work Programme	*(enclosed)*	*Damian Riley*
13.	To note the following Committees held meetings:		
	13.1 Group Risk Management Committee held on 15th May and 3rd July 2023	*(enclosed)*	
	13.2 Group Infection Control Committee held on 19th April 2023	*(enclosed)*	
	13.3 Group Quality and Safety Committee held on 13th June 2023	*(enclosed)*	
	13.4 Group Cancer Committee held on 23rd May 2023	*(enclosed)*	
	13.5 Group Safeguarding Committee held on 23rd May 2023	*(enclosed)*	
	13.6 Operational Excellence Board for the period July 2023 - August 2023	*(enclosed)*	

14. The next meeting will be held on Tuesday 24th October 2023 at 1:00pm

Agenda Item 9.1

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Directors
Paper prepared by:	Tanya Claridge, Acting Director of Clinical Governance
Date of paper:	September 2023
Subject:	Integrated Performance Report
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	The report details progress in meeting performance targets which are key to the delivery of the Trust's strategic aims.
Recommendations:	The Board of Directors is asked to note the content of the report.
Contact:	Name: Nick Gomm, Director of Corporate Business / Trust Board Secretary Tel: 0161 276 4841

Manchester University
NHS Foundation Trust

Integrated Performance Report

Reporting period to 31st July 2023

Introduction

The report provides the Board with an integrated focus on key performance indicators relating to quality and safety, operational performance, workforce and finance. The report is designed to enable the Board to have oversight of a range of metrics (including those monitored through the national contract and those locally derived) in the context of insight and assurance in relation to the:

- effectiveness of the controls and enablers in place to ensure improvement in the quality of care and operational efficiency aligned to the Trust's Strategic Aims, it is a key source of assurance to support the Board Assurance Framework.
- compliance with CQC fundamental standards across all the domains of quality and safety
    - Safe: patients, staff and the public are protected from abuse and avoidable harm.
    - Effective: care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence.
    - Caring: staff involve and treat everyone with compassion, kindness, dignity and respect.
    - Responsive: services are organised so that they meet people's needs.
    - Well-led: the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.
- core principles contained in the NHS Constitution of:
    - Equality of treatment and access to services
    - High standards of excellence and professionalism
    - Service user preferences
    - Cross community working
    - Best Value
    - Accountability through local influence and scrutiny

The Board's consideration will be supported by exception reports from relevant Scrutiny Committees , who routinely scrutinize the assurance and mitigation of risk in relation to the metrics where an area of performance is giving rise for concern, or where a significant improvement has been achieved.

Integrated Performance Report Navigation Panel

Delivering our Strategic Aims

Our Strategic aims	Our enablers 2023/24																
	Quality and Safety Strategy 2022/25	Patient Safety Plan 2023/24	Effectiveness Plan 2023/24	High Priority Audit Plan	What Matters to me	Mental Health Strategy	End of life care strategy	Urgent and Emergency Care Strategy	Inequalities strategy	Financial plan	Operational Plan 23/24	People Plan					
To focus relentlessly on improving access, safety, clinical quality and outcomes	●	●	●	●	●	●	●	●	●		●						
To improve continuously the experience of patients, carers and their families	●				●	●	●		●		●						
To make MFT a great place to work, where we value and listen to our staff so that we attract and retain the best	●										●	●					
To implement our People Plan, supporting our staff to be the best that they can be, developing their skills and building a workforce fit for the future											●	●					
To use our scale and scope to develop excellent integrated services and leading specialist services											●						
To develop our research and innovation activities to deliver cutting edge care that reflects the needs of the populations we serve											●						
To achieve and maintain financial sustainability										●	●						
To work with partners and play our part in addressing inequalities, creating social value and advancing the wider green agenda	●	●	●	●	●		●		●		●						

Understanding our performance

We use the objectives within our key enablers (our strategies and plans) to help us identify measures of success. Our measures of success are metrics (qualitative and quantitative) that are designed to help us make better decisions about how to improve services and to help us identify and monitor the effectiveness of our response to risks to the delivery of our strategic aims. We use this data to

- Provide measurable results to demonstrate progress towards outcomes
- Identify areas needing attention and opportunities for improvement
- Support continuous improvement.

Our measures of success will include

- System-level measures of community wellbeing and population health including reductions in avoidable deaths for treatable conditions, improved mental health and
- Trust level proxies for improved health outcomes such as avoidable admissions to hospitals, lengths of hospital stay, and patient safety
- Personal health outcomes to our patients, primarily relating to measures of responsiveness
- Resource utilisation
- Organisational processes and characteristics that support evidence that systems to support high-quality people centred care
- Patient and carer experiences of, for example, shared decision-making, care planning, communication and information sharing, and care co-ordination.

How we understand our performance and escalate any risks identified

Measuring our Performance

We, where possible and appropriate, use the identification of Special Cause Variation in our data to understand our performance. We use four specific tests in our data to look for unexpected variation in our Statistical Process Control Charts. Where SPC charts are not deemed the most appropriate use of data, alternative charts and display mechanisms have been included. It is important to note that whilst the variation and assurance symbols are predominantly associated with SPC charts, we have taken the approach of standardising their use within this document across all data types to ensure consistency of language and approach. Also included, where benchmarking data is available (for instance through national or locally derived standards) an indication of compliance with those standards. A summary of the action status is also provided aligned to each indicator.

The table below provides a summary of the symbols used within this integrated performance report.

Compliance

Target being met	Target not met	For information, no target set or target not due

Variation

Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values

Assurance

Variation indicates Inconsistently passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates Consistently (F)alling short of the target

Action Status

Active surveillance – continue to observe in order to better understand the current position	Improvement – continue actions to support improvement until steady state achieved	Deterioration or maintained underperformance – instigate or review actions to ensure drivers of current position are mitigated	Steady state – continue to monitor achievement of level of performance which is satisfactory, and which requires no intervention to maintain

Escalating performance concerns

Using the four SPC rules and outcomes of our benchmarking , we use an Alert, Advise and Assure model to ensure that both risks and improvements associated with performance are escalated appropriately using the Trust's risk escalation framework, through the Trust's Governance Infrastructure. Risks identified through the assessment of and assurance associated with any element of performance that may have an impact on the delivery of the Trust's Strategic Objectives are reflected within the Trust's Board Assurance framework.

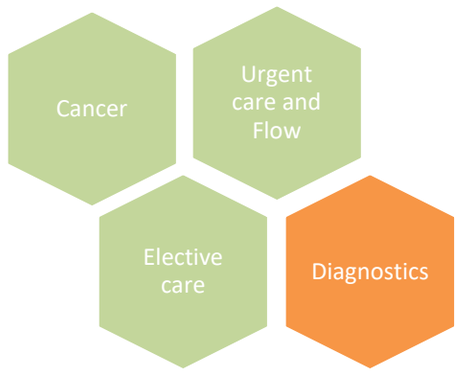
Alert	Advise	Assure

Integrated Performance Report Overview

Quality and Safety

The QPSC considered a number of elements of quality and safety performance, including the implications of a recent never event, maternity safety and assurance in relation to the actions taken in response to learning. The continued requirement for improvement in the governance associated with the effectiveness domain was subject to scrutiny by the Committee, with a detailed review scheduled for October.

Operational Performance



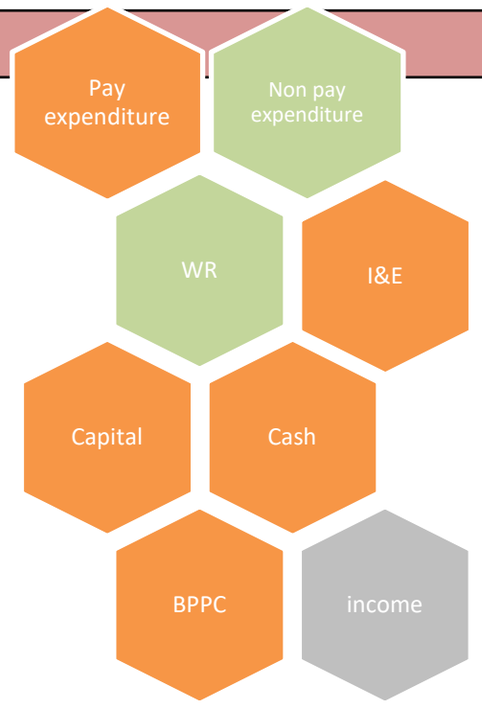
Diagnostic performance was considered in depth by the QPSC, using the assurance in provided within the key delivery workstream report to support the consideration of actions and the risks associated with compliance with national targets, and the impact on patient safety. Diagnostic performance is a being managed as a strategic risk, supporting the focused scrutiny of actions being taken in mitigation, and achievement of the performance target remains a significant challenge. The derogation in national target (4 hr waits in ED) was considered, and the compliance with the trajectory set by NHSE considered.

Workforce

The WSC considered the workforce metrics within the IPR at their meeting on 29/8. Current absence rates were discussed along with the actions being taken to boost staff retention and facilitate recruitment in vacant clinical posts. Work to improve the staff experience was presented including MFT's response to the results from the NHS staff survey and GMC training survey. The Diversity Matters Strategy is being refreshed alongside the adoption across MFT of a proactive anti-racist approach.

Finance

The FDSC met on the 5th September after the distribution of Board papers. The Group Chief Finance Officer's report, and the verbal report from the Committee Chair will be presented at the Board meeting.



Quality and Safety Report

Quality and Safety: Patient Safety Executive Summary

Key Performance Metric

Focus	Ref	Status	Variation	Assurance	Action status	Indicator	Indicator Type	Page
Oversight	S1					Serious Incidents Requiring Investigation (reported in Month) per 1,000 occupied bed days	local	6
	S2					Never Events	National	6
	S3					Notifiable patient safety incidents: Non-notifiable incidents (ratio)	Local	6
System reliability	S4					National patient safety alerts over deadline	National	6
	S5					Surgical Safety Checklist compliance	Local	
	S6					LocSSIP Compliance	Local	
	S7					Attributable Reportable organism infections	National	6
	S8					Maternity dashboard indicators alerting	New	6
	S8					Compliance with patient specific assessments	New	
	S9					PSIRP safety profiles alerting	Local	6
	S10					Deprivation of Liberty Standards	New	
PSIRP 23/24	S11					Patients waiting for access to care who experience associated harm	Local	
	S12					Notifiable incidents related to surgical procedures	Local	
	S13					Notifiable incidents related to invasive procedures	Local	
	S14					Notifiable incidents related to a patient with a mental health concern	Local	
	S15					Notifiable incidents related to medication safety	Local	
	S16					Notifiable incidents related to Ergonomic design	Local	
	S17					Notifiable incidents related to Discharge	Local	
	S18					Notifiable incidents related to the effective assessment and management of risk (Falls etc)	Local	
Learning and culture	S19					Prevention of future deaths notifications	Local	10
	S20					% patient safety risks not mitigated exceeding the deadline for mitigation	New	10
	S21					Culture: People Promise: We each have a voice that counts (staff survey 2022)	National	10

Joint Group Medical Directors' and Chief Nurse's Summary

In September 2023 the Trust will transition to the Patient Safety Incident Response Framework. The Group Quality and Performance Scrutiny Committee has received regular briefings in relation to the progress with the implementation plan over the past 2 years. The mandated Trust-wide Patient Safety Incident Response Policy and the Trust-wide Patient Safety Plan (including all the Site/MCS/LCO Patient Safety Incident Response Plans) are presented to the Committee as substantive agenda items for consideration of the recommendation of Board approval. The Group Quality and Safety Committee considered the Patient Safety Committee summary of the intelligence considered and contextualised through the safety oversight system. The Patient safety Committee reports on an exceptional basis from the Group Patient Safety Profile, and the deliberations of the Committee, alerting the Q&S Committee to opportunities for high impact learning and areas of actual, emergent or latent risk. It advises the Committee of action taken to ensure optimal approaches to learning. It assures the committee in relation to the effective mitigation of risk to patient safety and the outcomes of those actions. Where relevant it provides updates for the committee about the work being done nationally, regionally and the work we are doing across the Trust to understand patient safety and optimise our learning. Key areas escalated for consideration of the Committee were;

1) The impact of the risks associated with complex disaggregation on patient safety, particularly in relation to service transition and the impact on access and variation.
2) The Trust reported a further Never Event on 31st July.
3) The Trust has two outstanding national patient safety alerts, both relating to medicines safety.
4) The effectiveness of learning from the outcomes of legal processes (claims and inquests)
5) Improvement: focus on surgical and invasive procedures
6) The impact of the NPSA relating to Philips Ventilators (Capital impact)
7) The profile of serious incidents requiring investigation involving the death of a patient: MRI incidents accounting for 17 of the 42 Trust-wide incident profile)
8) Maternity- the escalation and governance associated with the use of the dashboard and the notifiable/serious incident profile and the outstanding assurance associated with indicators that had indicated a potential variation in performance (Still birth/neonatal deaths) for further review/validation of the data.

The QPSC receives a detailed Patient Safety Performance report provides more details of these escalations and the associated response.

Principal Risk

No.	Description	Strategic Risks	Highest scoring
1.	Failure to maintain quality of services	4	20

Risk Profile

Group Wide Risk Profile

No.	Strategic Risks	Risk Score
1150	Controlled drug storage	16
5182	Human System interaction	20
6352	Clinical Harm-waiting patients	15
5480	HIVE impact on patient safety	15

Quality and Safety: Effectiveness Executive Summary

Key Oversight Performance Metrics

Focus	Ref	Status	Variation/ data	Assurance	Action status	Indicator	Indicator Type	Page
Outcomes	E1					Hospital Standardised Mortality Ratio (HSMR)Rolling 12mth	National	
	E2					Hospital Standardised Mortality Ratio		
	E3					Hospital Standardised Mortality Ratio (HSMR) Crude Mortality (Trust)	National	
	E4					Summary Hospital-Level Mortality Indicator (SHMI) QUARTERLY	National	
	E5					% of deaths screened	National:	
	E6					Structured Judgement Reviews resulting in a Hogan Score of 3 or below	Local	
	E7					National audits: Outlier status	National	
	E8					National Audits (CQC Profile) recording outcome worse than expected	Regulator: No data	
	E9					Local Audits –limited assurance		
	E10					30 day readmission rate	Local	
	E11					% NICE Guidance: Evidence of implementation	Local	
	E12					% policy and clinical guidance in date	Local	
	E13					National Audit case ascertainment	Local	
	E14					% high priority local audits discontinued	Local	
	E15					CQUIN 1: Flu vaccinations for frontline healthcare workers	CQUIN (prioritised)	
	E16					CQUIN 2:Supporting patients to drink, eat and mobilise after surgery	CQUIN (prioritised)	
	E17					CQUIN 3: Timely communication of Medicines changes to community pharmacists	CQUIN (prioritised)	
	E18					CQUIN 4:Prompt switching of intravenous (IV) antimicrobial treatment	CQUIN (prioritised)	
	E19					CQUIN 5: Identification and response to frailty in emergency departments	CQUIN (prioritised)	
	E20					CQUIN Composite (all other indicators	CQUIN (prioritised)	

Joint Group Medical Directors' Summary

The Quality and Safety Strategy 2022-25 has acted as an enabler for the Trust to review its performance within the Effectiveness domain with a different lens than previously. The focus on insight as led to the initiation of a programme of work to identify the correct, proportionate and relevant metrics to measure progress to achieving the objectives identified in the Effectiveness plan. The metrics presented in the current version of the IPR are traditional and focus on mortality, the management of external recommendations, the key controls in place (clinical policies and guidance), performance in national audit and the national CQUIN scheme. Utilising data from Hive and also in an aggregated and benchmarked format in the Healthcare Evaluation Data (HED) the indicators are currently under review to support a more integrated approach to outcome data, with a clear focus on understanding and eliminating unwarranted variation.

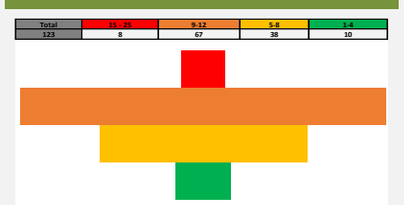
There are several important areas for escalation from the data available:
1.) There is a continued risk that assurance in relation to implementation of NICE guidance across the Trust has been sub-optimal. A revised process has now been put in place to provide ongoing assurance in relation to newly published or revised NICE guidance. There is a requirement to complete an assurance exercise in relation to previously published guidance, which has now been commenced. This is being monitored through the Clinical Effectiveness Committee with escalations to the Clinical Practice Oversight Committee.
2) There is a potential issue in relation to case ascertainment and data validation within the national audits related to the implementation of HIVE
3) NMGH are demonstrating an outlier position for a number of national audits
3) There is a requirement to review and refresh the governance associated with clinical effectiveness across the Trust
6) The Executive Director's have approved an ACE day in September where learning from deaths and the national audit programme will be a focus Trust-wide.
7) There are opportunities for change and improvement in relation to Learning from Deaths, there is a revised Group wide Policy in draft format and the Committee will receive the Annual Learning From Deaths Report at its meeting, for consideration for recommendation for approval by the Board of Directors.
8) There was a requirement for rapid improvement following a UKAS inspection of the Andrology Laboratory (SMMCS) which was addressed in a timely and successful way

Principal Risk

No.	Description	Strategic Risks	Highest scoring
1.	Failure to maintain quality of services	2	15

Risk Profile

Group Wide Risk Profile



No.	Strategic Risks	Risk Score
6352	Clinical Harm-waiting patients	15
5480	HIVE impact on patient safety	15

Quality and Safety: Caring Executive Summary

Key Oversight Performance Metrics

Focus	Ref	Status	Variation	Assurance	Action status	Indicator	Indicator Type	Page
Oversight						Friends and Family test (response rate)	Local	15
						What Matters to Me (Overall Score)	Local	15
						Mixed sex accommodation breaches	National	15
						Upheld complaints (rate)	Local	15
						Formal Complaints received	Local	15
						Re-opened complaints (rate)	Local	15
						Ombudsman referred complaints	Local	15
Learning and Culture						National Adult Inpatient Survey (2022): Composite metric (Results received – currently embargoed)	Local	15
						Excellence / Compliments Received	Local	16
						Innovation (metric to be agreed at Quality & Patient Experience Forum)	Local	16
						Improvement Priorities	Local	16
						National Children and Young People's Inpatient and Day Case Survey (2020) Composite metric	Local	15
						Urgent and emergency care survey 2022; Composite metric	Local	16
						National Maternity Survey (2022) (an analysis technique called the 'expected range' to determine if your trust is performing about the same, better or worse compared with most other trusts)	Local	16

Risk Profile

Under development post Quality & Experience Forum

Principal Risk

No.	Description	Strategic Risks	Highest scoring
3.	Failure to maintain quality of services	16	20

Chief Nurse's Summary

The **Family and Friends Test** response rate is monitored, as is the % of those who would recommend our services. During **July** we received a total of 15812 responses, 92.77% rated our services as good, and 4.29% rated services as poor. Feedback is provided directly to clinical areas, there is no special cause variation noted. In the LCO, FFT is also utilised less due to the nature of services delivered in people's homes. The LCO have introduced QR codes that can be accessed in homes and clinics. Analysis of themes and learning are monitored through the Patient Experience Forum. Active surveillance also includes What Maters to Me (WMTM) and Quality Care Round (QCR).

There has been a significant positive increase in the number of **What Matters to Me** (WMTM survey completions since January 2023.There is a slight decrease in April 2023 with 3507 responses, however there were 5945 and 6016 responses in June and July respectively. The Patient Experience and Quality Improvement Teams have identified meal provision as an area of focus, which has also been noted through Clinical Accreditation, with a refresh of mealtime processes being undertaken and a working group to review the diet orders on HIVE and meal requests on Saffron. WMTM Nutrition and Hydration data for July shows an overall score of 86.38% and was similar in June with 86.75%. In comparison QCR was 95.31% in July and 95.46% in June.

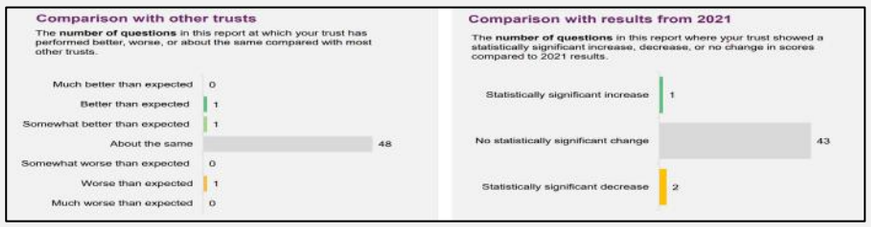
Mixed Sex accommodation breaches have occurred in critical care areas, where exemptions are in place that support delivery of single sex critical care services in mixed sex environments. At the point of discharge, the exemption is no longer applicable, and a 'breach' is said to occur if we have been unable to discharge a patient to a step-down area. There were 38 mixed sex breached in July , the reason for delay was availability of step-down beds.

During July there was an increase in the number of **formal complaints** received; themes in July remained static and include concerns raised about Treatment / Procedure and Communication. MFT has seen a slight increase in the number of **complaints that were upheld.** An initial review of the themes has identified confidentiality, infrastructure and clinical assessment in the category of Treatment and Procedure were the top three themes in July. Analysis is led by the Patient Experience Team to identify specific learning and inform action planning, which will be monitored through the Patient Experience Forum.

31 complaints were reopened during July 2023. A complainant may be dissatisfied with our response for a number of reasons; a key theme in June has been noted that we did not respond or resolve all the concerns they raised through our complaint response letter and often **new questions are asked**. The Patient Experience Team are leading focussed training (quality of response and investigation) to further reduce the rate at which complaints are re-opened, but more importantly to ensure that when concerns are raised there is good resolution and learning that can be spread across all sites.

Compliments are recorded through our electronic reporting systems. Compliments are sent directly to the clinical area. There were 24 compliments received in May, 143 in May, 64 in June and 42 received in July 2023.Compliments are recorded in Ulysses, NHS choices and directly to clinical areas. Work has commenced to centralise the process.

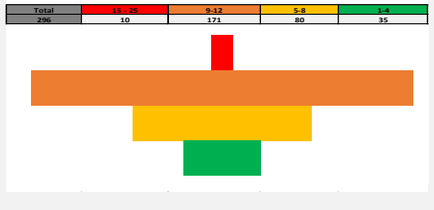
The results of the 2022 **National In-Patient survey** are currently being analysed – embargoed until September 23. The **Urgent and Emergency Care Survey** results have been released, our overall experience score has reduced to 6.9 (was 8.3 in 2020 survey). The Quality & Experience Forum will agree and monitor the hospital plans. In the National Maternity Survey, please below. An action plan is in place.



Quality and Safety: Responsiveness Executive Summary

Key Oversight Performance Metrics

Focus	Ref	Status	Variation	Assurance	Action status	Indicator	Indicator Type	Page
Oversight						Deaths with a Hogan score of <3 (Protected characteristics)	Local	18
						NI/Red complaint Protected characteristics	Local	18
		⊗	H	F	⊗	NI/Red complaint: Discharge/transfer	Local	18
		⊗	L	F	⊗	Duty of Candour compliance	Statutory	18
						7DS compliance	National	18
						Accessible Information standard compliance	Local	18
System Reliability		ⓘ	~	H	⇄	Clinical Accreditation	Local	18
		ⓘ	~	H	⇄	PLACE Outcomes	National	18
		⊗	H	F	⊗	Access to timely care/assessment and treatment	National	18
						% ReSPECT forms reviewed at each encounter	Local	19
Mental Health Strategy		ⓘ	~	H	👁	Mental Health Act 1983 (MHA) compliance: Section 132: % Provision of information to patients	Local	19
		ⓘ	H		⇄	Mental health training compliance	Local	19
		ⓘ				NI/Red Complaint (Mental health concern)	Local	19
		ⓘ				Mental health in acute Trusts: Quality standard compliance – Number of patients on s136 who remain in ED greater than 12 hours (not trolley wait)	Local	19
		ⓘ				Number of patients (over age 18 years) where Deprivation of Liberty Safeguards standards have been applied		19
LD Strategy		ⓘ			⊗	% of people with a Learning disability or who are autistic who have evidence of reasonable adjustments in place	Local	19



No.	Strategic Risks	Risk Score
6469	Urgent & Emergency Care – ED & Patient Flow	16
6470	Scheduled Care Inpatient and Outpatient Backlog	16
6475	Cancer Pathway Delays	12
6467	Diagnosis Delay – patients >6 weeks from referral to diagnostic test	15

Principal Risk

No.	Description	Strategic Risks	Highest scoring
3.	Failure to maintain quality of services	16	20

Joint Group Medical Directors' and Chief Nurse's Summary

The responsiveness metrics have been further developed during July 2023, with data made available specifically in metrics relating to **Mental Health.**

A theme of **complaints related to discharge or transfer** is end of life, or palliative care discharges. To further understand the theme, a review of 30 discharges (10 from MRI, WTWA, NMGH) has take place, which has identified completion of ReSPECT form, prescription of anticipatory medicines, and communication between localities. The Palliative & End of Life Groups will develop focussed actions to make improvements, including linking with the IQP teams.

Duty of Candour compliance is an area of significant development aligned to the implementation of the PSIRF, with a revised policy and training opportunities in place. The risk in relation to this area of patient engagement is recognised across the Trust with each Site/MCS/LCO proactively mitigating the risk through enhanced monitoring and dedicating specific staff for enhanced oversight.

In July 2023 16 **Clinical Accreditations** took place, since 1st April 68 accreditations have taken place. The Annual Clinical Accreditation Report is being received at the Board of Directors meeting in September 2023 (as part of the Patient Experience Annual Report).

Outcomes from the **PLACE** light visits are due to be received at the next Patient Quality & Experience Committee.

Compliance with **s132 of the Mental Health Act 1983** has been monitored since January 2023 following an initial review of Mental Health provision undertaken by the Trust Safeguarding Team. The main area of concern relates to bed availability and being able to effectively provide and record the correct information to patients in a timely manner.

Mental Health Training compliance is achieved at Level 1 (Mandatory) at 92.20% , with 25555 out of 27746 requiring training having achieved compliance

There were no **red complaints or incidents relating to Mental Health Concerns** in July 2023. 49 patients who were brought to ED under a s136, of these 16 remained in ED for more than 12 hours. Care reviews are underway to identify if any harm occurred as a result of their long stay including linking with colleagues at GMMH.

There is oversight of a range of safeguarding indicators through the Group Safeguarding Committee and the AOF, further to the previous report new indicators are now included in this report. **Deprivation of Liberty Safeguards** standard monitoring shows good compliance with urgent application to the Supervisory Body in appropriate timescales in all 297 cases. There were 4 notifications to the CQC in line with usual reporting mechanisms, where the Supervisory Body approved the application.

In respect of **Learning Disability / Autism and Quality Standard Compliance (new metric)** and through Hive, we now have realtime understanding of patients who require a reasonable adjustments through care planning, it is our aim that 100% of patients should have their plans in place within 48 hours of admission, during July this figure was 59%. 92 patients; 54 had plans in place with 48 hours.

Safeguarding Level 1 training compliance is achieved, trajectories and plans are in place to achieve **Levels 2 and 3 adult and children's Safeguarding Training,** to be reviewed at the Group Safeguarding Committee on 30th August 2023.

Operational Performance Report

Operational Performance: Executive Summary

Key Oversight Performance Metrics

Focus	Ref	Compliance	Variation	Assurance	Action status	Indicator	Indicator Type	Page
Urgent care and Flow	P1	✓	L	?	✓	A&E 4 hour standard	National	
	P2	✗	H	F	✓	Ambulance handover within 15 mins	National	
	P3	✗	L	F	✓	Ambulance handovers over 60 mins	National	
	P4	i	L		👁	Hours lost in month due to delayed handovers	Local	
	P5	✗	L	F	✓	Number of AED waits > 12 hours	National	
	P6	✗	L	F	✓	Number of A&E DTA waits ≥ 12 hours	National	
	P7	i	L		👁	UEC referrals	Local	
	P8	✗	H	F	✗	No clinical reason to reside	National	
Cancer	P9	✗	〰	?	✓	Cancer 2WW Performance (all)	National	
	P10	✗	L	?	✓	Cancer 31 day Performance	National	
	P11	✗	L	F	✗	Cancer 62 day performance	National	
	P12	✗	〰	F	✓	Cancer Backlog reduction	National	
	P13	✗	〰	?	✓	Cancer Faster Diagnosis	National	
Elective	P14	i	〰		👁	RTT total list size	Local	
	P15	✗	L	?	✓	RTT>78 week waiters	National	
	P16	✗	H	?	✓	Elective Inpatient Activity	Local	
	P17	✓	H	P	👁	Elective Outpatient Activity	Local	
	P18	✗	〰	?	✓	Patients Discharged to PIFU	National	
	P19	✗	〰	?	✓	Theatre Utilisation	Local	
Diagnostics	P20	i	H		👁	Diagnostics (DM01) total list size	Local	
	P21	✗	H	F	✗	Diagnostics (DM01) waits > 6 weeks	National	
	P22							

Chief Operating Officer's Summary

MFT has continued with an improving trend in A&E performance since April and is currently ranked first across GM with **July reporting 72.6% against the 4hr standard.** Plans and trajectories are in place to deliver the national expectation of 76% performance against the 4hr standard by March 2024. This has maintained a positive improvement in ambulance handovers and reduction in the number of patients spending >12hrs in our emergency departments. Particular challenges remain with Mental Health delays due to MH capacity pressures across the system. Throughout July **planning commenced for Winter** focusing on capacity/surge planning, accelerating recovery plans, workforce and effective system wide coordination. GM are placed in TIER1 for Urgent Care and support has been secured specifically for the MRI, as our most challenged site across the group.

MFT remain committed in reducing the number of patients waiting **>65 weeks to zero** by March 2024 and have continued to focus efforts to clear 78 week waits. The long wait position for July ended 321 over 78 week waits including 1 patient over 104 weeks. Breaches are predominantly due to patients choosing to wait and medically unfit. **Industrial action (IA) periods** will pose a risk to delivery of our plans**.** Since March MFT have rescheduled 15,448 patients across outpatients and inpatients as a result of IA. We are tracking ahead of plans in eliminating 65 weeks by the end of March 2024. The 23/24 plans require insourcing and mutual aid with conversations continuing to be held with the Regional and National Team through the weekly TIER1 calls.

The number of patients with suspected **cancer over 62 days** has remained static reporting 346 at the end of July compared to 358 end of June. This continues to be slightly behind trajectory but refreshed plans and recovery trajectories will aim to get us back on track by October. The most challenged tumour sites continue to be Gynaecology and Urology, who are furthest from plan. The national cancer waiting time standards have been updated, which will come into effect from 1st October and places heightened focus on delivering the 62 day and 31 day performance. We are tracking our progress against both measures ahead of the reporting changes.

Diagnostics remains a challenge, with the >6 week performance reporting 50% against a plan of 47.3% for the end of July. We remain committed to deliver 25% by March and have been working on plans to improve the position through the Diagnostic Improvement Workstream. The main areas of concerns remain with echocardiography and Non Obstetric Ultrasound Scans due to volumes and workforce challenges. Discussions are being held across GM to seek mutual aid support.

3.	Failure to maintain operational performance	4	16

Risk Profile

Group Wide Risk Profile

No.	Strategic Risks	Score
6469	Urgent & Emergency Care – ED & Patient Flow	16
6470	Scheduled Care Inpatient and Outpatient Backlog	16
6475	Cancer Pathway Delays	12
6467	Diagnosis Delay – patients >6 weeks from referral to diagnostic test	15

Workforce Report

Workforce: Executive Summary

Key Oversight Performance Metrics

Focus	Ref	Status	Variation	Assurance	Action status	Indicator	Indicator Type	Page
Workforce capacity	W1					Establishment WTE	Local	8
	W2					Staff in Post WTE	Local	8
	W3					Vacancy WTE	Local	8
	W4					Vacancy Percentage	Local	8
	W5					Temporary Staffing WTE	Local	8
	W6					Temporary Staffing Cost	Local	8
Looking after our people	W7					Attendance Percentage	Local	9
	W8					Call Back & Return to Work Compliance %	Local	9
	W9					Level 1 Mandatory Compliance Percentage	Local	10
	W10					Level 2 & 3 Mandatory Compliance Percentage	Local	10
	W11					Appraisal – Non Medical Compliance Percentage	Local	10
	W12					Appraisal – Medical Compliance Percentage	Local	10
Belonging	W13					Staff Engagement Score	Local	11
	W14					*% of BME in Medical and Dental pay scales*	Local	11
	W15					% BME in band 8a and above roles	Local	11
	W16					*% BME in band 7 and below*	Local	11
	W17					*% Disability in Medical and Dental pay scales*	Local	11
	W18					*% Disability in band 8a and above roles*	Local	11
	W19					*% Disability in band 7 and below*	Local	11
Future focus	W20					*Turnover %*	Local	12
	W21					*Retention/Stability %*	Local	12

Director of Human Resource's Summary

Workforce metrics are adversely affected by a challenging operational context including sustained industrial action. Although absence due to sickness is well below the rates witnessed during the pandemic, they have not returned to pre-pandemic levels. As of June 2023, the Trust attendance rate was 94.4%. The single month attendance rate has seen a steady improvement since December 2022, however the rolling 12 Month sickness absence rate has continued to increase into 2023/24. Each Hospital/ MCS/ LCO/ Corporate area has a bespoke target and plan to reduce sickness absence. Areas of focus include case management approach, review of long term cases, improving compliance with policy via the Absence Management system, and continued focus on both preventative and supportive Health & Wellbeing activity.

Workforce turnover (12-month average) has seen a small improvement to 13.7% in June 2023, however this remains above target. Stability/retention percentage is also showing an improvement on last month at 87.1% yet under achieving against target of 93%. Vacancy rate is in keeping with turnover and retention trends above target throughout the last 12 months, currently at 12.1% against a target of 7.5%. The ongoing delivery of our MFT People Plan continues to support staff retention.

Mandatory training compliance levels are showing a general improvement over the last 6 months. Level 1 Mandatory compliance for June 2023 achieved against target at 92.0%. However, further attention is needed in relation to levels 2 & 3 compliance which remain below target at 80.8%. Appraisal compliance is also showing a general improvement over the last 6 months, although it remains below target of 90%. Non-medical appraisal compliance for June 2023 was 83.6% against a 90% target. Medical appraisal compliance for June 2023 was 89.0%, which is a slight decrease from May 2023 when the Trust achieved against target at 92.9%. HR Directors continue to lead local compliance plans with Trust level oversight via the Assurance Oversite Framework (AOF). A review of mandatory training content is also underway to streamline and reduce time to train.

Our key metrics in relation to the theme of 'Belonging' show a mixed picture. Key areas to improve on include our staff engagement score which is currently 6.4 for June 2023 against a target of 6.8, and % BME staff in Band 8a and above roles which is currently 10.5% for June 2023 which is much lower than the BME population of Greater Manchester at 23.6% (reported by ONS) and our patient demographics with BME representing 29%. Staff engagement and inclusion have been key focus areas in 2023, aligned with the arrival of our new CEO. Key initiatives include CEO Listening Events, Big Conversation, Staff Retreat, Staff Survey, 'Inclusionist' campaign, and 6 High Impact ED&I Actions – all of which we anticipate will deliver improvements.

The Workforce agenda remains a strategic priority for the Trust, particularly in relation to staff experience / engagement, and workforce productivity and efficiency. Following the release od the NHSE Long Term Workforce Plan, the MFT People Plan will be refreshed to ensure it continues to deliver against organisational priorities.

Principal Risk

No.	Description	Strategic Risks	Highest scoring
3.	Failure to sustain an effective and engaged workforce	1	15

Group Wide Risk Profile

No.	Strategic Risk	Risk Score
4003	Staff Psychological wellbeing	15

Finance Report

Finance: Executive Summary

Focus	Ref	Status	Variation	Assurance	Action Status	Indicator	Indicator Type	Page
I&E	F1					Financial performance against budget YTD (£'000s)	External	
Pay Expenditure	F2					Total pay expenditure against budget YTD (%)	Internal	
	F3					Consultant spend - variance to budget YTD (%)	Internal	
	F4					All other Medics spend - variance to budget YTD (%)	Internal	
	F5					Agency spend compared to total pay expenditure YTD (%)	Internal	
	F6					Bank spend compared to total pay expenditure YTD (%)	Internal	
Non Pay Expenditure	F7					Drugs - variance to budget YTD (£'000s)	Internal	
	F8					Clinical Supplies - variance to budget YTD (£'000s)	Internal	
Income	F9					Income inlcuding Elective - variance to income in finance plan (£'000s)	Internal	
WRP	F10					WRP - variance to plan (£'000s)	Internal	
Capital	F11					Capital expenditure (GM plan) - variance to plan YTD (%)	Internal	
	F12					Capital expenditure (total plan) - variance to plan YTD (%)	Internal	
Cash	F13					Cash balance - variance to plan in month (%)	Internal	
BPPC	F14					Performance against Better Payment Practice Code in month (% by value)	External	

Principal Risk

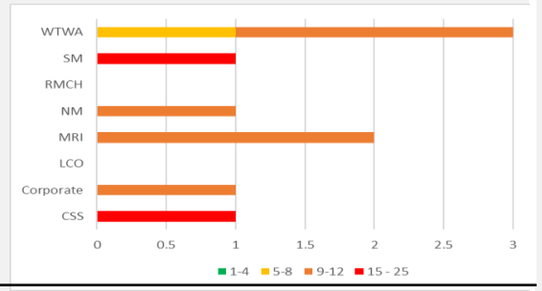
No.	Description	Strategic Risks	Highest scoring
3.	Failure to maintain financial sustainability	1	20

Risk Profile

Group Wide Risk Profile

No.	Strategic Risk	Score
5092	Capital finance	15

Site/MCS/LCO Risk Profile



Director of Finance's Summary

Month 4 position

After four months, the year-to-date position for the Trust is a £47.9m deficit against a planned deficit of £24.8m, this is an adverse variance of £23.1m. The main reason for this adverse variance is continued material overspends on pay budgets, in particular relating to the costs of providing cover for medical staff taking Industrial Action.

Within that YTD position the Trust delivered an in-month position for July 2023 of a deficit of £13.1m against a planned deficit of £1.5m, an adverse variance of £11.6m.

Year to date income is overall £4.8m worse than plan. The main drivers of this under-performance are Income for Cost Pass Through (CPT) drugs and devices which is lower than planned (£5.6m), again for which there is an offsetting underspend in non-pay and under performance in other operating income (e.g. private patient income, catering income).

In accordance with national guidance, the Trust is not showing any over or underperformance in relation to income associated with elective activity performance, therefore all income for the planned elective activity is assumed to be received in these year to date figures. However, the assessed scale of risk associated with the year to date activity delivery would be £12.2m for elective activity within the GM envelope, and £2.5m from providers outside GM. Therefore, the reported position would be further £14.7m further adverse to plan. This could translate to a risk of £40-50m by the year end, although the risk has reduced since month 3 as activity is increasing each month.

Year to date pay expenditure is overspent by £17.5m, c.£9.2m relates to the costs of covering industrial action and the remainder relates mainly to additional medical staffing above planned levels, additional costs for enhanced care for individual patients, undelivered WRP and impacts of prior year spending decisions

Year to date non-pay expenditure is overspent by £0.8m. Underspends on CPT drugs are offset by additional clinical supplies requirements to deliver activity, inflation and the impacts of historic spending decisions.

Actions to deliver plan

The Trust continues to forecast delivery of the plan, with a breakeven position at year end. Given the current run-rate of the Trust, action is being taken to reduce expenditure and increase the delivery of WRP. The Trust has engaged external support to identify both productivity and efficiency opportunities and to support the development of action plans to improve this position. Controls are being strengthened and significant action at pace is required across all areas of the Trust to reduce the current run rate. It is recognised that there is a system-wide requirement for further savings, however at this time the Trust's assumption is that no additional savings will be required of MFT.

Capital and cash

The cash balance at 31st July was £150m which is below plan by £38m. Cash is lower than the planned value primarily due to timing differences which are expected to mainly unwind over the next two quarters but work is ongoing to confirm assumptions and profiling.

Capital expenditure year to date is underspent by £9.5m. The key driver for this underspend relates to delays to approvals for the New Hospital Programme at NMGH.

Agenda Item 9.2

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Finance Officer
Paper prepared by:	Paul Fantini, Deputy Director of Group Financial Reporting & Planning Rachel McIlwraith, Operational Finance Director
Date of paper:	September 2023
Subject:	Financial Performance for Month 4 2023/24
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 Sustainability for both the short and medium term
Recommendations:	The Board of Directors is recommended to note the Month 4 I&E position and Forecast against the 23/24 plan and Cash and Capital positions for the Trust.
Contact:	Name: Jenny Ehrhardt, Group Chief Finance officer Tel: 0161 276 6692

Executive Summary

1.1	**Delivery of financial plan and associated risk**	The financial regime for 2023/24 continues the focus on recovery of elective activity, reduction of waiting lists that have reached historic highs across the NHS and the continued drive to prevent unnecessary hospital admissions. Added to this will be increased scrutiny on the finances of organisations as the DHSC looks to reduce overall costs of the health service and reduce underlying deficits across the NHS. Block contracts will remain in place for 2023/24 for the majority of the Trust's income allocation, but there has been a shift back towards PbR for elective activity in an effort to help organisations focus efforts to improve productivity and to increase numbers of patients seen and treated. Consequently, although the Trust's planned funding envelope remains broadly the same as 2022/23 overall, there is a much greater risk to income realisation, this is estimated at circa £40-£50m if the activity targets are not achieved in full. Other key risks to delivery of the plan for 2023/24 are continued industrial action by various staff groups, which has the impact of disrupting the ability to deliver elective recovery and also causes increased costs over the strike days; these strikes and their resolution is outside of the Trust's control. Other workforce concerns include the ongoing high sickness levels which the Trust has set an internal improvement target for in addition to a target to reduce staff turnover, thereby reducing the impact of the difficulties in recruiting all levels of range of staff groups that persist across the wider NHS. It also must be noted that the breakeven plan relies on achieving an historic high WRP target of £136.4m, which currently poses an estimated financial risk of circa £40m to the Trust. Therefore, at the end of month 4, year to date to 31st July 2023, the Trust has delivered a deficit of £47.9m against a planned deficit of £24.8m, being adverse by £23.1m YTD. This reflects an in-month deficit for July 2023 of £13.1m. There is £12.2m income assumed in the YTD actuals for elective activity that represents a risk within GM Contracts based on indicative activity numbers to month 4. When including income from outside GM this risk rises to £14.7m YTD.
1.2	**Run Rate**	In July 2023 expenditure was £231.6m which is a decrease of £1.8m compared to the month 3 value of £233.4m. Pay costs have reduced by £5.6m with higher expenditure against Consultant costs, primarily for WLI claims against both cover for the Junior Doctor's strike days and for additional sessions to help deliver some of the activity targets around 78ww of £1.0m, offset by lower expenditure in month 4 on nursing staff of £2.4m and Support to Nursing staff of £0.9m. In addition, unrequired balance sheet flexibility of £3.4m has been used in month 4. Non pay costs rose by £3.7m with expenditure on Clinical Supplies, linked to improvements in activity, and increased costs of Insourcing/Outsourcing being the main drivers. There is also a stepped increase in the planned WRP in July, thereby reducing budget.
1.3	**Cash & Liquidity**	As at the 31st July 2023, the Trust had a cash balance of £150m which is a reduction of £38m to the cash balance at the 30th June 2023. The cash balance at the end of July was less than the £186m forecast, with the reduction primarily reflecting the timing of payments to suppliers and income receipts and is currently under review. A revised cashflow will be reviewed and agreed during August.

1.4	**Capital Expenditure**	The capital plan is currently reflective of the as yet unagreed 2023/24 capital plan submission by GM and is awaiting approval by NHSE. The Trust's element of the submission, with GM agreement, is a total plan of £151.2m, with the GM envelope component being £73.4m. To advance the capital programme whilst the allocation of the GM envelope is finalised, MFT capital leads were authorised to commence the "in-progress and contractually committed capital" schemes (totalling £33.5m) at the start of 2023/24. A further capital funding release of £10.4m has been approved by the Executive Directors Team in July ahead of formal GM approval; this is to avoid operational delays and a possibility of being unable to complete capital schemes within the 2023/24 financial year. For the period up to 31st July 2023, total expenditure was £19.0m against a plan of £28.5m, an underspend of £9.5m. Expenditure included within the GM envelope was £12.1m against the submitted plan of £11.7m, an overspend of £0.4m. The full year forecast for the total capital programme is £122.9m and is a £28.3m reduction to plan relating to a £32.4m reduction in the North Manchester New Hospital Programme (NHP) due to the delay in the approval for its Phase 2 enabling works bid which is partially offset by an additional £4.1m of PDC funding for the Targeted Lung Health Check (TLHC) and CDC schemes. In relation to IFRS 16 CDEL, the current 2023/24 capital budget guidance sets out that there will continue to be nationally ring fenced CDEL cover for the impact of IFRS16, though advising it is subject to future updates and further application guidance. The current plan submission totals £45m, however, the level of CDEL cover available is still subject to approval. For the period up to 31st July 2023, IFRS 16 capital spend totalled £0.57m. The full year forecast for IFRS 16 capital is £41.5m.

1.5	**Forecast Outturn and Risks to delivery**	There are several material risks to delivery of the 23/24 breakeven plan, which have been considered as part of the regular review of the forecast year end position The key risks and opportunities recognised within this forecast are; - Further cost pressures – inflationary, pay award costs - Delivery of the Trust's WRP target - Delivery of the Trust's activity and income plans - Changes to the national income framework relating to the industrial action to offer additional income - Use of further flexibilities available - The impact of additional control measures being put in place. However, there remain other risks to the Trust's delivery, which are harder to quantify but which would have a financial impact: - Sickness absence levels remaining high, failure to deliver the 2% reduction target - Turnover levels remaining high, failure to deliver the 1.5% reduction target The most significant external risk not included within the forecast remains the GM "system risk". This additional risk could not be mitigated within MFT. The Trust will endeavour to hit its NHSE plan but the accumulated impact of risks identified above mean that will be extremely challenging.

Financial Performance

Income & Expenditure Account for the period ending 31st July 2023

I&E Category	NHSE 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	312,497	306,906	(5,590)
ICBs	453,245	453,245	0
NHS Trust and Foundation Trusts	1,491	1,491	(0)
Local authorities	12,424	12,422	(2)
Non-NHS: private patients, overseas patients & RTA	3,840	3,561	(279)
Non NHS: other	4,226	5,709	1,484
Sub -total Income from Patient Care Activities	**787,722**	**783,335**	**(4,387)**
Research & Development	24,704	25,074	370
Education & Training	29,284	29,302	18
Misc. Other Operating Income	30,412	29,576	(836)
Other Income	**84,400**	**83,952**	**(448)**
TOTAL INCOME	**872,122**	**867,287**	**(4,835)**
EXPENDITURE			
Pay	(529,408)	(546,921)	(17,513)
Non pay	(327,761)	(330,566)	(2,805)
TOTAL EXPENDITURE	**(857,169)**	**(877,487)**	**(20,318)**
EBITDA Margin	**14,953**	**(10,200)**	**(25,153)**
INTEREST, DIVIDENDS & DEPRECIATION			
Depreciation	(23,141)	(21,944)	1,197
Interest Receivable	2,691	3,457	766
Interest Payable	(17,282)	(17,236)	46
Gain / (Loss) on Investment	0	0	0
Dividend	(2,008)	(2,008)	0
Surplus/(Deficit) before gain / (loss) on investments	**(24,787)**	**(47,931)**	**(23,144)**
Gain / (Loss) on Investment			0
Surplus/(Deficit)	**(24,787)**	**(47,931)**	**(23,144)**
Surplus/(Deficit) as % of turnover	**-2.8%**	**-5.5%**	
Impairment	**(41,120)**	**(16,574)**	**24,546**
Gain / (Loss) on Absorption	**0**	**0**	**0**
Non operating Income	**200**	**40**	**(160)**
Depreciation - donated / granted assets	**(551)**	**(469)**	**82**
Surplus/(Deficit) after non-operating adjustments	**(66,258)**	**(64,934)**	**1,324**

For the year to 31st July 2023, the Trust has delivered a deficit of £47.9m against a planned deficit of £24.8m, an adverse variance of £23.1m.

Income

Year to date income is adverse to plan by £4.8m which is due to:

- Under-performance against CPT drugs of £4.9m (offset by a reduction in expenditure)
- Under-performance against CPT devices of £0.9m (offset by a reduction in expenditure)
- Under-performance against Other Operating Income of £0.8m (vaccine income, income generation such as from catering etc)
- Private Patient income was £0.7m behind plan
- R&D income and RTA income were each favourable to plan by £0.4m
- Deferred income utilised in month was £1.5m

Both the internal and external plan has been restated to reflect the increase in both income and pay expenditure related to the improved pay award to negate the need to explain the variance each month.

It must be noted that providers have been asked to assume full delivery of income related to the Aligned Payment Incentive monies (API), also referred to as ERF, which has been included as required. There is, however, a risk of circa £12.2m year-to-date for elective activity within the GM envelope and a further £2.5m from providers outside GM that could translate up to a level of a combined £40-50m of risk by the end of the financial year. This risk has reduced since month 3 with month 4 activity figures showing an improvement.

Pay

Staffing costs are adverse to plan by £17.5m YTD to month 4 – the main reasons are:

- Consultant costs, primarily WLI payments due to cover for Industrial Action by Junior Doctors in April and for elective activity recovery work, adverse £14.6m
- Other Medical costs were adverse to plan by a further £5.7m, partly due to IA and partly covering vacancies
- Nursing Support Worker costs were £3.0m greater than plan due to cover for vacancies and sickness – a slight improvement over month 3 with a favourable in-month variance to plan and also offset when consolidated with the Registered Nursing cost expenditure
- Registered Nursing costs are favourable to plan by £4.5m
- Scientific and Technical staff costs are also favourable to plan by £2.4m
- Under-delivery of WRP targets across the Sites and the impact of prior year spending decisions also accounts for a proportion of the variance.

Mitigation plans are being developed and additional controls are being put in place to reduce this overspend.

There was a high level of bank staff spend YTD at £7.4m adverse to plan, which was caused by high levels of vacancies, sickness, unplanned enhanced care needs and supernumerary roles (new starters). Expenditure on agency staff was favourable to plan by £1.7m with the continued efforts to switch to more cost effective bank cover and is a further reason for the bank overspend.

Non Pay

The expenditure against non pay categories is adverse to plan by £0.8m YTD, a movement from the favourable variance at month 3 of £8.1m driven by much increased activity despite further Industrial Action days but no bank holidays in month 4. In addition, some, such as the favourable variance against Drugs, are partly related to the lower than planned income received for Cost Pass Through (CPT) items. The key variances YTD are:

- Drugs costs favourable to plan by £1.1m (CPT element £4.9m)
- Clinical Supplies costs were adverse to plan by £8.2m as a result of much increased activity in month 4

- General Supplies offsets this, favourable to plan by £6.4m
- Depreciation on NMGH IT assets is lower than plan by £1.7m
- These were offset by some adverse variances across other categories accounting for the remainder of the difference

Costs are forecast to increase across some of these categories, such as Clinical Supplies and Drugs, as the year progresses with the need to improve productivity and decrease waiting lists to address the need to improve 78ww and 65ww numbers. This will not, however, bring in further income but if delivered will mitigate the risk around activity linked income that is already in the plan.

Waste Reduction Programme

Within the respective Hospital, MCS, LCO and Corporate Control Totals for the year is a Waste Reduction target totalling £60.9m with a further £75.5m to be delivered through schemes developed at Trust level, a total requirement of some £136.4m.

The tables below outline the month 4 23/24 YTD position against the planned savings. The Committee is reminded that the phasing of the Waste Reduction Programme is skewed towards the later part of the year, therefore a lower delivery is anticipated in Q1, rising in Q2 and again for Q3 and Q4. Against this plan, on a consolidated basis, the Trust achieved above the target delivery of £25.0m by £9.2m, delivering £34.1m YTD. Current forecasts show a shortfall in full delivery of the 23/24 programme of £24.6m – an improvement on the adverse £36.4m forecast in month 3 - and work is ongoing to identify schemes to close this gap.

Workstream	Savings to Date				Forecast 23/24 Position			
	Plan (YTD) £'000	Actual (YTD) £'000	Variance (YTD) £'000	Financial BRAG (YTD)	Plan (YTD) (23/24) £'000	Act/F'Cast (23/24) £'000	Variance (23/24) £'000	Financial BRAG (YTD)
Admin and clerical	1,469	1,463	(6)	100%	5,480	5,474	(6)	100%
Budget Review	806	806	806		3,108	3,108	0	100%
Contracting & income	2,503	2,503	0	100%	6,745	6,745	0	100%
Hospital Initiative	2,146	2,351	205	110%	6,734	6,939	205	103%
Length of stay	371	371	0	100%	1,114	1,114	0	100%
Non Pay Efficiencies	927	917	(11)	99%	3,102	3,063	(38)	99%
Outpatients	4	4	0	100%	19	19	0	100%
Pharmacy and medicines management	823	750	(73)	91%	2,185	2,111	(73)	97%
Procurement	1,185	1,179	(7)	99%	4,012	4,097	86	102%
Theatres	31	31	0	100%	93	93	(0)	100%
Workforce - medical	2,124	1,909	(215)	90%	6,988	6,683	(305)	96%
Workforce - nursing	1,477	1,048	(429)	71%	5,182	4,565	(617)	88%
Workforce - other	1,371	1,411	40	103%	2,465	2,506	40	102%
Informatics	791	791	0	100%	2,791	2,791	(0)	100%
Total (L3 or above)	**16,029**	**15,534**	**(496)**	**97%**	**50,018**	**49,309**	**(709)**	**99%**
Trust Initiative	8,925	18,585	9,659	208%	62,555	62,555	0	100%
Unidentified	-	-	0		23,843		(23,843)	
MFT Total	**24,955**	**34,118**	**9,164**	**137%**	**136,416**	**111,864**	**(24,552)**	**82%**

Summary against Target M1-4	YTD
Target	24,955
Actuals (L3 or above)	34,118
Variance to Target	9,164
Lost opportunity (value of schemes below L3)	1,321
Variance to target if all schemes delivered as plan	10,484

Summary against Target 23/24	Act/F'Cast
Target	136,416
Actuals/Forecast (L3 or above)	111,864
Variance to Target	- 24,552
Value of schemes below L3	6,783
Variance to target (all schemes)	- 17,769

Financial BRAG

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

- 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	23/24 Target	23/24 Actual/Forecast	23/24 Variance	23/24 % Variance
Corporate	5.0	4.9	(0.1)	-1%
CSS	12.6	11.3	(1.3)	-10%
EYE	1.7	1.9	0.2	14%
Dental	0.5	0.4	(0.2)	-32%
LCO	3.8	3.1	(0.7)	-19%
MRI	9.1	9.4	0.3	3%
NMGH	4.6	3.7	(0.9)	-20%
RMCH	6.2	3.3	(3.0)	-47%
St. Mary's	5.8	4.7	(1.2)	-20%
WTWA	11.5	6.7	(4.8)	-42%
Hospital/MCS/LCO Total	**60.9**	**49.3**	**(11.5)**	**-19%**
Trust (Group)	75.6	62.6	(13.0)	-17%
MFT Total	**136.4**	**111.9**	**(24.6)**	**-18%**

Statement of Financial Position

	M12 Restated 22/23 £000	M04 £000	Movement in YTD £000
Non-Current Assets			
Intangible Assets	11,369	10,970	(399)
Property, Plant and Equipment	1,060,566	1,041,570	(18,996)
Investments	858	858	0
Trade and Other Receivables	17,318	17,511	193
Total Non-Current Assets	**1,090,111**	**1,070,910**	**(19,201)**
Current Assets			
Inventories	25,374	26,378	1,004
NHS Trade and Other Receivables	100,604	40,742	(59,862)
Non-NHS Trade and Other Receivables	56,004	94,815	38,811
Non-Current Assets Held for Sale	210	210	0
Cash and Cash Equivalents	240,943	149,893	(91,050)
Total Current Assets	**423,135**	**312,038**	**(111,097)**
Current Liabilities			
Trade and Other Payables: Capital	(36,707)	(18,724)	17,983
Trade and Other Payables: Non-capital	(436,632)	(388,683)	47,949
Borrowings	(36,700)	(37,094)	(394)
Provisions	(29,276)	(29,196)	80
Other liabilities: Deferred Income	(51,880)	(63,328)	(11,448)
Total Current Liabilities	**(591,195)**	**(537,025)**	**54,170**
Net Current Assets	**(168,060)**	**(224,987)**	**(56,927)**
Total Assets Less Current Liabilities	**922,050**	**845,922**	**(76,128)**
Non-Current Liabilities			
Trade and Other Payables	-	-	-
Borrowings	(495,308)	(484,114)	11,194
Provisions	(11,423)	(11,423)	-
Other Liabilities: Deferred Income	(2,805)	(2,805)	-
Total Non-Current Liabilities	**(509,535)**	**(498,342)**	**11,194**
Total Assets Employed	**412,515**	**347,581**	**(64,935)**
Taxpayers' Equity			
Public Dividend Capital	471,920	471,920	0
Revaluation Reserve	163,396	163,396	0
Income and Expenditure Reserve	(222,801)	(287,736)	(64,935)
Total Taxpayers' Equity	**412,515**	**347,580**	**(64,935)**
Total Funds Employed	**412,515**	**347,580**	**(64,935)**

There has been a £19m decrease in the carrying value of Property Plant and Equipment from £1,061m as at 31st March 2023 to £1,042m at 31st July 2023. The decrease is due to depreciation of £21.8m and impairment of £16.6m which has been partially offset by in-year capital additions (including right of use assets) of £19m.

NHS trade and other receivables have decreased from £101m at the 31st March 2023 to £41m at 31st July 2023. This is primarily as a result of the receipt of income relating to the pay award of £51.8m and a reduction in accrued income relating to ICBs of £4.8m, NHS Specialised Commissioning of £3.1m and drugs income of £1.9m.

Non-NHS trade and other receivables have increased from £56m at the 31st March 2023 to £95m at 31st July 2023. This movement is primarily made up of an increase in central accrued income of £20m, an increase in trade receivables of £6.5m, and an increase in VAT receivable, reflecting the £15m recoverable VAT to be included in the annual VAT review that was submitted in August.

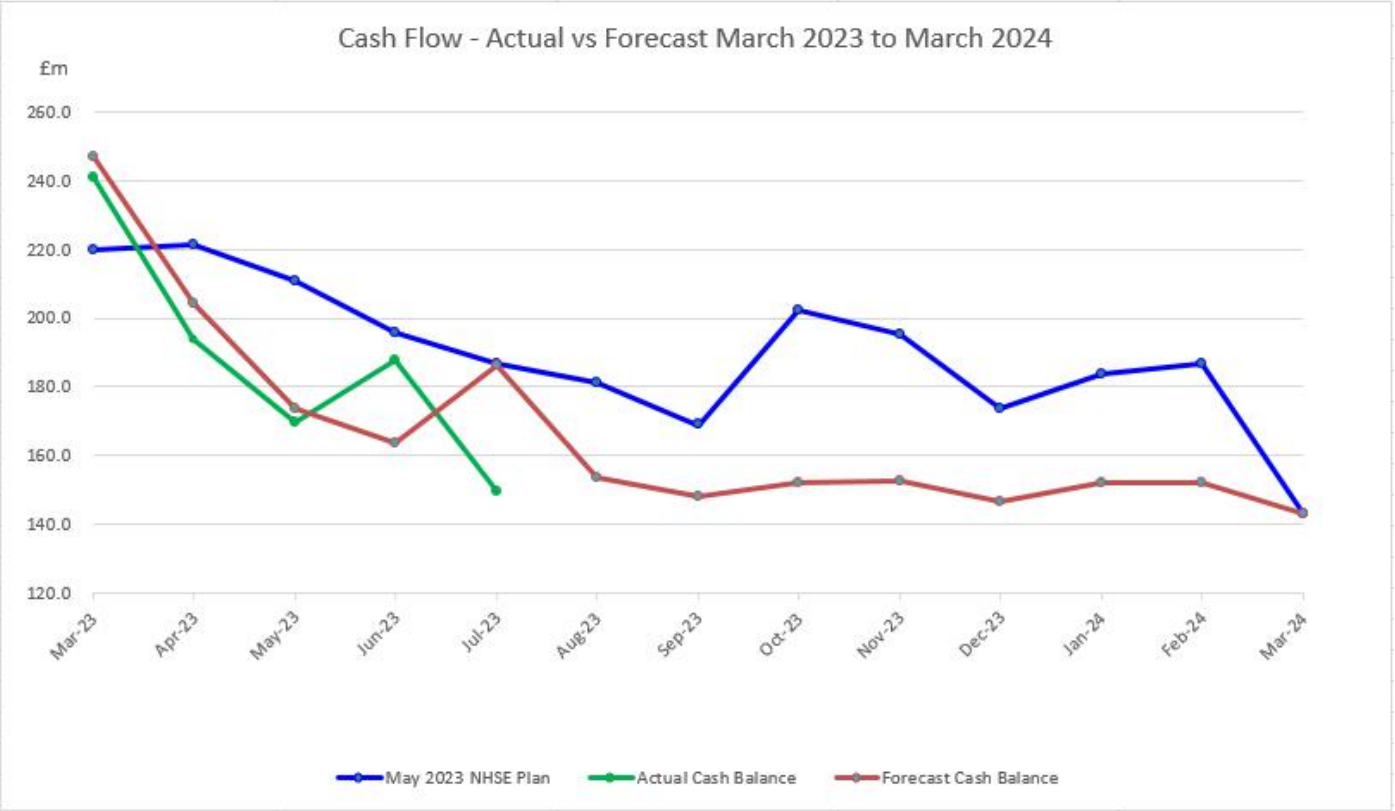
Since the year-end, there has been a reduction in non-capital trade and other payables, primarily driven by a reduction of £50m in accruals relating to the majority of the pay award.

The escalation of capital activity towards the end of the 2022/23 financial year resulted in a high year end capital creditors balance. This has started to unwind in 2023/24 as a high value of invoices and payments are processed, resulting in a reduction in capital creditors from £36.7m at the 31st March 2023 to £18.7m at 31st July 2023, with a corresponding reduction in cash.

Deferred income has increased from £55m at the 31st March 2023 to £66m at 31st July 2023. The main driver of the increase is income received in advance relating to research and innovation (£6.4m) and from the Integrated Care Board (£9.8m) and NHS Specialised Commissioning (£7.5m). This was partially offset by a reduction of deferred income relating to the recognition of income received in advance from Health Education England (£13m).

As previously reported, the 2022/23 year-end process resulted in two restatements of M12 2022/23 figures- the opening balance sheet has been restated for two reclassifications in relation to capital payable to receivables (£0.8m) and between capital and non-capital payables (£3.2m).

Cash Flow



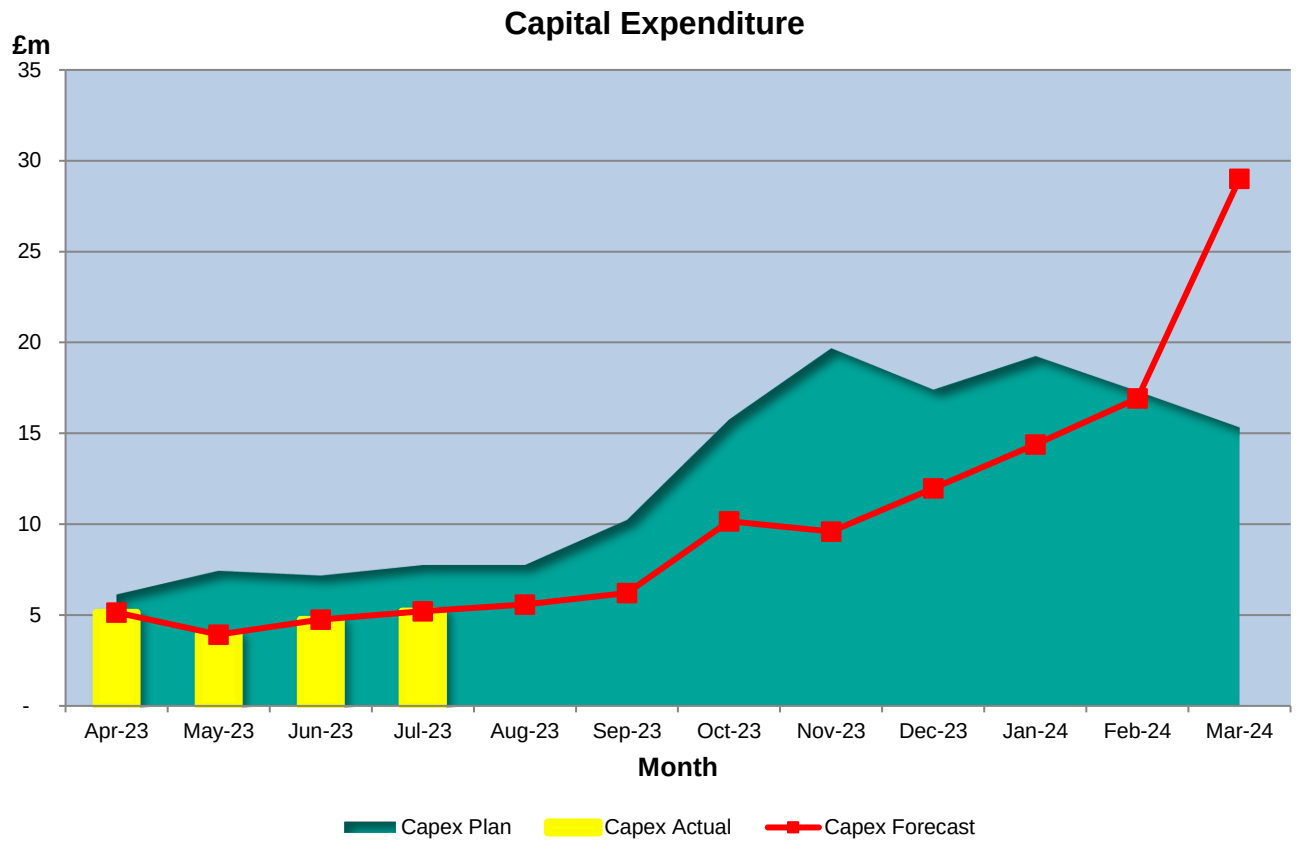
As at 31st July 2023, the Trust had a cash balance of £150m. This has significantly decreased compared to the balance of £188m as at 30th June 2023. This in-month decrease is primarily due to cash outflows relating to payroll costs of £156m and non-pay expenditure of £98m, partially offset by operating income of £223m.

The cash balance at the end of July 2023 was lower than forecast by £36m, this was primarily due to higher than forecast payments to suppliers of £28m. The following factors have resulted in this significant variance: M1-4 cash overspends compared to forecast relating to NHS Supply Chain (£3m), Sciensus (£3m) and Northumbria Healthcare NHS Foundation Trust (£2m); a forecasted decrease of £5m in other cash payments did not materialise; a forecasted decrease in Allocate and NHSP payables of £8m did not materialise due to the increase in staffing requirements; and the cash payment to Catalyst was above forecast by £5m. The cashflow forecast has since been updated to reflect the increased payment figures as a result of the continued high levels of inflation. Cash receipts in July were also £7m less than forecast, primarily driven by lower than forecast cash receipts for LVA (low value activity) in M4 (£4.3m) and Trafford Council income (£2.6m).

The capital spend in July 2023 resulted in a closing capital creditors balance at 31st July 2023 of £18.7m, this represents a slight decrease from the balance as at 30th June 2023 of £20.4m. This balance is slightly higher than forecast due to a YTD cash capital underspend (compared to forecast).

The variances to the plan are mostly due to timing issues and, at the current time, are expected to unwind throughout the remainder of the financial year. However, the assumptions underpinning the forecast are subject to an ongoing review and scrutiny to ensure they remain valid. In addition the current deficit has a natural negative impact on the cash balance.

Capital Expenditure



In the period to 31st July 2023, £19.0m of capital expenditure has been incurred against a plan of £28.5m, an underspend of £9.5m. Expenditure included within the GM envelope was £12.1m against the original plan of £11.7m, an overspend of £0.4m.

The £9.5m underspend is primarily driven by:

- £7.5m New Hospital Programme due to delays in funding approval;
- £3.5m Project RED initial timing delays;
- £2.1m Estates PDC schemes (i.e. TIF, Wythenshawe JAG and CDC) initial timing delays; and
- £0.7m IM&T schemes – delayed start until GM allocation is approved.

These underspends have been partially offset by overspends, notably:

- £3.5m H&S Backlog, this spend is being managed to be in line with plan by year-end; and
- £1.4m Data centre due to items received ahead of plan but expected to be in line with plan by year-end.

The Trust's current total capital plan value for 2023/24 is £151.2m. £73.4m of this plan relates to the Trust's allocation against the GM envelope component and is still subject to approval. Whilst the GM envelope is still under discussion, at the start of 2023/24, the Trust authorised capital leads to spend £33.5m in relation to the in-flight and contractually committed capital schemes. A further capital funding release of £10.4m has been approved by the Executive Directors Team in July ahead of formal GM approval; this is to avoid operational delays and a possibility of being unable to complete capital schemes within the 2023/24 financial year. At the time of writing this report, it is anticipated that the Trust's allocation of the GM envelope will be a maximum value of £55m. However, this remains subject to agreement and approval at GM level.

The current 2023/24 full year forecast is £122.9m, this is a reduction of £28.3m compared with the £151.2m submitted plan relating to the following:

- a £32.4m reduction in the North Manchester Hospital Programme (NHP) due to the delay in the approval for its Phase 2 enabling works bid; which is
- partially offset by an additional £4.1m of PDC funding for the TLHC and CDC schemes.

The current 2023/24 capital budget guidance sets out that there will continue to be nationally ring fenced CDEL cover for the impact of IFRS16.

The current IFRS 16 plan submission totals £45m, however, the level of CDEL cover available and the period for which this ringfenced cover will apply are still subject to approval, awaited from NHSE. Consequently, CDEL approval for new leases is being limited to leases already inflight at 31st March 2023 (totalling £8m) until final approval is received. Any impact this has on the continued operational performance of the Trust will also be assessed and action taken as necessary. In the period to 31st July 2023, IFRS 16 capital spend totalled £0.57m. The full year forecast for spend against the IFRS 16 capital allocation is £41.5m.

Agenda Item 9.3

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Deputy Chief Executive / Hive SRO
Paper prepared by:	Dave Pearson, Programme Director
Date of paper:	September 2023
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 are asked to note the progress made in stabilisation and the benefit delivered as we approach the first anniversary of Hive Go live.
Contact:	Name: Julia Bridgewater, Deputy Chief Executive / Hive SRO 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 now has an Electronic Patient Record (EPR) solution, **Hive**, which will support its vision to be a world-class academic and teaching organisation.

1.2 Julia Bridgewater, Group Deputy Chief Executive, remains the SRO for the programme and continues to provide **Executive level oversight** and leadership, ensuring optimisation and benefits realisation are achieved.

1.3 Jane Eddleston, Group Medical Director continues to provide **senior clinical leadership** to the Hive programme

1.4 Given the vital importance of Hive and the wider Digital and Informatics Strategy moving forward, MFT has created a new Group Executive role – **Group Chief Digital Officer**. The recruitment process has been initiated with interviews planned for Autumn.

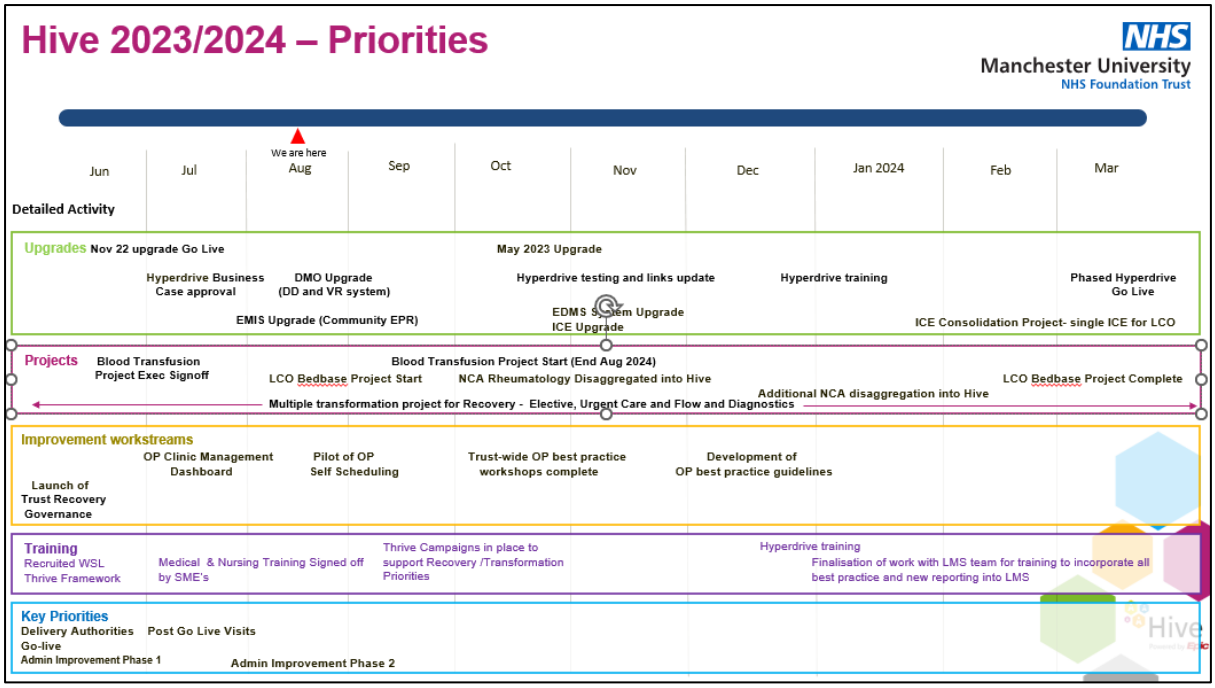
1.5 The **first-year anniversary** of the Hive 'Go Live' is on 8th September 2023. Significant progress has been made during this first year of Stabilisation and there is still important work to complete as the Stabilisation Phase continues. As reported at the last Board, MFT is now beginning to transition to the optimisation phase where Hive becomes the key enabler for MFTs ambitious digitally enabled **Transformation Programme**. MFT now has all the components in place to deliver this single Trust wide ***Clinically led, Operationally delivered and digitally enabled*** **strategy.**

1.6 This paper provides an update on key progress in the Stabilisation phase since the last Board and also outlines **Key Hive benefits** that have been delivered which will be bult upon as we move to Optimisation.

2. Hive Stabilisation Phase Update

2.1 Considerable progress has been made during the Stabilisation Phase. The Stabilisation Governance, overseen by the Hive Senior Responsible Officer has further matured with the formation of the Hive Delivery Authorities and a relaunch of the Hive Pathway Council which will further strengthen governance.

A summary of the Hive Priorities for 23/24 is tabled below. These align with the MFT productivity and Improvement programme.



2.2 The three Hive Delivery Authorities are: Inpatients, Outpatients and Support Services. Following the appointment of a **Clinical Chair** for each authority and a paediatric clinical co-chair, the authorities were formally launched in May 2023. Membership of the authorities is made up of Hive, Technical, Transformation, Business Intelligence, Epic, Clinical and Operational Hospital/MCS representatives.

2.3 Reporting into the Stabilisation Board, the Hive Delivery Authorities are responsible for:

- Overseeing the **prioritisation**, design and delivery of Hive Stabilisation, Optimisation and Benefits Realisation workstreams, which require Hive build; transformation; training and technical solutions.

- Ensuring that all Trust workstreams that require Hive enablement are included in a **single set of delivery plans** which are prioritised against the Trust's annual plan/priorities.

2.4 The Hive Delivery Authorities are **key enablers** supporting the Trusts Productivity and Improvement Programme for 2023/24 and will ensure capacity for delivering Hive solutions is aligned accordingly.

2.5 The Delivery Authorities continue to mature following their launch in May 2023. A key immediate focus of the Delivery Authorities has been to prioritise Hive-related initiatives, acknowledging that the limited capacity of the Hive team, and associated teams (e.g. Technical, Transformation, Business Intelligence), needs to be carefully allocated. In prioritising, particular focus has been given to **supporting delivery of the Trust's recovery and improvement targets.**

2.6 The activity prioritised to date by each Delivery Authority is outlined below:

Outpatient Delivery Authority

- Increasing clinic capacity and supporting outpatient transformation via clinic template workshops supported by data analysts
- Improving Patient Initiated Follow Up (PIFU) process
- Epic predictive DNA capability.
- Improving virtual clinic appointment process and reporting

Inpatient Delivery Authority

- Improving the provider Care Team and Early Warning Score pathways
- Discharge pathway optimisation.
- Improving Results acknowledgment process including dashboard design
- Developing enhanced Tertiary referral process
- Hospital at Home Pathway
- Theatre tools for improving pathways including Trafford Elective Hub workflow improvements

Support Services Delivery Authority

- Blood transfusion pathway improvements and project to deliver substantive new solution
- Supporting laboratory demand management and reduction.
- Radiology, particularly in relation to efficiency.
- Sampling processes, particularly reducing duplicate requesting.
- Increasing capacity in diagnostics.

The operation of the Delivery Authorities will continue to mature and new prioritisation metrics, consistent with the wider digital portfolio are being introduced. Support is being provided to establish robust management and reporting arrangements, and to set in place effective working mechanisms with other forums, such as the Pathway Councils.

2.7 The overall operating framework for 2023/24 is the most challenging for the last decade however, with **Hive as the vehicle for change and transformation and recovery**, MFT looks uniquely placed to navigate this challenge and those that follow in the years to come. The **Carnal Farrar Elective Recovery** work encompasses the Hive pathways and reporting required to support the elective recovery plans.

2.8 Good progress has been made since the last Board on the **Administration Workstream** which has been a key escalation theme since December 23. A large number of escalations in relation to Hive build and training of staff have now been addressed however, there is still a significant piece of work to complete over the coming 6 months to ensure delivery is complete.

To ensure continued effective management and oversight, the muti-disciplinary team (MDT) established with representation including Hive Applications, Business Intelligence, Group Performance, Clinical leadership and Data Quality remains firmly in place.

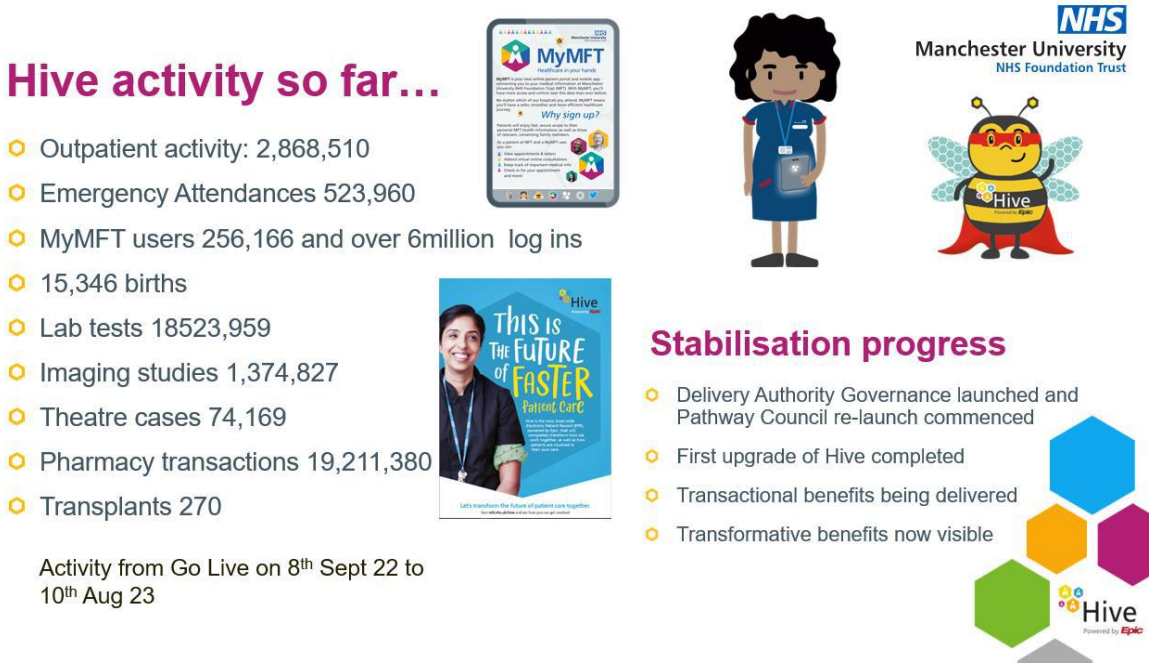
Progress on the root and branch review which has informed a continuous development plan is reported into the Data Quality Board to ensure Executive oversight.

2.9 Planning and business case development continues to take place for the delivery of **Epic Hyperdrive** project. Hyperdrive is Epic's new lightweight and web-enabled client application replacing the Classic Hyperspace. MFT must complete the move to Hyperdrive in line with the Epic EPR upgrade programme as future releases of Epic upgrades will become non-compliant with the legacy Hyperspace. High level benefits of Hyperdrive for end-users and the organisation include:

- A more readily available functionality enhancements & future upgrade process
- A potential to provide future reduction in required licences
- A more streamlined access to the Hive EPR
- Improved opportunities for device integration

2.10 The Hyperdrive business case has now been finalised. Project Board governance is established for Hyperdrive which reports into the Stabilisation Board with progress updates. The current plan is to commence and complete Hyperdrive rollout in Q4 for 23/24 (Jan to March). No system downtime will be associated with the Hyperdrive rollout.

2.11 A summary of the Hive activity so far and stabilisation headlines is as follows:



3. Training – Stabilisation progress Update

3.1 Training teams across Hive and other IT systems continue working with all stakeholder groups to develop **Future State Training**. The team have been trained in the production of eLearning and the lesson plans across the professions have now been signed off with

stakeholders. The team are now working on bringing the training materials into an eLearning format so that they are of a higher standard and easier to access.

3.2 The nursing materials are now being prepared for launch they have been through a process of review and sign off through the Digital NMAHP team and the identified Subject Matter Experts. The new learning materials are now being added to the learning management system (LMS) ready to launch at beginning of September 2023 with midwife material ready at the end of September. The training team and the LMS team will test this over August to ensure it is all ready for launch. This will mean that the newly registered nurses will be undertaking the new training offer.

3.3 The training team, Digital NMAHP and Saint Marys are also working on a best practice model for 'skill drills' where Hive documentation/functionality is trained alongside the clinical skills to support new midwives.

3.4 Training team have been supporting the junior doctor training running Microsoft Teams sessions to support them with specific elements of workflow and enabling live question and answer sessions.

3.5 The Hive team have recruited a Training Workstream Lead who will be onboarding in September 2023 and are looking at further recruitment to give training the appropriate management capacity for longer terms delivery. This will ensure that the training workstream can effectively support all of the Improvement Boards and Delivery Authorities to ensure that changes made in system are effectively embedded with clinical and operational teams.

4. Governance and Risk Management

4.1 Robust external assurance arrangements remained in place with Deloitte providing regular gateway reviews throughout the programme. As reported at the last Board, the final Gateway review (Gateway 5) was undertaken in March 2023and this was presented to the EPR Scrutiny Committee on 26th April.

4.2 The overall key recommendation from the Deloitte Gateway 5 review was for MFT to agree a **single, digital transformation strategy** i.e. ensuring that there is a single governance process in place to manage MFTs new digitally enabled operating model.

This is now firmly in place with the new Hive Delivery Authorities linking directly with the Trust's Productivity and Improvement Programme.

4.3 The management of the Hive Programme continues to have robust risk management strategy in place that continues to align to and report directly into the Trust Group Risk Oversight Committee (GROC) as required. This has enabled clear executive ownership on Hive risks and also ensured that the risks were assessed and mitigated in line with interdependences on all the other Trust workstreams.

4.4 **Blood Transfusion** is Hive's highest priority optimisation project. Implementation of the third-party system was moved to optimisation before Go Live as it was not safe to proceed

and the legacy laboratory system was retained. Significant work has taken place during Stabilisation to improve the blood transfusion workflow using the legacy system and also to support staff with training. Given the complexities, multiply stakeholders, cross Trust impact and the workarounds that are required, Blood Transfusion remains at level 15 (high level) risk on the Trust Risk Register and is reported into GROC ensuring Board level oversight whilst the substantive solution is planned and delivered.

Planning for the substantive solution has now been finalised with an accompanying business case agreed and funded. The project will take 12 months to complete with a Go Live planned for August 2024

5 Technical Update

5.1 The Technical teams have continued to support the system and responsibilities sit within the Informatics business as usual structure within the IT Operations and IT Infrastructure teams. Developing the collaboration across the Application (Hive and Connected), Information Services and Programmes has enabled the teams to support each other with improving the business-as-usual processes and support each other during escalations.

5.2 During the time since last reporting there have been two unplanned occasions of system unavailability. The first unplanned incident was on 19 June 2023, Hive was impacted with an unplanned downtime of approximately 1 hour. This was due to human error when resolving an issue in Hive, a full root cause analysis has been completed including lessons learnt. The incident was managed by Informatics and supported by Hive, EPRR and Communications team.

5.3 The second unplanned incident was on 03 August 2023 and caused the unavailability for Hive and other core systems having a significant impact to Wythenshawe and Withington Hospitals. The cause of the incident was a chiller failure in the data centre, resulting in the data centre overheating causing equipment to automatically shut down to protect from damage. Systems started to become unavailable from 7am on 03 August. Internal incident management was established utilising support from Informatics, Hive, Estates, EPRR and Communications. Hive access was restored to all users by 10:00, however Wythenshawe and Withington continued to experience issues accessing computers. The incident was led by EPRR whilst Informatics focused on the restoration of services.

5.4 Access to all critical systems was restored by 11pm on 03 August except for one system which remained in business continuity. The full restoration of the Wythenshawe Data Centre was completed by 9am on 04 August 2023 with Informatics teams working with suppliers through the night to progress with restoration. Systems including Hive, blood transfusion, point of care testing and telephony were impacted during the outage. A EPRR lead root cause analysis is underway, this will be reported via the Finance & Digital Scrutiny Committee.

5.5 On 14 July 2023 monitoring tools identified that there was a performance degradation on the host server that supports Hive. To ensure that Hive did not suffer an unplanned outage a decision was made to complete a planned restart of the system, which required a downtime of 1 hour.

5.6 Access & Identity Update – Following improvements made in the provisioning process the team were able to successfully support the August intake of 900 junior doctors. There were a small number of issues identified but the support process put in place ensured these were resolved in a timely manner. The team will continue to make improvements to the processes followed in preparation for the smaller September intake.

5.7 Network Issues Update – Informatics technical teams are developing a medium- and long-term road map for the network infrastructure improvement, which will be presented back in September. Additional activities have been undertaken at North Manchester Hospital to replace the desktops within the workstations on wheels (WOWs) to provide a more stable Wi-Fi connection, this was completed on 28 June 2023. Further work to improve WIFI connectivity at NMGH has been delayed due to delays with the physical challenges of the estate. Informatics and estates continue working together to establish a recovery plan on when the work will complete, the timescales to be confirmed with 3rd party contractors completing enablement works.

5.8 Technical Walkaround Update – The Chief Nursing Information Officer has led a multi-disciplinary team from Digital NMAHP, Delivery Authority Chairs and Technical teams in attending site visits to review the clinical and technical workflows. This has been well received by the areas visited and enabled identification of technical, workflow and training issues. Action plans have been developed for the technical issues which are being managed by the Head of IT Operations to ensure resolution and clear communication back to end users. In addition to this, there are scheduled weekly visits by the IT Operations teams to all ED departments to seek to proactively support in resolving issues.

6 Transformation

6.1 The Improvement workstreams (Urgent Care, Outpatients, Theatres and Diagnostics) are now fully established with identified Transformation priorities outlined within their programmes of work.

6.2 Each workstream has a strong digital improvement element at its heart to leverage the functionality of Hive to deliver the improvement benefits.

6.3 The Hive Delivery Authority Chairs and Epic colleagues are key members of the workstreams driving support to deliver ‘the basics’ and also innovation to maximise potential.

6.4 The outputs from the external support for the Trusts Elective Recovery programme from Carnall Farrar will align to the relevant Improvement workstreams, with a Group wide PMO being developed to provide oversight and assurance for the deliverables.

6.5 Key Transformation updates from the improvement workstreams are as follows:

- **Outpatients - Template optimisation and self scheduling**

  Focussed work with identified specialities is ongoing to ensure that the Outpatient templates meet the requirements to support improved productivity and enable a pilot of self scheduling for patients through the MyMFT app.

  Data has already identified that the DNA rate for patients using MyMFT is 4% better than patients who do not use it. The ability to self schedule should improve this further. It will also support the development of the Patient Initiated Follow Up (PIFU) pathway. The first pilots for self scheduling will start at the end of August 2023.

  In August 2023 a pilot commenced utilising the function of 'Fast Pass' functionality in Physiotherapy and Trauma and Orthopaedic services. The 'fast pass' enables patients on MyMFT to receive a notification that an appointment has become available within that service (eg through another patient cancelling). The patient can then opt to select that appointment if it is convenient to them. This supports the reduction in 'wasted' appointment time through cancelled appointments. For those patients that have used them in T&O and Physiotherapy have reduced their average wait for an appointment by 42 and 13 days respectively

  Also supporting Access and DNA issues is the development of the Inequalities Dashboard. This allows targeting at the Primary Care network (PCN) level to address at source issues that certain groups of patients experience with accessing our services.

  Work has been undertaken on developing the Clinic Utilisation reports which are now available in POWER BI allowing services to monitor their efficiency more closely.

- **Urgent care – standardisation of the front door pathways** - **using real time data from Hive to support escalation and action.**

  The Urgent Care Improvement workstream Clinical Lead (Dr Matt Makin) led an ED front door workshop focussed on standardising the ED pathways with a focus on maximising the functionality of Hive to improve patient flow. A Standard Operating Model is being developed with Medical Director Leadership for implementation on all sites. Future workshops are planned for Patient Flow and SDEC services.

- **Theatres - optimising the Preoperative Pathway**

  A pre op oversight board with Executive leadership has been established with a focus on standardisation and the use of the MyMFT functionality to support the pre op assessment. This supports the patients to provide information prior to their appointment meaning that their appointment time can be tailored to their needs.

- **Diagnostics - development and training of front-line staff** throughput
  Through a robust data quality validation approach a training programme is being developed to enable the teams to maximise the utilisation of Hive, supporting the flow of patients through the diagnostic pathways. This is for both clinical and administration teams Work is underway to develop the functionality in Hive to support the teams to better manage demand and capacity across the diagnostic pathways, using best practice advisory approach to support decision making on diagnostic requests.

7 Benefits Realisation

7.1 The affordability of Hive is dependent upon the Trust's ability to realise all expected benefits (cash releasing, non-cash releasing and non-financial) from the transformation of its clinical and patient administration services.

7.2 There is a financial delivery risk within the Hive related elements of the FY23/24 Waste Reduction Programme. At year to date, Plans are £7.8M short of target (c.£11.5M against an expected £19.3M). There is therefore focussed attention by the organisation to develop and deliver further value.

7.3 Senior Responsible Officers and Programme leads for current financial programmes are submitting progress highlight reports to Hive Stabilisation Board primarily aimed at:

7.3.1 improving the level of ownership and accountability for delivery within the organisation; and
7.3.2 providing visibility of blockers to progress and issues requiring escalation for immediate Group support.
7.3.3 Providing assurance to EPR Programme Board.

7.4 There is continued focus on reporting of benefits using Hive. It is key that the focus remains on further developing reporting that supports both operational delivery and benefit level reporting.

7.5 The Hive team are continuing to track and report progress against planned benefits. Where schemes are identified as a risk to delivery of the benefit, a realignment across the other schemes is being undertaken to identify the opportunities to deliver further and faster.

7.6 The benefits identified are aligned to the MFT Improvement workstreams and forums such as ORA are also utilised to share best practice and shared learning relating to benefits realisation to maximise delivery.

8 Benefits Summary – a year after implementation & Communications Update

Hive's implementation and integration over the last 12 months has highlighted a wide variety of benefits to both patients and staff. These benefits range from improving how staff connect with one another to how we make our patients journeys smoother and more efficient.

A key communications objective at this stage is to share the benefits delivered as an organisation. This includes financial and but also the positive difference we've seen in **staff and patient experience**, care delivery and operational working.

Below is an overview of some key benefits seen since Go Live:

8.1 Patient Safety

Bar Coded Medication Administration (BCMA) is now in place with Hive. This workflow delivers positive patient identification from bar coded care at the bedside which supports the avoidance of drug errors

Laboratory and Radiology demand management – Hive functionality is being used to support managing the demand coming in to the services with secure chat being used between clinicians to review the requests and ensure they are being managed in the right way.

Surgical Checklist Dashboard – has been developed by Theatre to monitor compliance against defined surgical checklist metrics that is used to inform improvements and developments,

8.2 Connectivity and efficiency

Hive has introduced new workflows, functionality and processes that aim to improve how we work and communicate with each other, our colleagues outside of MFT, and of course how we care for our patients.

Secure Chat – Integrated messaging within Hive that reduces reliance on external systems and aids faster decision making and the sharing of secure patient information. Secure Chat enables streamlined conversations and is especially beneficial to those off site and on-call.

- Over 3 million secure messages sent safely in Hive
- between 22,000 members of staff
- holding over 100,000 group conversations.

Clinical Photography – The availability of diagnostic quality images is often key to patient diagnosis, treatment, and ongoing care. With Hive, a more efficient workflow has meant that the Clinical Photography team can attend to patients faster and images are available in half the time.

- The Clinical Photography team have better access to patient location and requirements reducing the time taken to respond to a patient from 40 minutes to 15 minutes.
- High quality images are now processed in 10 minutes, down from 20 minutes, due to using just one system rather than multiple separate systems.

Care Everywhere – With Hive in place at MFT, powered by Epic software, we can now share and receive patient information with other Epic sites safely and securely within the same system, supporting more joined up care and transparency.

- We have shared 34k patient records with other Epic sites.
- Other Epic sites have shared 53K patient records with MFT.

In Basket – Hive's In Basket allows staff to manage tasks and communicate with colleagues in a centralised location. Actions are fully embedded in the patient record so unlike email there is no duplication and actions are transparent.

- One Radiology team have seen that using In Basket over previous processes for vetting and avoiding duplication has recently saved on average 2-3 minutes per patient.
- When using In Basket and other functions such as letter writing, Smart Tools and templates can be used to auto-create content ready to edit for each patient. In one Outpatient clinic this has saved ~10-20% of consultant time that was previously spent on dictation of clinic letters.

8.3 Patient experience

Alongside the benefits above which all streamline how MFT staff care for patients on a daily basis, Hive also provided a new way for patients to manage their own care in the form of MyMFT.

MyMFT – MyMFT launched with Hive and now a quarter of a million MFT patients are signed up and using the patient portal to take control of their care whenever and wherever it suits them. Early highlights include:

- Over 4,000 parents or carers are utilising MyMFT to look after their dependant's care.
- Interesting early data showing MyMFT users to have a lower DNA rate than the MFT average - with 28k appointments cancelled via the app. DNA rate is 4% lower for patients who use MyMFT.
- Positive feedback regarding MyMFT supporting patients and their families who are dealing with complex and long-term conditions.
- Almost 30k questionnaires submitted via MyMFT, streamlining appointments and care.
- The Maternity Centre in MyMFT means that all pregnancy care information is stored digitally in one place.
- A dedicated helpdesk ensures patients have direct access to support which is key in this early stage.
-

8.3 Streamlining and Sustainability

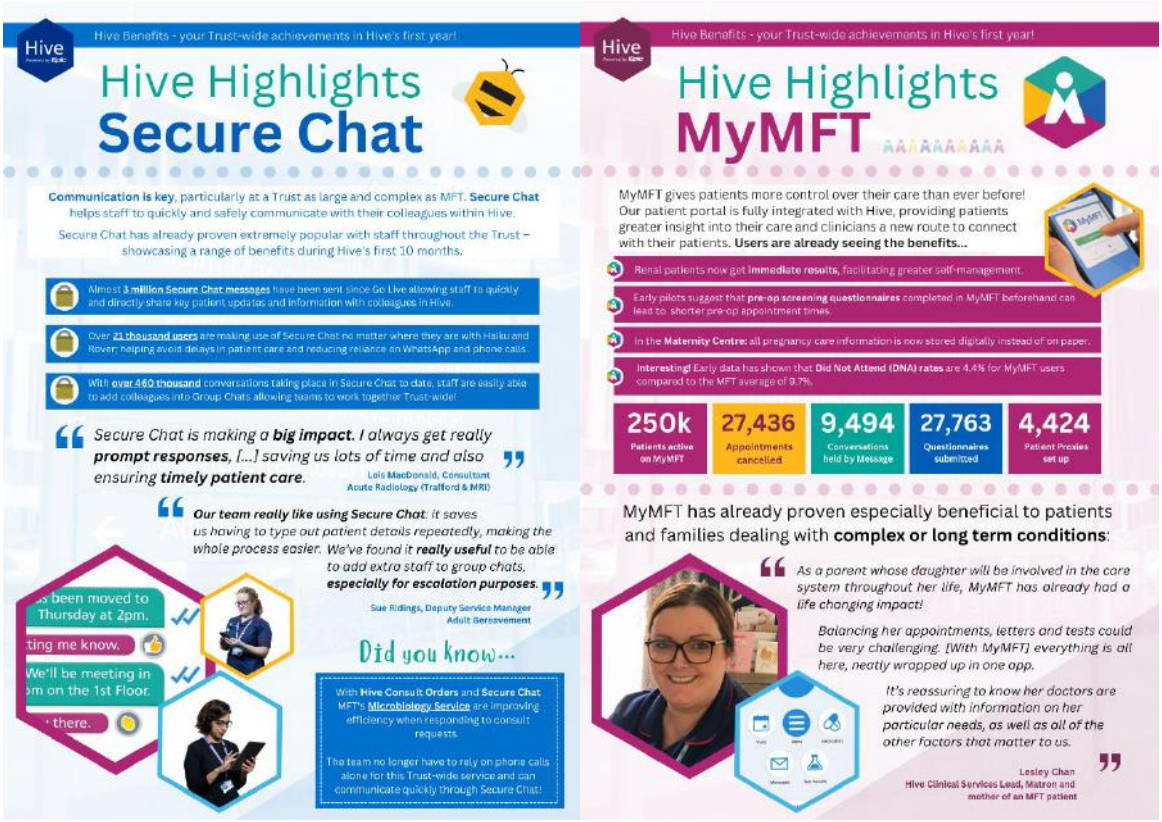
Paper reduction – By moving to an integrated electronic patient record system, a key priority for MFT to was to reduce the amount of paper used across the Trust. Since Go Live in September 2022, the Trust has saved over 14 million sheets of paper and seen a reduction in printing processes, contributing to our Trust-wide sustainability goals.

Reduction in legacy systems –Since Go Live 19 legacy systems have already been decommissioned with 9 more planned by March 2024

8.4 Ongoing Benefit and Communications

Further sharing of these benefits and achievements is planned for the upcoming months, across both our internal MFT communications channels and with our stakeholders.

"Hive Highlights" help share the benefits internally Examples of Secure Chat and MyMFT Hive Highlights can be seen below:



9 Next Steps

9.1 As the first anniversary of the Hive Go Live approaches the benefits for staff, patients and their relatives are evident, as are future opportunities. The governance is now maturing so that there can be a real focus on optimisation and benefit realisation. It is essential however that key stabilisation activities continue to remain a high priority so that a firm foundation can be built upon.

9.2 Hive is the **key enabler** for delivery of MFTs organisational priorities, focussed on supporting **recovery of both the Elective and Urgent Care delivery** as outlined in the operating framework for 23/24,

9.3 Hive is also a key enabler in keeping sustainable improvements in workforce, research, productivity and improvement..

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

10 **Recommendation**

10.1 The Board of Directors are asked to note the progress made in stabilisation and the benefit delivered as we approach the first anniversary of Hive Go live.

Agenda Item 9.4

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Director of Operations
Paper prepared by:	Rachel Bayley, SMH Director of Operations / Group Director of EPRR James Lomas, Head of EPRR and Business Continuity Stefano Piscitelli, EPRR Manager
Date of paper:	September 2023
Subject:	2023/2024 Emergency Preparedness Resilience and Response (EPRR) Core Standards
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:	To achieve high standards of patient safety and clinical quality across the Trust demonstrated through performance outcome measures
Recommendations:	The Board of Directors is asked to note and approve the contents of the report.
Contact:	Name: Rachel Bayley, SMH Director of Operations / Group Director of EPRR Tel: 0161 276 6718

2023-24 MFT EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE CORE STANDARDS SELF-ASSESSMENT

1. INTRODUCTION

The purpose of this report is to provide the Board of Directors with the annual MFT self-assessment against the NHS England Core Standards for Emergency Preparedness Resilience and Response (EPRR) for the period of 2023-24.

2. CONTEXT

The Civil Contingencies Act 2004 and the NHS Act 2006 as amended by the Health and Social Care Act 2012 underpin EPRR within health. Both Acts place EPRR duties on NHS England and the NHS in England. Additionally, the NHS Standard Contract Service Conditions (SC30) requires providers of NHS funded services to comply with NHS England EPRR guidance.

Under the CCA 2004 Acute Providers are Category 1 responders, which are recognised as being at the core of emergency response and are subject to the full set of civil protection duties including: risk assessment of emergencies, to have in place emergency plans and business continuity management arrangements and a requirement to share information and cooperate with other agencies.

The minimum requirements Acute Providers must meet are set out in the NHSE Core Standards for EPRR, which are in accordance with the CCA 2004 and the Health and Social Care Act 2012. In line with contractual requirements the Trust is required to provide an annual assurance of compliance with the Core Standards, with a 2023-24 submission deadline of 28/10/2022 comprising key documents of:

- Statement of compliance
- Associated action plan
- EPRR Core Standards Spreadsheet, which outlines the evidence and RAG rating against each individual standard.

There are a total of 64 standards and additionally each year a ‘deep dive’ is conducted to gain additional assurance into a specific area. The 2023 ‘deep dive’ topic is Responder Training, whilst important to undertake, the deep dive does not contribute towards the overall Trust compliance level. There are 4 levels of compliance:

Full	**Substantial**	Partial	Non-Compliant
Compliant with **all** standards	The organisation is **89-99%** compliant	The organisation is **77-88%** compliant	The organisation is compliant with **76% or less**

Updates since the 2022-23 EPRR Core Standards Submission

The 2020-21 and 2021-22 EPRR Core Standards submissions were both reduced to take into account the impact of the COVID-19 pandemic.

In addition, NHSE made a number of changes to the standards in 2022-23 which meant comparison with previous years was not equivalent.

Following these amended submissions and significant recent changes to the EPRR landscape, further overarching changes have been made to the 2023-24 EPRR Core Standard submission. This includes

several revisions or additions of new evidence requirements to more than 50% of the 64 standards, preventing direct comparison with any submission from the previous 3 years.

MFT have raised at Local Health Resilience Partnership, and further with both GM and regional EPRR colleagues that the significant changes made to the set of EPRR Core Standards each year over the last 3 consecutive years is in breach of the agreement that only minor amendments will be made annually, and a full review would be conducted in 2018, 2021 and then not again until 2024. Furthermore, that the current submission date of October is out of sync with the financial year, which raises ambiguity around the period of assurance. In agreement, regional colleagues have taken this to national EPRR colleagues – with a proposal that the 2023-24 set are re-released in February 2024 following the usual minor updates, with a clear reporting period of the previous financial year. **For Trusts this will mean that a further submission is undertaken at the end of the 2023/24 financial year to enable realignment of the reporting period, which is welcomed and will provide clarity.**

2022-23 MFT Rating Substantial

MFT overall assurance rating was 'substantial' with full compliance against all standards with the exception of five, on which it declared partial compliance. Following successful implementation of the action plan included in last year's Board Report, **four of those five partial compliance standards have been marked as full compliance for the 2023-24 submission**, and the Core Standard related to responder training has been rolled over into the action plan for 2023/24.

3. 2023/24 COMPLIANCE

There is a misalignment of the deadline for submission of the EPRR Core Standards on 6th October and MFTs Quality and Performance Scrutiny Committee and Board of Directors meetings which receive the annual declaration. Therefore, a provisional report is provided to state the expected level of compliance, recognising that work on the standards is ongoing through August and September. A further final report will be provided to ensure completeness of MFTs EPRR governance arrangements.

Current Provisional Position (August 2023):

79.0% Partial Compliance - However, further work is being undertaken to action 11 of the 13 partial compliant standards with the expectation that these will be compliant by final submission in October. The breakdown of the current compliance against the 62 NHSE EPRR Core Standards applicable to MFT is as follows:

Level of Compliance	Standards	Comments
Full compliance	49 standards	4 standards are compliant but require strengthened evidence in line with new requirements, and will be included in the action plan
Partial compliance	13 standards	
Non-compliance	Zero	

Anticipated Final Compliance as of October 2023

The Trust is expecting to achieve its highest level of compliance in 2023/24 with a compliance rating of 96.7% - Substantial overall

MFT receiving a rating of 'Substantial' should not be perceived as a poor assurance rating, as a Trust MFT are delivering against each NHS Core Standards for EPRR. However, it indicates there are opportunities for the Trust to further improve over a period, through the implementation and monitoring of effective action plans.

Level of Compliance	Standards	Comments
Full compliance	60 standards	4 standards are compliant but require strengthened evidence in line with new requirements, and will be included in the action plan
Partial compliance	2 standards	Core Standard 17 – Lockdown Policy Core Standard 24 – Responder Training
Non-compliance	Zero	

Actions to address the partially compliant standards are in place as outlined in Appendix A. The action plan will be overseen by the MFT EPRR Committee to ensure delivery, with assurance to the Group Management Board via Committee minutes. Cascade of actions will be undertaken through the MFT EPRR governance structure to local hospital EPRR Forums. The full standards are included in Appendix B for completeness.

In addition, external oversight, and peer review of provider EPRR self-assessments and associated action plans, is provided through the Local Health Resilience Partnership. It should be noted, Greater Manchester's Integrated Care Board can 'check and challenge' MFTs EPRR Core Standard submission with 48 hours' notice.

4. RECOMENDATIONS

The Board of Directors are asked to note and approve the MFT EPRR statement of compliance for 2023-24, with assurance of delivery of actions and future improved compliance through the MFT EPRR governance structure. Noting this has been approved by Quality and Performance Scrutiny Committee on the 29th August 2023.

5. APPENDICES

The following appendices are included for reference:

- Appendix A: Partially compliant standards for 2023-24
- Appendix B: Core standards marked fully compliant for 2023-24 with an improvement action plan to further strengthen
- Appendix C: Core standards marked partially compliant in 2022-23 with status updates in 2023-24.
- Appendix D: NHSE EPRR Core Standard Submission 2023-24 v2

Greater Manchester Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2023-2024

STATEMENT OF COMPLIANCE

Manchester University NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, Rachel Bayley, MFT Deputy Director of Operations will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Substantial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Julia Bridgewater

Signed by the organisation's Accountable Emergency Officer 21/08/2023

29/08/2023	11/09/2023	01/03/2024
Presented at Quality and Performance Scrutiny Committee	Date (to be) presented at Public Board	Date published in organisations Annual Report

Appendix A – Partial Compliant Standards Action Plan 2023-24

#	Domain	Standard	Standard Detail	Compliance Rationale	MFT Actions	Responsible Officer	Timescale for Full Compliance
17	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Partial – Lockdown Policy is out of date – owned and updated by MFT Security. EPRR have provided comments on most recent draft (09.05.2023)			November 2023
24	**Training and exercising**	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as	Partial – MFT keep records manually of has attended training / exercising but currently does not compile portfolios.			March 2024

#	Domain	Standard	Standard Detail	Compliance Rationale	MFT Actions	Responsible Officer	Timescale for Full Compliance
			well as any training undertaken to fulfil their role				

Manchester University NHS Foundation Trust

Appendix B – Fully Compliant Standards (opportunity to strengthen evidence) Action Plan 2023-24

#	Domain	Standard	Standard Detail	Current Compliance	New standard / updated evidence requirements and action required
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	**Local EPRR Forums and Group EPRR Committee monitor for any new or anticipated risks through their quarterly reports as this is a standing item. Community and national risk registers are monitored via the Local Health Resilience Partnership.** **To improve this process, Rachel Bayley and Nicky Shaw are to hold EPRR Risk Summit facilitated by Tanya Claridge to review the Group Risk Register process and incorporate elements of horizon scanning.**	• *Evidence that EPRR risks are regularly considered and recorded* • *Evidence that EPRR risks are represented and recorded on the organisations corporate risk register* • *Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather*
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating,	**MFT already has a Group Major Incident and Business Continuity Risk Register to record and**	*Evidence* • *EPRR risks are considered in the organisation's risk*

			and escalating EPRR risks internally and externally	**assess risks which is held and monitored by the Group EPRR Committee.** **To improve this process, Rachel Bayley and Nicky Shaw are to hold EPRR Risk Summit facilitated by Tanya Claridge to review the Group Risk Register process and incorporate elements of horizon scanning.**	*management policy* *• Reference to EPRR risk management in the organisation's EPRR policy document*
46	**Business Continuity**	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	**Due to the size and complexity of MFT. business impact analyses have been completed for all services at hospital / MCS / LCO level meaning Directors of Operations can easily identify essential services, and mitigations to disruptions of these services as identified by the plan owners.** **To improve this, MFT could compile a strategic BIA for the entire Trust, to provide Executives on-Call an**	*The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme.* *Documented process on how BIA will be conducted, including:*

				overview of all essential services in one place. E.g., in the event of a critical incident.	*• the method to be used* *• the frequency of review* *• how the information will be used to inform planning* *• how RA is used to support.* *The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA:* *• Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption.* *• A consistent approach to performing the BIA should be used throughout the organisation.* *• BIA method used should*

					be robust enough to ensure the information is collected consistently and impartially.
63	**Hazmat/CBRN**	**Hazmat/CBRN training resource**	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Marked as fully compliant – with plans to improve. Currently each sites CBRN / HAZMAT lead receives the NWAS Train the Trainer and then delivers locally to their response teams. To be improved by rolling out internal MFT standardised.	*Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy)* *Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination* *Documented evidence of training records for Hazmat/CBRN training - including for:* *- trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update)* *- trust staff - with dates of the training that that they have undertaken*

					Developed training programme to deliver capability against the risk assessment.

Appendix C – 2022-23 Core Standards marked partial compliance – revised status following actions

Domain	Standard	Standard Detail	Status in 2022-23	MFT Actions	Date of Completion / Forum for approval	Status in 2023-24
9	**Collaborative Planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders to ensure the whole patient pathway is considered.	Partial compliance	This standard is now included in the updated MFT EPRR Policy V3.0 (2023).	Group EPRR Committee 16.08.2023.	Full compliance
13	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the	Partial compliance	Plan Draft is being distributed for comments & feedback	Group EPRR Committee 18.10.2023.	Full compliance

		organisation has arrangements in place to respond to a new and emerging pandemic				
22	**EPRR training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Partial compliance	Training needs analysis updated and included in the Training and Exercising Schedule 2023-24.	Group EPRR Committee 16.08.2023.	Full compliance
25	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain	Partial compliance	Under review by MFT EPRR and the Local Health Resilience Partnership.		Partial compliance – now linked to core standard 24 in appendix A.

		a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role				
65	**CBRN Training Programme**	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.		NWAS Train the Trainer has been delivered at both MRI and NMGH for all MFT staff.	Marked as fully compliant – with plans to improve. Currently each sites CBRN / HAZMAT lead receives the NWAS Train the Trainer and then delivers locally to their response teams. To be improved by rolling out internal MFT standardised.	Full compliance – now linked to core standard 63 in appendix B.

Agenda Item 10.1

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Strategy
Paper prepared by:	Caroline Davidson, Director of Strategy
Date of paper:	September 2023
Subject:	Strategic Development Update
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	All individual strategic developments are risk assessed and monitored through the Board Assurance and Risk Management processes.
Recommendations:	The Board of Directors is asked to note the updates in relation to strategic developments nationally, regionally and within MFT.
Contact:	Name: Caroline Davidson, Director of Strategy Tel: 0161 276 5676

1. Introduction

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

2. National Issues

2.1 NHS Long Term Workforce Plan

On 30 June NHS England (NHS E) published the first NHS Long Term Workforce Plan. It sets out a strategic direction for the long term, as well as concrete and pragmatic action to be taken locally, regionally and nationally in the short to medium term to address current workforce challenges. This is the subject of a separate Board paper.

2.2 Reformed NHS Cancer Standards

Ministers have approved proposals to slim down 10 existing cancer standards into three key measures. They are:

- 28-Day Faster Diagnosis Standard (FDS) which means patients with suspected cancer who are referred for urgent cancer checks from a GP, screening programme or other route should be diagnosed or have cancer ruled out within 28 days.
- 62-day referral to treatment standard which means patients who have been referred for suspected cancer from any source and go on to receive a diagnosis should start treatment within 62 days of their referral.
- 31-day decision to treat to treatment standard which means patients who have a cancer diagnosis, and who have had a decision made on their first or subsequent treatment, should then start that treatment within 31 days.

The new standards will come into effect in October.

2.3 Specialised Commissioning

NHS E has recently set out the next stage in its plans to delegate specialised commissioning to integrated care boards (ICBs). This year, 59 specialised services NHSE judged to be suitable for delegation are being jointly commissioned by ICBs and NHSE at a regional level. From April 2024, NHSE plans to delegate those services fully to ICBs, or groups of ICBs.

In preparation for this, ICBs have been asked to undertake a self-assessment to assess whether systems have built the right capacity and capability to take on specialised commissioning functions.

NHSE's national moderation panel will meet in October 2023 and will determine which of three delegation models each area will adopt from April 2024:

- Category one: full delegated commissioning responsibility from April 24.
- Category two: delegated commissioning responsibility from April24 subject to developmental conditions being attached.
- Category three: not ready for full delegated commissioning responsibility

NHSE board will make a final decision on the delegation to ICBs at its meeting in December 2023.

2.4 NHS IMPACT

NHS IMPACT (Improving Patient Care Together) is the new, single, shared NHS approach to improvement. It has been launched to support all NHS organisations, systems and providers to develop the skills and techniques to deliver continuous improvement. The approach has five components:

- Building a shared purpose and vision
- Investing in people and culture
- Developing leadership behaviours
- Building improvement capability and capacity
- Embedding improvement into management systems and processes.

These five components, used consistently, create the right conditions for continuous improvement and high performance and delivering better care for patients and better outcomes for communities.

Organisations, systems and providers are at different stages and it will take time for NHS IMPACT to be fully embedded across all organisations.

3. Regional and Local

3.1 Greater Manchester Integrated Care System (ICS) Operating Model

The principles of a refreshed Operating Model for Greater Manchester ICS have now been set out. They provide more clarity about how the constituent organisations work together as a system, notably:

- Being more explicit about how the vision and missions translate into how the system is organised
- Being clearer about where decisions sit, and under what authority key meetings take place;
- A clearer description of the roles of each partner in the system - the role of NHS Greater Manchester, the role and remit of Locality Boards and Place Based Leads, the focus and contribution of provider collaboratives, and the role of the Integrated Care Partnership;
- A clear description of how every function of the Integration Care System is discharged and who is responsible for what.

The model is draft at this stage and requires final approval from the Integrated Care Board.

4. MFT Developments

4.1 Sickle Cell Disease

Our bid to be a sickle cell hyper acute unit pilot has been successful. We will be one of three and the only one outside London. The aim is to provide a new pathway for patients in crisis which delivers more rapid access to specialist advice and care including admission, if necessary, on a 24/7 basis, wherever patients live, and bypassing their local emergency department. Phased implementation is planned from autumn. NHS England have asked for elements of the pathway to be available across the whole of the North West to include Liverpool/Merseyside patients, and discussions are commencing to explore this with Liverpool colleagues. Partnership working across GM/NW and patient involvement will be central to implementation.

MFT has been selected as one of six centres in the UK to provide Exagamglogene autotemcel gene therapy, if the therapy is approved by regulators over the coming year. This is a gene editing therapy adults and older children with severe sickle cell disease or transfusion dependent thalassaemia. While there remain steps to launching a service, this marks a significant milestone and achievement both for the patient group, as well as MFT's aspirations in advanced therapies and precision medicine.

4.2 Genomics

As a result of national initiatives led by NHS England, there are a number of exciting service developments in Genomics for which MFT intends to bid. These include the creation of a Cellular Pathology Genomic Centre for Greater Manchester, the Cancer Vaccine Launch Pad and circulating tumour DNA (ctDNA) testing. Teams across MFT, primarily from Saint Mary's MCS and Clinical and Scientific Services, are working to develop plans and submit proposals for the relevant initiatives.

4.3 Gender Development Service

RMCH is working in partnership with Alder Hey Children's Hospital forming a 'north hub' service, and also with Evelina, South London and Maudsley, and Great Ormond St Hospital (the 'south hub') as part of a national initiative to provide a new Gender Development Service for Children and Young People. The programme to design and deploy a new service has developed rapidly. A new clinical model has been approved by NHS England. There is a significant workforce requirement and a recruitment strategy is now in an advanced stage of development. We are working on the governance and associated partnership arrangements with Alder Hey and the current proposal is that Alder Hey is the lead provider for the North Hub. NHS E intends to launch the new service in April 2024.

4.4 Sexual Health Service

The Northern Sexual Health Service led from MRI has been awarded the tender to provide the integrated sexual health service for the City of Salford for five years from 1 January 2024, with an option to extend for up to a further five years. The award of the contract to the Northern Sexual Health Service enables us to extend our expertise to the population of Salford, to harness the geographical and health needs synergies of bringing this service together with the existing Manchester/Trafford service and provides continuity of care for Salford residents who already access clinics run by the Northern Sexual Health Service.

4.5 Single Service for Infectious Diseases

The Managed Single Service for Infectious Diseases was successfully implemented on 1 August 2023. This means that we now have a single clinical and management leadership structure for Infectious Diseases across WTWA, MRI and NMGH.

5. Actions / Recommendations

The Board of Directors is asked to note the updates in relation to strategic developments nationally, regionally and within MFT.

Agenda Item 10.2

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Strategy
Paper prepared by:	Caroline Davidson, Director of Strategy
Date of paper:	September 2023
Subject:	Annual Planning
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	All individual strategic developments are risk assessed and monitored through the Board Assurance and Risk Management processes.
Recommendations:	The Board of Directors is asked to note: – The revised annual planning process – The high-level timeline and the earlier start to the process – The progress to date and the next steps.
Contact:	Name: Caroline Davidson, Director of Strategy Tel: 0161 276 5676

1. Introduction

The Annual Plan sets out what we intend to do in the coming year in order to respond to the immediate challenges facing us and to make progress towards achieving our longer-term vision and strategic aims. It quantifies the workforce requirements and shows how the plan will be delivered within budget.

Through a single annual planning process we produce:

- Activity, finance and workforce operational plans that form part of the Greater Manchester Integrated Care System plan
- Hospitals / MCS /LCO annual plans, including activity plans, for 22/23 that set out what each Hospital /MCS plans to deliver and how they plan to do it, within their allocated resources.
- MFT level Annual Plan for 22/23 that brings together the Hospital / MCS plans with the plans of the corporate teams under each of the Trust strategic aims.

Each year we seek to improve the process and in particular increase the degree to which our activity, finance and workforce plans are aligned.

The purpose of this paper is to describe some key changes that we are making to the process this year and to set out the timeline for the 24/25 planning round and the next steps.

2. Changes to the Process

The annual planning process adopted last year was reviewed to identify what worked well and where improvements could be made. As a result the following key changes are being made to the process:

- Bringing forward the process starting the preparatory work in July and the actual planning in September.
- Establishing an Executive Director led Annual Planning Oversight Group to oversee design and delivery of the process including timelines, products and triangulation of plans.
- A greater degree of bottom-up Hospitals / MCS / LCOs planning which will be aggregated into an overarching MFT plan.

3. Timeline

The high-level timeline for the planning process for 2024/25 is set out in attachment A. This is being further developed into a more detailed programme plan that aligns the requirements of all of the annual planning and related processes including:

- Production of Operational Plan templates for NHS England
- Development of MFT Annual Plan
- Development of Hospital/MCS/LCO Annual Plans
- Financial planning and budgeting
- Workforce planning
- Waste reduction programme
- Capital planning.

4. Progress to Date

The Annual Planning Oversight Group has been established. Its primary purpose is to bring together all of our planning and ensure workforce, finance and activity planning is aligned and all internal plans and submissions to NHS E have been triangulated. Executive Directors on the group will keep the relevant Scrutiny Committees appraised of progress prior to final approval by the Board of Directors.

Through this group we are currently developing the planning guidance which includes developing the principles, templates and agreeing the underpinning assumptions.

A process to establish our priorities for 2024/25 has commenced. This has included engagement with the Hospitals/MCS/LCOs and the Board of Directors. Engagement with the Council of Governors on priorities for 2024/25 will take place through the Forward Planning workshop.

5. Next Steps

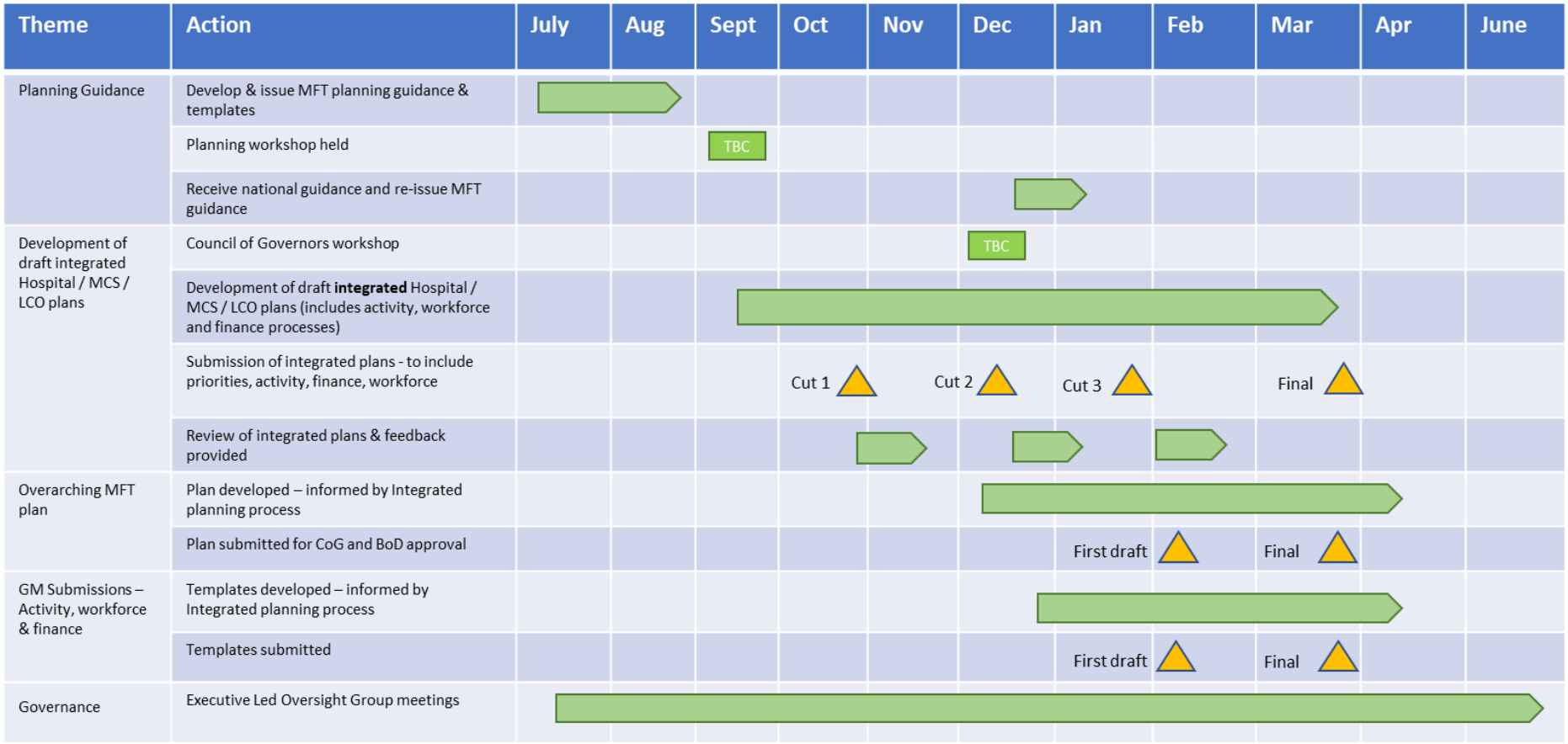
The next steps are to finalise the process and guidance through the Annual Planning Oversight Group. The actual planning will begin following the Annual Planning workshop in September although Hospitals, MCSs and the LCO are starting to prepare by for example working on their capacity plans in advance.

6. Actions/recommendations

The Board is asked to:

- Note the revised annual planning process
- Note the high-level timeline and the earlier start to the process
- Note the progress to date and the next steps.

High-Level Annual Planning Timeline



Agenda Item 10.3

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce and Corporate Business
Paper prepared by:	Peter Blythin, Group Executive Director of Workforce and Corporate Business Claire Macconnell, Group Director of HR
Date of paper:	September 2023
Subject:	Report of the Group Executive Director of Workforce and Corporate Business
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:	In the absence of sufficient operational and strategic effort on workforce matters the sustainability of MFT would be compromised.
Recommendations:	The Board of Directors is asked to receive and note the work underway to align the current MFT People Plan with the National Long Term Workforce Plan.
Contact:	Name: Peter Blythin, Group Executive Director of Workforce and Corporate Business Tel: 0161 276 5850

1.0. Overview

1.1. The NHS Long Term Workforce Plan 2023 covers a 15-year assessment of the workforce requirements for the future and provides a costed plan of how to develop the current NHS workforce.

1.2. Commissioned and accepted by the Government, the plan explains how the NHS will develop to meet existing and future demand to support the health and wellbeing of the population. To aid the process over £2.4 billion has been committed to fund additional education and training places over the next five years. This is on top of existing funding commitments.

1.3. The plan sets out the strategic direction for the long-term as well as short to medium-term actions to be undertaken locally, regionally and nationally. Those actions fall into three priority areas:

i. **Train:** growing the workforce

Substantially growing the number of doctors, nurses, allied health professionals and support staff underpinned by the £2.4 billion funding commitment.

ii. **Retain:** embedding the right culture and improving retention

Renewing the focus and ushering in a major drive on retention, with better opportunities for career development and improved flexible working options. This comes alongside reforms to the pension scheme, with an aim to have 130,000 staff stay working in the NHS for longer.

iii. **Reform:** working and training differently

Working differently, delivering training in new ways with new roles as part of multi-disciplinary teams. Advances in technology and treatments will be explored and implemented to help the NHS modernise and meet future requirements.

1.4. The plan also sets out next steps, which offers principles for reviewing the plan and engaging stakeholders. While this is a national plan, it allows for priority decisions to be taken at system and local level. There is also a commitment to the plan not being a one off but iterative, with further versions being developed and published on a more regular basis as actions and assumptions are tested through the application of data.

2.0. Delivering and embedding the plan

2.1. The plan recommends actions at every level of the NHS across employers, systems and national organisations.

2.2. NHS England (NHSE) will refresh the plan at least every two years, to ensure the assessment of demand stays up to date – initiating an ongoing programme of work to embed an integrated approach to planning and delivery.

2.3. Integrated Care Systems (ICS) are expected to play a critical role in connecting the NHS to local authorities and wider system partners, building on progress to date. The plan most

urgently recommends ICSs prioritise actions that drive recruitment and retention of 'one workforce' across health and care.

2.4. Systems must determine their approach in view of local needs and opportunities, setting out priorities for workforce action in their five-year joint forward plans.

2.5. NHSE acknowledges ICS leadership of the work is dependent on having sufficient capacity and technical capability for workforce planning, so they are expanding their support offer, including through a new tool providing system-level workforce intelligence, and facilitating an accredited strategic workforce planning course.

3.0. Ongoing refinement of the NHS Long Term Workforce Plan

3.1. Planning over a 15-year horizon requires an adaptable approach, so NHSE will keep the plan iterative and the position under assessment - refreshing modelling and reviewing training and education expansion.

3.2. This extends most immediately to the assumptions on productivity improvement, a review of which may require increased levels of international recruitment in the short term or increase reliance on more expensive temporary staffing, until additional staff could be trained and recruited.

3.3. It will also consider whether required increases in capital investment and digital infrastructure are taking place, alongside the ability of the social care sector to play a role in reducing demand for NHS services.

4.0. Productivity and capital

4.1. NHS leaders share the desire to increase healthcare productivity; doing so will allow the NHS to meet demand of an older population with more complex needs. The plan is based on an ambitious workforce productivity assumption of 2% which will require continued effort to achieve operational excellence, reducing the administrative burden through technological advancement and better infrastructure, care delivered in more efficient and appropriate settings (closer to home and avoiding costly admissions), and using a broader range of skilled professionals, upskilling, and retaining our staff.

4.2. This will require major extra capital investment. The plan acknowledges the scale of this. Capital spending in the NHS declined in real-terms between 2010/11 and 2017/18 and lags behind other OECD countries.

5.0. Social care workforce

5.1. Social care is absent from the plan. Various national bodies such as the NHS Confederation, NHS Employers, etc have written to the Prime Minister to urge the Government to begin work on a social care equivalent. This would help to:

- Raise the status and value of careers in all social care settings and services.
- Transform staff experience, career development and productivity.
- Invest in pay and conditions to both attract people to the sector and reduce turnover.
- Enable better service integration between social care and health.
- Training and education.

6.0. Entry and reform of training and education

6.1. Apprenticeships will be critical if the size of the NHS workforce is to strengthen through the attraction of more people from diverse backgrounds. Apprenticeships will provide a particular boost in areas where it is harder to recruit staff and reduce barriers to enable more diverse entrants looking to start a career in healthcare.

6.2. Over the years however, investment in NHS staffing roles outside of hospitals has been limited. The plan aims to correct this with ambitious growth targets for recruiting more staff into mental health, community care and primary care roles. This reflects the need to catch up from what has been a historically low starting point in these areas, especially in mental health nursing.

6.3. A commitment to increase GP training places, creating opportunities for training placements in general practice will help primary care. Not only will this better reflect activity levels within the NHS (approximately 90 per cent of all activity takes places within primary care) but it is also necessary to meet the ambitions of system-working, moving care upstream and – crucially – addressing workforce shortages that have left general practice seeing 12 per cent more patients than pre-pandemic with fewer full-time GPs.

6.4. Further, the plan sets out a commitment to use the primary care workforce to its best ability, laying the foundations for a greater role for community pharmacy as described in the delivery plan for the recovery of primary care access. The expansion of training places for roles that form part of the Additional Roles Reimbursement Scheme (ARRS) is also a step in the right direction, especially given that, by the latest estimates, 29,000 professionals have been recruited via the Scheme, exceeding the goal of 26,000 by 2024.

6.5. The plan also shows a commitment to training more healthcare scientists with the ambition that this will support the adoption and embedding of health research into the NHS.

6.6. Training more healthcare workers involves a large amount of funding for both commissioned medical staff, but also for the placements necessary for non-commissioned roles like nurses. For this reason the Government has committed new money to increase training budgets rather than insisting that new training is paid for out of existing budgets. Increased capital investment is also to be made available.

7.0. Retention

7.1. The plan outlines a renewed focus on retention. Aiming to provide reassurance to staff that NHS England is committed to improving working conditions for them and improve care for patients. The mix of measures the plan proposes around flexible working, culture and training time will support this.

7.2. International competition for professionally qualified staff, however, means the UK must compete on pay with peer nations. Recent pay increases have gone someway to ease the situation.

8.0. The data, digital and technology workforce

8.1. Better use of technology to innovate and deliver value for money and high-quality care is important. Although recognised in the plan greater use of technology is not be seen as an alternative to adequate, safe levels of staffing – levels which must keep pace with demand and grow as our population ages.

8.2. The number of digital, data and technology staff to meet their levels of ambition is challenging given the ongoing struggle in some areas to recruit and retain this workforce. NHS England is preparing to publish a separate digital data and technology workforce plan over the coming months.

9.0. Next steps - Moving Forward

9.1. The detailed modelling that underpins the national plan is to be published alongside implementation and funding arrangements. At that point the opportunities, capacity and infrastructure required to deliver the ambitions set by the Government will be reviewed in the context of the overall MFT People Plan, organisational strategy, clinical service changes, annual planning and associated processes including research and development.

9.2. This will be managed in the context of NHS England having identified a central role for ICSs to deliver the Long Term Workforce Plan. To help position MFT well discussions have already commenced with the ICS and an action agreed at the Greater Manchester (GM) Workforce Collaborative Steering Group to establish a specific workshop in October. This will involve a broad membership including higher education institutes, other education providers, the Nursing Midwifery and Allied Health Professionals Programme Management Office and the Greater Manchester Education Transformation Alliance.

9.3. Complementary to the pan-GM work the GM People Board will provide the principal focus for progression of the Long Term Workforce Plan.

9.4. GM HR Directors have met on several occasions to review the plan as provider organisations ahead of the scheduled ICB workshop in October.

9.5. In addition, the Joint Medical Director and Group Executive Director of Workforce & Corporate Business have met the Manchester University Director of Undergraduate Medical Studies to begin discussions about apprenticeship routes to pre-registration medical education. Further discussions are planned.

9.6. Finally, the MFT Apprenticeship Strategy and underpinning MFT Ofsted rating and provider status will be applied to ensure the Trust maximises entry routes and access to the apprenticeship levy.

9.7. Appendix 1 illustrates the key programmes of work relating to the Long Term Workforce Plan themes aligned from the MFT People Plan.

10.0. Recommendations

10.1. The Board of Directors is asked to receive and note the work underway to align the MFT People Plan with the National Long Term Workforce Plan.

Appendix 1

NHS Long Term Workforce Plan – MFT People Plan

Agenda Item 11.1

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce and Corporate Business
Paper prepared by:	Nick Gomm, Director of Corporate Business and Trust Board Secretary
Date of paper:	September 2023
Subject:	NHS England's Fit and Proper Person's Framework for board members (August 2023)
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 national Fit and Proper Person Framework reinforces and strengthens individual accountability and transparency, ensuring there is high quality leadership within MFT to deliver our strategic aims.
Recommendations:	The Board of Directors is asked to note the requirements of the new NHS England Fit and Proper Person Test Framework for Board members.
Contact:	Name: Nick Gomm, Director of Corporate Business and Trust Board Secretary Tel: 0161 276 4841

1. Introduction

1.1 A new 'Fit and Proper Persons Test (FPPT) Framework for board members'[1] was published by NHS England (NHS E) on the 2nd August 2023 in response to recommendations made by Tom Kark KC (2019 review).

1.2 The aim of the new framework is to prioritise patient safety and good leadership in NHS organisations, helping board members build a portfolio to provide assurance that they are fit and proper, whilst preventing demonstrably unfit board members from moving between NHS organisations.

1.3 The Framework introduces a number of new checks and processes which NHS bodies should undertake on appointment of a new board member and on an annual basis thereafter. The Framework also introduces the use of the national Electronic Staff Record (ESR) for the storage of FPP-relevant information about board members.

1.4 The Framework is effective from 30th September 2023, at which stage the national ESR will have been updated to include the new requirements and should be implemented by all boards going forward from that date. NHS organisations are not expected to collect historic information to populate ESR or local records, but to use the Framework for all new board level appointments or promotions, and for annual assessments going forward.

2. Summary of changes

2.1 Recruitment/new appointments

2.1.1 The Framework introduces a number of new checks and considerations NHS bodies are required to undertake to assess good character; possession of the qualifications, competence, skills required, and experience; and financial soundness. The full FPPT assessment is required in the following circumstances.

- New appointments in board member roles, whether permanent or temporary, where greater than six weeks, this covers.
    - New appointments that have been promoted within an NHS organisation.
    - Temporary appointments (including secondments) involving acting up into a board role on a non-permanent basis.
    - Existing board members at one NHS organisation who move to another NHS organisation in the role of a board member.
    - Individuals who join an NHS organisation in the role of board member for the first time from an organisation that is outside the NHS.
- When an individual board member changes role within their current NHS organisation (for instance, if an existing board member moves into a new board role that requires a different skillset, e.g. chief financial officer).
- Annually (within a 12-month period of the date of the previous FPPT) to review for any changes in the previous 12 months.

[1] https://www.england.nhs.uk/wp-content/uploads/2023/08/PRN00238-i-kark-implementation-fit-and-proper-person-test-framework-2-aug-2023.pdf

2.1.2 Once the Framework is fully embedded across all NHS organisations, the new reference process (see 2.4 below) will mean that much of the information should be provided from the NHS organisation the new member of staff is coming from. However, for Non-Executive Directors (NEDs) without recent NHS Board level experience, new staff coming from outside the NHS, or staff who did not previously hold an NHS post subject to the FPPT, the information will need to be gathered prior to confirmation of an appointment.

2.2 Annual FPPT assessment

2.2.1 The Framework introduces a number of new steps into the annual FPPT process. These include.

- Annual completion of the increased range of checks referred to above.
- Increased accountability for the Chair to oversee the process, review board members' assessments, and present an annual report to a public Board meeting and to the Council of Governors.
- Accountability for the Senior Independent Director (SID) or Deputy Chair to review and confirm that the Chair is meeting the requirements of the FPPT.
- Submission of an annual return to the NHSE Regional Office.

2.3 Annual attestation

2.3.1 As part of the annual appraisal process, the Framework requires Board members to attest whether they have the requisite experience and skills to fulfil minimum standards against the six domains of the Leadership Competency Framework. A board member appraisal framework will be published by NHSE ahead of the 2023/2024 appraisal process to support this process.

2.4 References

2.4.1. The Framework introduces a standard board member reference to be completed by the NHS body the board member is leaving. This will assess the individual against the six domains of Leadership Competency Framework as well as provide information as to the character, qualifications, and financial soundness of the individual based on the enhanced checks referred to above.

2.4.2. For new appointments from outside of the NHS, NHS bodies should seek the necessary references to validate a period of six consecutive years of continuous employment (providing an explanation for any gaps) or training immediately prior to the application being made.

3. The scope of FFP within MFT

3.1 The NHSE guidance states that 'The FPPT is applicable to all board members: executive and non-executive, interim and permanent, and voting and non-voting'. For MFT this would mean it was applied to.

- Group Executive Directors
- Group Non-Executive Directors
- Trust Board Secretary

Bearing in mind MFT's Group structure, it would also be appropriate to include Chief Executives of the Hospitals, Managed Clinical Services (MCSs) and Local Care Organisations (LCOs) within the scope of the Framework.

3.2 In MFT, the current FPP Policy is applied to Board members; those who report to a Group Executive Director; Hospital/MCS/LCO Chief Executives; and those who report to them. This amounts to 127 people.

3.3 A decision will be required on the precise scope of the application of the guidance within MFT, considering the spirit and focus of the new guidance, practicality of implementation, and the additional capacity required to apply it to a wider group of staff. Work is underway to assess this and a decision will be made through the appropriate MFT governance processes and reported to a future Board meeting.

4. Implementation

4.1 A FPP working group has been established to oversee implementation of the new Framework within MFT in line with the prescribed national timeline as follows.

- In September 2023, communicate with all in-scope individuals whose details will be included in ESR for the purpose of FPPT in your organisation.
- From 30th September 2023, use the new Board member reference template for references for all new board appointments.
- From 30th September 2023, complete and retain locally the new Board member reference for any board member who leaves the board for whatever reason and record whether or not a reference has been requested.
- From 30th September 2023, use the Leadership Competency Framework (LCF) as part of the assessment process when recruiting to all board roles.
- 31st March 2024, fully implement the FPPT Framework incorporating the LCF, including updating the ESR database.
- Q1 2024, incorporate the LCF into annual appraisals of all board directors for 2023/2024, using the board appraisal framework.

5. Recommendation

5.1 The Board of Directors is asked to note:

i. The requirements of the new NHS England Fit and Proper Person Test Framework for Board members.

ii. To support the implementation actions cited in section 4 of this report.

Agenda Item 11.2

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Gail Meers, Corporate Director of Nursing, Quality and Patient Experience
Date of paper:	August 2023
Subject:	Annual Patient Experience Report 2022/2023
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:	Delivering an excellent experience for patients, their families and their significant others.
Recommendations:	The Board of Directors are asked to: • note the content of the report; and, • Support the actions required to ensure continuous improvement
Contact:	Name: Gail Meers, Corporate Director of Nursing, Quality and Patient Experience Tel: 0161 276 8862

Content

ANNUAL PATIENT EXPERIENCE REPORT

2022 / 2023

Section One

1. Executive Summary

1.1 The Manchester University NHS Foundation Trust (MFT) Annual Patient Experience Report 2022/2023 is a summary of feedback received by MFT from 1st April 2022 to 31st March 2023. This includes a description of themes and findings, activities undertaken by our staff to make improvements, and an outline of plans for the 2023/24.

1.2 The report also incorporates the Annual Clinical Accreditation Report.

1.3 At MFT we welcome and encourage feedback from patients, carers and family members. Information about how to provide feedback is provided to our patients, carers and their families through a variety of sources including through posters, leaflets, and focussed feedback forms / QR codes at the point of care delivery and via our website.

1.4 Using the feedback we receive, we work with patients, carers, their families, and external stakeholders to ensure that the services we provide are responsive to the needs of the communities we serve. To put the report into context, during 2022/2023 the number of inpatient consultant episodes and attendances at outpatient appointments were 450,081 and 1,854,418 respectively. Not taking PALS and Complaints feedback into consideration the Trust received 147,659 pieces of patient feedback[1] through the other range of routes and frameworks.

1.5 The report provides an overview of the feedback received from patients, families and carers via a wide range of sources, including:

- What Matters to Me (WMTM) Patient Experience Programme
- Friends and Family Test
- NHS Choices Website
- Patient Opinion
- National In-Patient / Maternity Surveys

1.6 The report includes an overview of some of the improvement work and activity of the Trust's Patient Services teams:

- The Patient Experience team
- Voluntary Services
- Quality Improvement Team (including Bee Brilliant, Small Change Big Difference and Proud to Care on Camera)
- Chaplaincy and Spiritual Care; and
- Interpretation and Translation Services

[1] Excluding formal and informal complaints which are included in the MFT Annual Complaints Report

- MyMFT

1.7 A summary of the Trust's results for the mandatory national surveys that have been published since the Trust's Annual Patient Experience Board of Directors Report 2021/22 are included in this report. These are the:

- Adult National Inpatient Survey (2021)
- National Maternity Services Survey (2022)

1.8 In comparison with the Trust survey results for the 2021 National Maternity Services Survey, the results for 2022 demonstrate positive experiences of care, with improvements across two aspects of maternity care, whilst the remaining aspects are predominantly 'about the same'.

1.9 Continuous improvement activity at all levels is underpinned by the Trust's Improving Quality Programme (IQP) methodology and validated through the Clinical Accreditation Programme. Clinical Accreditations are key to real time monitoring of quality and practice standards across clinical areas and examine how quality and patient experience data is used to drive improvement for the benefit of patients.

1.10 This report provides details of the MFT performance with comparisons provided where possible against the Shelford Group, a collaboration of ten of the largest teaching and research NHS hospital trusts in England.

1.11 Included within the appendices of this report are highlights from across all Hospitals/Managed Clinical Services/Local Care Organisations (Hospitals/MCS/LCO).

1.12 The report provides an overview of actions to be taken during 2023/2024 to make further improvements to patient experience across the Trust.

Section 2

2. Background

2.1. Patient Experience is recognised as a core element of quality, with good experience of care, treatment and support increasingly seen as an excellent part of health care provision, alongside clinical effectiveness and safety. Improving patient experience requires across MFT requires leadership, a receptive culture and systematic approaches to collecting, analysing, using and learning from patient feedback and at MFT is grounded in our Patient Experience Frameworks, underpinned by quality improvement methodology.

2.2. Patients' experiences of care and treatment provide key information about the quality of services provided, which can be used to drive improvements both nationally and locally.

2.3. Patient Experience feedback provides a rich source of data to support continuous improvement of the services provided by MFT. Patient feedback is sought continuously through a range of formats. These findings inform improvement activity at both strategic and local levels.

2.4. The report sets out achievements and improvements that have been undertaken across the Trust based on feedback from patients and relatives, whilst acknowledging that there are further improvements required in the context of continuous improvement.

Section 3

3. Our commitments to Patients, Families and Carers

3.1. Across MFT we gather information about our patients experience of the quality of care, safety, and experience of our services through the commitments set out in our Experience & Involvement Strategy: Our Commitments to Patients, Families and Carers 2020 – 2023[2]:

- We are committed to empowering patients, families and carers to take control of their journey by involving them as much as they wish in every aspect of their care as well as the direction of our organisation.
- We are committed to communicating with each other in an accessible, friendly and respectful manner.
- We are committed to creating an inclusive and welcoming community for patients, carers and staff.
- We are committed to listening to, acting on and learning from feedback from all service users and staff.
- To make our commitments meaningful in helping the Trust improve patient experience, we know how important it is to listen to the views of our patients, their carers and families.

Section 4

4. Capturing Patient Feedback – Local Surveys

4.1. What Matters to Me (WMTM)

What Matters to Me (WMTM) is our personal approach to thinking about patient experience, through this approach we receive real time feedback data from the Trust's 'What Matters to Me' patient experience surveys. The survey is administered via a hand-held electronic device in the clinical areas and asks patients a series of questions about their experience of care and treatment. These local surveys are based on the questions included the National Patient Experience surveys and ask patients about their experiences across the following themed categories:

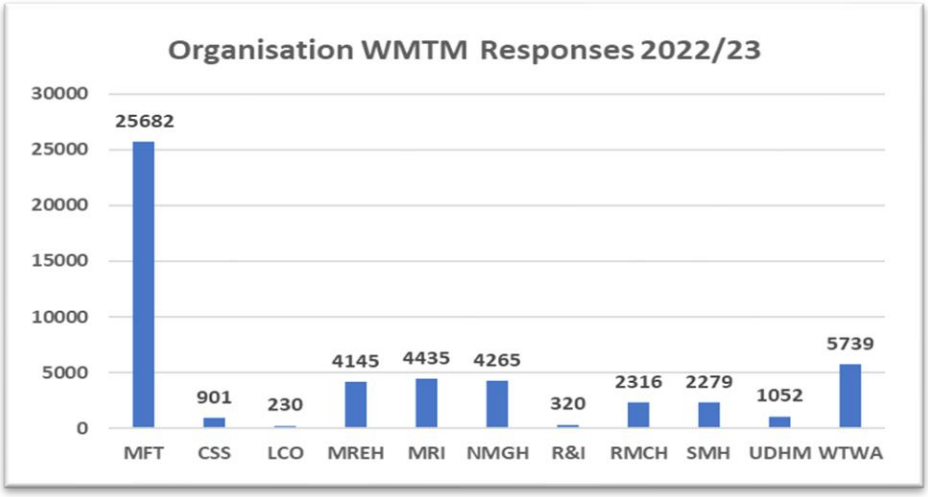
- Communication
- Equality and Diversity
- Hygiene and Personal Care
- Patient and the Carer
- Infection Prevention (IP)Control
- Nutrition and Hydration

[2] Our Strategy is being refreshed, separating Patient Experience and Carers Strategies in Q1 23/24.

- Pain
- Patient Safety
- Privacy and Dignity

The internal baseline target for the WMTM surveys 85% achievement in all domains.

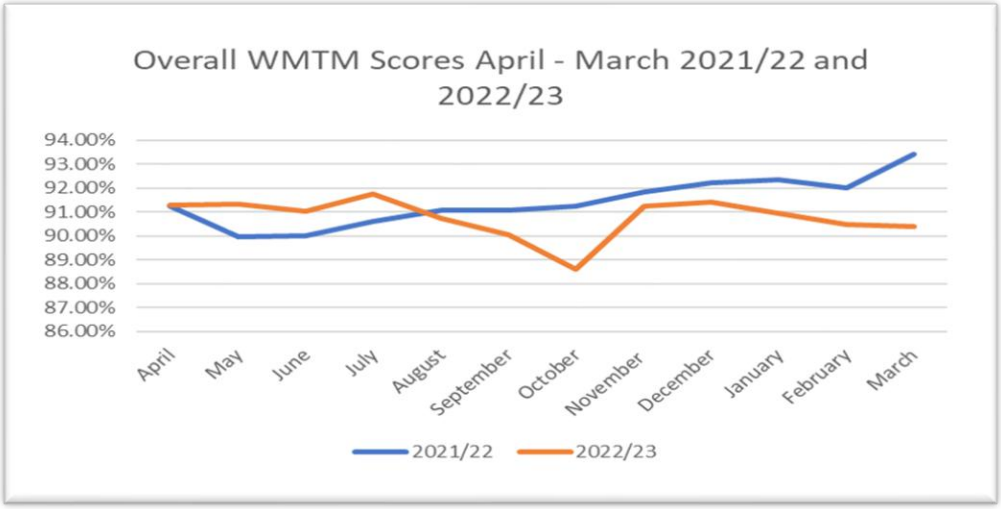
Graph 1 below highlights that in 2022/23 a total of **25,682** WMTM questionnaires were completed, including the WMTM totals for each Hospital/MCS/LCO.



Graph 1: WMTM Patient Experience Survey Responses 2022/23

Analysis of 'What Matters to Me' survey data shows an increase in the average overall patient experience score for 2022/23 of 90.77% compared to 90.5% in 2021/22.

There has been month by month variation, with the lowest score of 88.61% in 2022/23 compared with 88.4% in 2021/22. The highest score in 2022/23, 91.74%, shows a 0.96% decrease compared to highest score in 2021/22, 92.7%. **Graph 2** shows the overall Patient Experience score.



Graph 2: MFT Overall Patient Experience Score 2022/2023

Positive WMTM feedback themes were noted across the Trust during 2022/2023 **Table 1** below, shows the top 3 positive feedback WMTM themes that were reported at Trust level during 2022/23. The top positive feedback WMTM themes reported during 2022/23 were Emotional and Physical Support, Friendliness, Compassion, Professional and Competent, Helpfulness and Hygiene.

Top Three Positive WMTM Themes 2022/23			
WMTM	**Theme 1**	**Theme 2**	**Theme 3**
MFT Total	Emotional & Physical Support	Friendliness	Compassion
CSS	Professional & Competent	Emotional & Physical Support	Compassion
LCO	Hygiene	Emotional & Physical Support	Compassion
MREH	Professional & Competent	Friendliness	Emotional & Physical Support
MRI	Friendliness	Emotional & Physical Support	Compassion
NMGH	Emotional & Physical Support	Professional & Competent	Helpfulness
R & I	Professional & Competent	Friendliness	Compassion
RMCH	Friendliness	Emotional & Physical Support	Compassion
SMH	Emotional & Physical Support	Compassion	Friendliness
UDHM	Friendliness	Professional & Competent	Emotional & Physical Support
WTWA	Emotional & Physical Support	Friendliness	Helpfulness

Table 1: Top 3 Positive Themes based on WMTM feedback captured during 2022/23 by Hospital/MCS/LCO

Table 2 below shows the top 3 primary feedback relating to What Matters To Me (WMTM) themes.

The top area for improvement WMTM theme in 2022/23 was ‘Waiting’ for eight Hospitals and MCS.

For the Manchester and Trafford Local Care Organisation (LCO) and Clinical Scientific Services (CSS) the ‘Food and Beverages’ was the top area for improvement WMTM theme and the Royal Manchester Childrens Hospital (RMCH) reported that Hygiene was the top area for improvement WMTM theme. Further detail is provided below and **Appendix 5** regarding the improvement work being undertaken across the trust in relation to ‘waiting’, ‘food and beverages and ‘pain’.

Top Three Areas for Improvement WMTM Themes 2022/23			
WMTM	**Theme 1**	**Theme 2**	**Theme 3**
MFT Total	Waiting	Food & Beverages	Hygiene
Clinical Scientific Services	Food & Beverages	Waiting	Pain
Manchester and Trafford Local Care Organisation	Food & Beverages	Pain	Comfort
Manchester Royal Eye Hospital	Waiting	Food & Beverages	Politeness
Manchester Royal Infirmary	Waiting	Food & Beverages	Hygiene
North Manchester General Hospital	Waiting	Pain	Food & Beverages
Research and Innovation	Waiting	Emotional & Physical Support	Communicating to Patients
Royal Manchester Children's Hospital	Hygiene	Waiting	Food & Beverages
Saint Mary's Hospital	Waiting	Pain	Food & Beverages
University Dental Hospital of Manchester	Waiting	Hygiene	Privacy, Dignity & Respect
Wythenshawe, Trafford, Withington and Altrincham Hospital	Waiting	Food & Beverages	Hygiene

Table 2: Top 3 Areas for Improvement based on WMTM Feedback captured during 2022/23 by Hospital/MCS/LCO

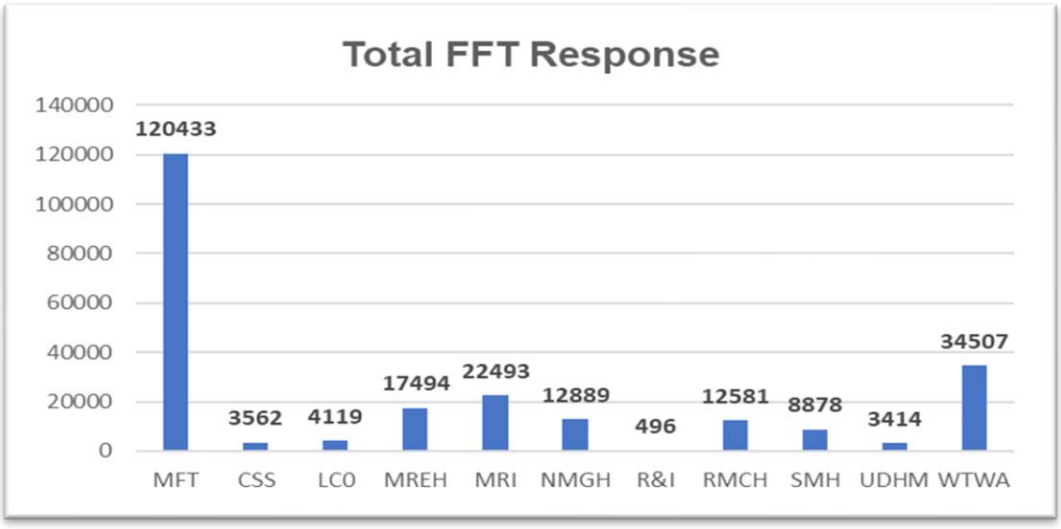
Themes have been correlated with findings / results from other sources of feedback including FFT, an overview of MFTs response to the WMTM results is therefore included in the following section.

4.2. Family and Friends Test

The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service that they have experienced to friends and family who may need similar treatment or care. Patients are asked for suggestions as to how the Trust might further improve the service they have experienced.

To maximise feedback from the FFT, responses are captured through a variety of different methods including FFT cards, tablet devices, Hospedia bedside entertainment screens, online surveys, and SMS text messaging.

Graph 3 shows that in 2022/23 a total of **120,433** FFT responses were collected; and includes the FFT totals for each of the Hospitals/MCS's/LCO.



Graph 3: Total Number of FFT Responses during 2022/23

The FFT question is asked at the point of discharge.

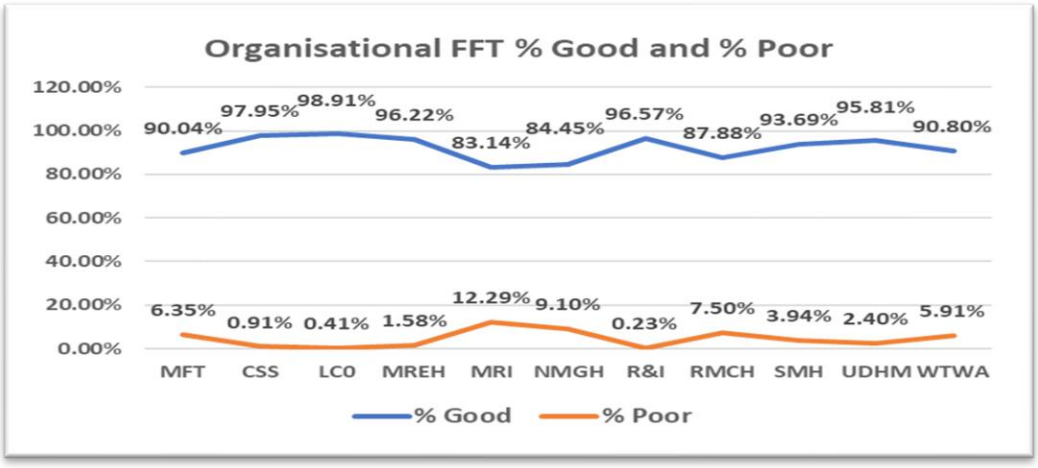
- *Thinking about your recent visit, overall, how was your experience of our service?* (This is rated, please below)

Patients, carers, or family members can rank their answer by choosing one of the following:

- Very good
- Good
- Neither good nor poor
- Poor
- Very poor
- Don't know

The score is a simple comparison of the percentage of those completing the test who would recommend their experience as good and very good, against the percentage of those who would not recommend the care experience and rate the scores as very poor or poor.

Graph 4 below shows five areas where the Trust achieved above the Trust upper benchmark of 95% of people saying their experience was **good** or **very good**. These areas include Clinical and Scientific Services, (CCS) Local Care Organisation (LCO) Research and innovation (R&I), Manchester Royal Eye Hospital (MREH) and University Dental Hospitals Manchester (UDHM).



Graph 4: Trust overall FFT results 2022/23

Three areas received scores below 90%: Royal Manchester Childrens Hospital (RMCH), Manchester Royal Infirmary (MRI), and North Manchester General Hospital (NMGH).

The Shelford Group Hospital Trusts Comparison

During 2022/2023, the percentage of MFT in-patients who scored '*very good'* and '*good*' about the care they received was **86%** - with waiting being the top negative reason. MFT scored in the lower range of the Shelford Group Trusts[3] and below the average of **86.9%** (See **Table 3**).

Friends and Family Test Results: Inpatients 2022/23	
Trust	**% score 'very good' and 'good'**
Newcastle upon Tyne Hospitals NHS Foundation Trust	89.6%
Imperial College Healthcare NHS Trust	87.9%
Cambridge University Hospitals NHS Foundation Trust	87.6%
University College London Hospitals NHS Foundation Trust	87.4%
Oxford University Hospitals NHS Foundation Trust	87.3%
Guy's and St Thomas' NHS Foundation Trust	87%
University Hospitals Birmingham NHS Foundation Trust	86.6%
Kings College Hospital NHS Foundation Trust	86.2%
Manchester University Hospitals NHS Foundation Trust	86%
Sheffield Teaching Hospitals NHS Foundation Trust	83.8%

Table 3: MFT Inpatient FFT responses compared to Shelford Group Trusts 2022/23

The overall Emergency Department FFT responses for the Shelford Group hospital trusts during 2022/2023 range from 62.5% to 77.6%, as demonstrated in **Table 4** below**.** The percentage of patients who rated MFT's Emergency Department Services as '*very good'* and '*good*' is **66.3%**, which is below the Shelford Group average of **69%**.

Friends and Family Test Response and Results: Emergency Departments 2022/23	
Trust	**% score 'very good' and 'good'**
University College London Hospitals NHS Foundation Trust	77.6%
Newcastle upon Tyne Hospitals NHS Foundation Trust	75.5%
Imperial College Healthcare NHS Trust	75.0%
Guy's and St Thomas' NHS Foundation Trust	74.8%
Sheffield Teaching Hospitals NHS Foundation Trust	73.9%
Manchester University Hospitals NHS Foundation Trust	66.3%
Oxford University Hospitals NHS Foundation Trust	63.8%
University Hospitals Birmingham NHS Foundation Trust	62.8%
Cambridge University Hospitals NHS Foundation Trust	62.5%
Kings College Hospital NHS Foundation Trust	58.6%

Table 4: Comparison of MFT Emergency Department FFT response score compared to Shelford Group Trusts in 2021/22

Themes from FFT feedback

A follow up question that requires a free text response is also included:

- *Please can you tell us what was good about your care and what we could do better.*

Analysis of free text responses is achieved through Pansensic, an AI-based hybrid text analytics platform with the ability to identify and extract emotions within the qualitative text data.

Positive FFT themes were noted across the Trust during 2022/2023. **Table 5** shows the top 3 positive feedback FFT themes that were reported at Trust level during 2022/23.

Top Three Positive FFT Themes 2022/23			
WMTM	**Theme 1**	**Theme 2**	**Theme 3**
MFT Total	Friendliness	Emotional & Physical Support	Professional & Competent
CSS	Emotional & Physical Support	Friendliness	Compassion
LCO	Friendliness	Emotional & Physical Support	Professional & Competent
MREH	Professional & Competent	Emotional & Physical Support	Emotional & Physical Support

MRI	Friendliness	Emotional & Physical Support	Helpfulness
NMGH	Friendliness	Emotional & Physical Support	Professional & Competent
R&I	Friendliness	Professional & Competent	Helpfulness
RMCH	Friendliness	Emotional & Physical Support	Compassion
SMH	Emotional & Physical Support	Compassion	Helpfulness
UDHM	Friendliness	Professional & Competent	Emotional & Physical Support
WTWA	Friendliness	Professional & Competent	Emotional & Physical Support

Table 5: top 3 positive feedback FFT themes.

Ten out of eleven Hospitals/MCS/LCO reported that Friendliness and Emotional and Physical Support were in their top three positive FFT themes. Seven areas reported Professional and Competent, three areas reported Compassion and three areas reported Helpfulness in their top themes.

Areas of improvement noted across the Trust during 2022/2023 were 'waiting', 'pain', and 'emotional support'.

Table 6 below shows the top 3 primary Friends and Family Test (FFT) themes. The top theme across all hospitals/MCS/LCO's is 'Waiting'.

This theme correlates with the top Patient Advice and Liaison Service (PALS) category, namely 'Appointment Delays/Cancellations' which was seen in many PALS concerns received, and also in the What Matters to Me feedback.

Top Three Areas for Improvement FFT Themes 2022/23			
WMTM	**Theme 1**	**Theme 2**	**Theme 3**
MFT Total	Waiting	Pain	Emotional & Physical Support
Clinical Scientific Services	Waiting	Food & Beverages	Pain
Manchester and Trafford Local Care Organisation	Waiting	Emotional & Physical Support	Facilities
Manchester Royal Eye Hospital	Waiting	Facilities	Emotional & Physical Support
Manchester Royal Infirmary	Waiting	Pain	Emotional & Physical Support

North Manchester General Hospital	Waiting	Pain	Comfort
Research and Innovation	Waiting	Emotional & Physical Support	Professional & Competent
Royal Manchester Children's Hospital	Hygiene	Emotional & Physical Support	Pain
Saint Mary's Hospital	Waiting	Emotional & Physical Support	Comfort
University Dental Hospital of Manchester	Waiting	Pain	Facilities
Wythenshawe, Trafford, Withington and Altrincham Hospital	Waiting	Pain	Food & Beverages

Table 6: Top 3 Areas for Improvement based on FFT feedback captured during 2022/23 by Hospital/MCS/LCO

Overall themes for improvement

The top three areas of improvement for WMTM and FFT captured during 2022/23 include Waiting: Pain and Emotional and physical Support. In comparison the top three Trust complaints received during 2022/23 include Treatment and Procedure: Communication and Attitude of staff.

Similarly, improvement plans have been developed locally within the Hospitals/MCSs/LCO with specific focus on the two areas namely, Pain Management and Communication. This links in with the complaint's themes reported during 2022/23 around communication.

Waiting

It is recognised that the COVID-19 pandemic has had a detrimental impact on the waiting times and waiting lists for patients across many NHS services. The Hospitals/MCS's/LCO's have been working towards reducing delays for patients through recovery programmes in both elective and non-elective pathways to improve waiting times.

The Paediatric Emergency Department team are working with Communications/MFTV team and HIVE to provide digital waiting time displays that update parents/patients with robust processes.

Communication Rounding in the outpatient settings and Emergency Eye Department (EED) has been implemented across MREH. In addition to this The Rapid Access Clinics have also been increased in frequency.

The Senior Leadership Team at Saint Mary's Hospital are fully focused on addressing the backlog of new patients waiting longer than expected. Additional clinics, theatre sessions and weekend working has been implemented to reduce waiting times.

Further details of these waiting time initiatives are provided later in the paper.

Pain

Management of patient's pain is key to ensuring positive experience and alignment to the CQC's key lines of enquiry. The WMTM questions ask patients if their pain is controlled and if they believe the staff have done everything to relieve their pain.

Improvement plans were developed by the Hospitals/MCSs for pain management and communication post operation/procedure. All other questions were within the 'remains the same' category. Examples of improvement work in relation to 'pain' are detailed below:

The RMCH MCS Pain team facilitated education sessions throughout departments with staff and parents regarding pain assessment and documentation.

Poor pain management both post-delivery and post-surgery remained a focus for the Postnatal Ward at Wythenshawe Hospital. They delivered a Quality Improvement programme through the Always Events programme to improve the timeliness of analgesia provision and the assessment of effectiveness of treatment.

Emotional and Physical Support

Chaplains promote pastoral, spiritual and religious wellbeing through skilled compassionate person-centred care for patients, their families and their carers, NHS staff, volunteers and students. Chaplains take an empathetic approach, listening to each person's story, and respecting what matters.

The value of pet therapy is widely accepted as a powerful aid to both cognitive and physical stimulation. Studies have shown that the presence of animal interactions with animal assisted therapy animals can improve the wellbeing of patient lowering their anxiety and making the environment happier. Voluntary Services currently has four registered Pets as Therapy Dogs (PAT Dogs) and they contribute to enhancing the health and wellbeing of patients at MFT.

Additionally, as described later in the paper The King's Fund report on gardens and health, found that the mental health benefits of gardening are broad and diverse, with reduction in depression and anxiety and improved social functioning, emotional well-being and physical health. Across all critical care areas, the vision is to have a dedicated space on each site to support the rehabilitation of patients, their families/friends/carers and staff. The NMGH Critical Care Garden space was officially opened in November 2022.

Food and Beverages

In relation to the Food and Beverage theme, there has been a significant focus across the Trust to improve mealtime standards for patients across all ward and departments to improve the dining experience of our patients.

Manchester Royal Infirmary celebrated Nutrition and Hydration week by focussing on breakfast delivery, patient feedback and food chart compliance. Staff were also encouraged to make pledges to "Making a Difference Everyday" in terms of delivering the best patient experience in terms of patient dining.

During Malnutrition Awareness Week MRI embedded the Mealtime standards and undertook a baseline meal audit in all their inpatient areas.

Further improvement work saw RMCH participate in a Paediatric focused Nutrition and Hydration week during March 2023. Ward 84 and Ward 81 facilitated Patient and Parent/Carer engagement sessions with food tasting and 'What Matters To Me' feedback. Both areas have now moved to the two-week menu following feedback and have seen improvements in their WMTM data. Based on feedback, RMCH has also introduced drinks rounding to improve patient hydration and experience.

Hygiene

Good hygiene significantly reduces the risk of cross-contamination and transmission of contagious infections. Therefore, to protect our patients, staff we must encourage and promote actions we can all take to reduce the spread of pathogens and prevent infections.

Following MRI's Education team's successful Small Change Big Difference bid for a mouth head simulator the team provided teaching sessions during 2022/23 promoting the importance of good oral hygiene to all staff and students.

Additionally, Hospital/MCS's/LCO's review the WMTM and FFT themes from the patient experience feedback received and staff are empowered to implement and evidence local improvements based in real time, to address themes seen in the data.

Across the Trust, staff continually look at ways to increase response rates and improve uptake of both FFT and WMTM. For example, QR codes are used in community areas to increase FFT responses, and in specific focussed areas, such as the three Maternity Triage Units across Saint Mary's Managed Clinical Service (Saint Mary's MCS) QR codes are in development.

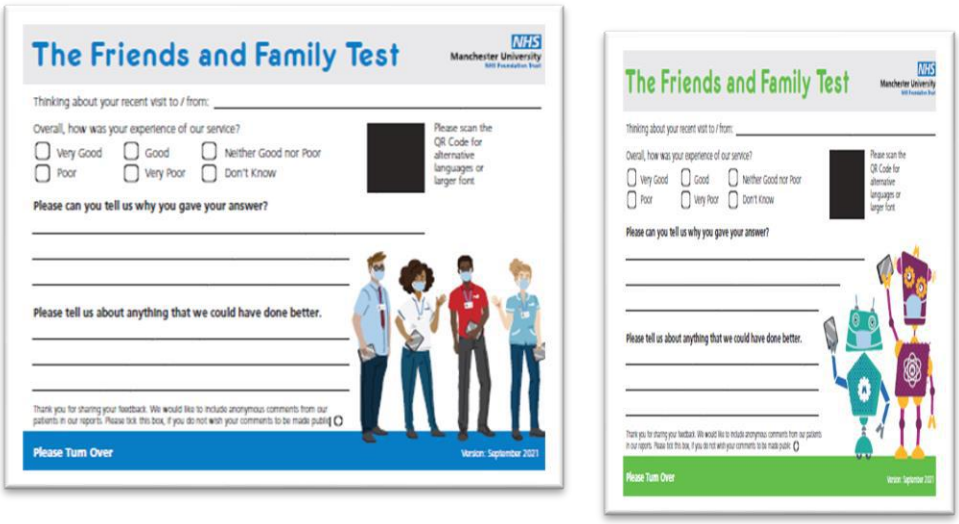


Figure 1: FFT Cards (adult and children)

A bespoke FFT card for children and young people is in place at the RMCH and has colouring and wording suitable for children and young people. The cards were updated in April 2022. **Figure 1** above demonstrates the new Adult (blue) and Children and Young People (green) FFT card.

An overview of the work that hospitals/MCS/LCO have undertaken in general when

responding to WMTM and FFT feedback is included at Section 14 of this report.

In addition to the Trust's WMTM patient experience surveys, FFT allows patients to rate their experiences of our services through one singular question. The Quality Care Round (QCR) also captures patient feedback. The QCR is an MFT designed self-assessment audit tool completed monthly by the ward manager or matron. The assessment is completed in all hospital-based clinical areas; inpatient; day case areas; outpatients; theatres and urgent care areas and includes the same domains as the WMTM patient experience surveys.

Planned Developments for use of FFT across MFT

To further develop our use of FFT feedback to improve patient experience, the following actions are planned, and in some cases already in place, for 2023/24:

- To publicise the updated FFT guidance and collaborate with each Hospital/MCS/LCO to increase FFT response rates and promote the FFT survey.
- Working in collaboration with Voluntary Services, to promote and recruit volunteer roles to support targeted areas that have low response rates in collecting quality FFT feedback.
- To publicise the importance of FFT to staff and patients using various medium for advertisement, e.g., posters with QR codes.
- Focus on a specialty area or a trigger point to promote FFT/engaging with users where numbers of responses fall too low.
- Explore the introduction of improvement thresholds to increase uptake.
- To carry out dedicated 'ward walks' to increase the Corporate Patient Experience Team's visibility and address issues on the spot.
- Provide support and staff training in the Patient Experience Platform, CIVICA to ensure staff can access FFT responses and feedback comments.
- Feedback received through the FFT will continue to be triangulated with other quality and patient experience data to ensure focused quality improvement, with a particular focus on:
    - Waiting
    - Pain
    - Emotional and Physical Support
    - Food and Beverages
    - Hygiene

Section 5

5. NHS Website and Care Opinion Feedback

The NHS Website (formerly NHS Choices) receives over 43 million visits per month from across England. Visitors can leave their feedback on the website relating to the NHS services where they received care.

Care Opinion is an independent healthcare feedback platform service whose aim is to promote honest conversations about the patient experience between patients and health service providers. The CQC utilises information from both websites to help monitor the quality of services provided by Trusts.

There have been **221 postings** about MFT submitted to the NHS Website during 2022/23. This is a **66% increase** in comparison to the previous year.

Posts are categorised as: *positive, negative,* or *mixed comments*. **Table 7** below, demonstrates that the majority of comments received in 2022/23 were significantly positive; with 56% positive comments. This is however, a 10% decrease compared to 66% positive comments in 2021/22.

38% of comments received related to a negative experience of MFT services, an increase of 11% compared to 2021/22 where 27% of comments received related to a negative experience at MFT. Mixed comments accounted for 6% of the overall responses, down 1% from 2021/22.

Wythenshawe, Trafford, Withington and Altrincham Hospitals (WTWA) received the greatest number of positive postings during 2022/23, with 44% of the total positive comments relating to the WTWA. 67% of comments reported for North Manchester General Hospital (NMGH) were positive during 2022/23. St Mary's Hospital (SMH) received the least number of positive comments; with only 26% positive comments.

Number of NHS Website / Care Opinion Postings received by Hospital/MCS 2022/23			
Hospital/MCS	**Positive**	**Negative**	**Mixed**
Clinical Scientific Services (CSS)	0	0	1
Corporate Services	0	0	0
Local Care Organisation (LCO)	3	4	3
Manchester Royal Infirmary (MRI)	19	25	3
Research & Innovation (R&I)	0	0	0
Royal Manchester Children's Hospital (RMCH)	3	2	0
Saint Mary's Hospital (SMH)	6	16	1
University Dental Hospital of Manchester (UDHM) / Manchester Royal Eye Hospital (MREH)	11	13	1
Wythenshawe, Trafford, Withington and Altrincham (WTWA)	54	15	1
North Manchester General Hospital (NMGH)	24	9	3
Total	**120**	**84**	**13**

Table 7: Number of NHS Website / Care Opinion postings by MFT Hospital/MCS/LCO 2022/23

Table 8 below provides examples of feedback received and the subsequent responses posted by MFT staff on the Care Opinion and NHS Website that were published in 2022/23.

Wythenshawe Hospital
'Absolutely superb' *'I attended the one stop clinic- I received my appointment in 10 working days. I was seen promptly by*

the doctor, then I had an Ultrasound and then I saw the doctor again— absolutely incredible. Everyone from the lass on reception to the nurses and the doctors were kind and helpful. We are unbelievably lucky to have such an amazing service in the NHS'.

Response:

Thank you for taking the time to share your positive feedback on the NHS website regarding your care received at Wythenshawe Hospital. It is always good to read such positive words in response to the conscientious work of our staff and efficiency of the service being provided. We have forwarded your message on to the Head of Nursing and all the staff involved. The Patient Experience Team.

Manchester Royal Infirmary

Excellent Experience

★★★★★

Rated 5 stars out of 5

by Anonymous - Posted on 15 December 2022

My mum attended the Dept. of Nuclear Medicine today (15/12) for a scan. She was extremely nervous however she said the whole experience was excellent. She was seen on time and was very well looked after. My auntie escorted her and she was kept well informed of what was happening. The admin. team pre-procedure were also very helpful and professional giving all the information that she needed by phone in light of the postal strikes.

The only criticism I would give is that I called ahead and spoke to Patient Advice and Liaison Service staff to check if there were volunteers at main reception to act as guides, or to take people to the correct dept. I was assured that there were but unfortunately there were none there and the dept. was some distance from main reception for her to walk - luckily she had allowed plenty of time to get to her appointment. Thank you.

Response:

Thank you for your positive comments posted on the NHS website regarding the care you received at the Department of Nuclear Medicine.

It was very kind of you to take the time to write and compliment the staff as it is always good to receive positive feedback which reflects the hard work and dedication of our staff. It was reassuring to read that you thought your mum was well informed throughout her appointment and that she received all the information she required pre-procedure via telephone in light of the postal strikes.

On behalf of MFT, please accept our sincere apologies that we were unable to offer volunteer support to escort to reception. Due to unforeseen circumstances, overall volunteer numbers for meeting and greeting were reduced that day. Those in attendance may have been assisting other patients at the time.

I can assure you that we have passed on your thoughts to the Matron who will share your comments the staff involved.

The Patient Experience Team

University Dental Hospital of Manchester

'Very poor communication'

First visited this place in November 2021. It was agreed what procedures I would need. I went back to my personal dentist to get my gums cleaned out. To then find this dental hospital had took me off their books. Fast forward to July I had to act as an admin because this place just didn't want to know at all. I finally got a letter sent to me this week to come in. They have a phobia of being on the phones it seems because it's impossible to get through so rather than ring me and ask what date is convenient they just sent me a random date in which it conflicts with my working hours. Cancelled the appointment and now here I am for two hours this morning trying to get through on the phone and

they just won't pick up. Utterly useless and would advise people to steer well away! How can you treat people like this. It's now been a year and I am no closer to getting my surgery done. Appalling how you treat your customers
Response:
We are very sorry to receive your comments and concerns via the NHS Choices website about your experiences in October 2022. In response to your comments, I can tell you that your concerns have been escalated to the administrative team to ensure that staff are aware of the importance of answering the telephones. The hospital has been experiencing significant issues with our telephone systems and we are working closely with the telecommunications team in an attempt to get these resolved as soon as possible. We would like to apologise for the inconvenience and the frustration that this may have caused you. Alternatively, if you would like to contact us directly to change, cancel or chase up an appointment you can email us via: dental.appointmentbooking@mft.nhs.uk our staff will be more than happy to assist you.

Table 8: Examples of feedback posted on the Care Opinion and NHS Website

The top three areas for improvement in Care Opinion and NHS Website were: Care and treatment, Communication and Staff Attitude.

Section 6

6. National Surveys

6.1. National Adult Inpatient Survey 2021

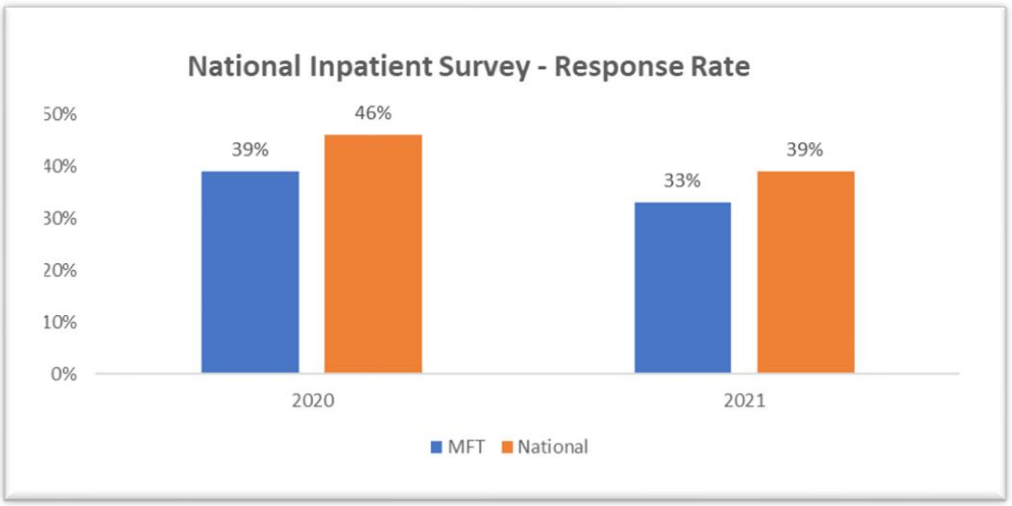
The CQC published the results of the National Adult Inpatient Survey (2021) in September 2022. The survey is part of the National Patient Survey Programme, undertaken on behalf of the Trust by an independent provider. To participate in the survey patients must be over the age of 16 and have stayed at least one night in hospital during November 2021.

A series of questions are asked, each is allocated a score of out 10 based on the responses provided by the respondents. A higher score is a positive response, and a lower score is a negative response. Each question is categorised based on comparison to other organisations scores as '*better', 'about the same'* or *'worse.'*
The survey is arranged into 10 sections following the patient journey:

- Admission to Hospital
- The Hospital and Ward
- Doctors
- Nurses
- Your Care and Treatment
- Operations and Procedures
- Leaving Hospital
- Feedback on the quality of care
- Respect and dignity
- Overall Experience

National Adult Inpatient Survey 2021 Results

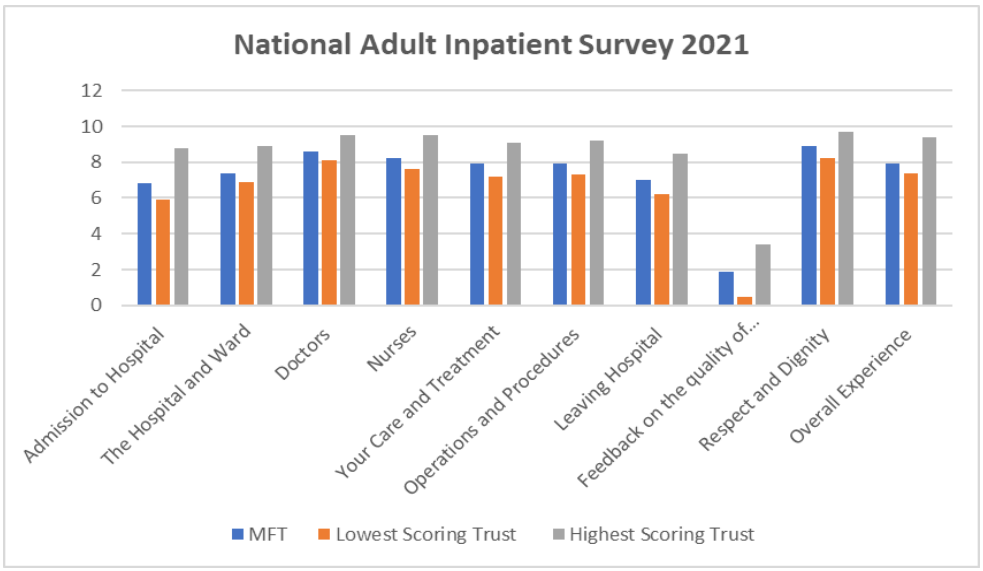
Nationally, the response rate for the National Adult Inpatient Survey 2021 was 39%, which is a reduction of 7% in comparison to the 2020 national rate of 46%. Likewise, the Trust's response rate was 33% (401 respondents), a reduction of 6% in comparison to the Trust's 2020 rate of 39%. See **Graph 5** below for comparisons.



Graph 5: MFT response rate 2021/2022 compared to national average

Themes

Graph 6 below shows the results for MFT for each of the ten themes and overall experience; the highest and lowest scores achieved nationally are also presented. As in previous years, this graph highlights that the Trust's scores are generally midway between the highest and lowest scoring trusts for most key themes.



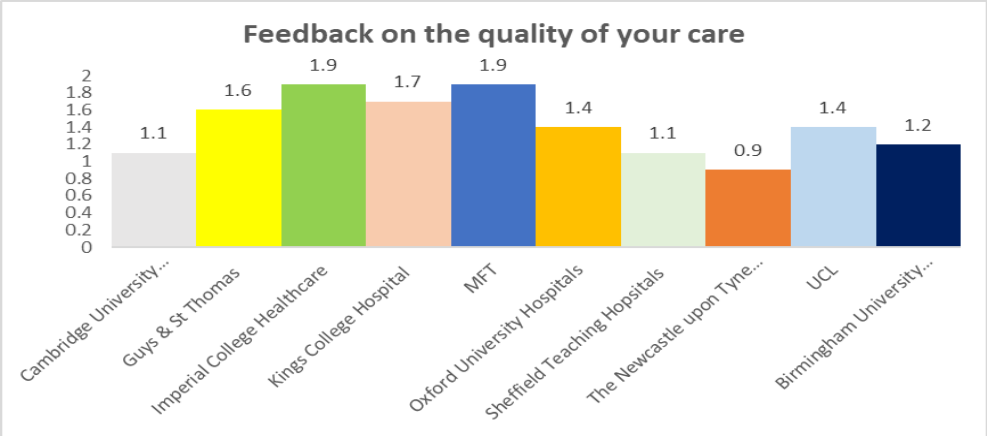
Graph 6: MFT scores compared to the highest and lowest scoring Trusts.

Comparison with the Shelford Group

The response rates for the Shelford Group Trusts ranged from 31% (Imperial College) to 48% (Newcastle Upon Tyne Hospitals). The response rate of 33% for MFT places the Trust in 9th position when compared to the other Shelford Group Trusts.

The two highest scoring areas for the Trust are 'Doctors' with a score of 8.6 and 'Respect and Dignity' with a score of 8.9. A significantly low score is for 'Did you have the opportunity to Feedback on the Quality of your Care' which scored 1.9.

The Trust was joint first for 'Feedback on the Quality of your Care', see **Graph 7**.



Graph 7: Comparison with Shelford Group Trusts for 'Were you offered an opportunity to provide feedback on the quality of your care'

Hospital Results – MRI, Wythenshawe Hospital and NMGH

Detailed results are provided in **Appendix 1** for the MRI, Wythenshawe Hospital and NMGH and compare each hospital with the overall Trust score for 2021 and 2020. The results for individual hospitals are only available when questions have received 30 responses or more. Therefore, there are no specific site results for any other Hospitals/MCSs/LCO within MFT.

National Benchmarking

In relation to overall experience, the national highest scoring average was 9.4, with the lowest being 7.4. MFT scored 7.9, which is a reduction from the 8.2 the previous year.

When compared to 2020 survey results, the same two questions scoring low scores (5.0 or below) in 2021 remained unchanged. **Table 9** below provides a breakdown of the notably low scores for 2021 compared to 2020.

Question	MFT Score 2020	MFT Score 2021	National Average	National Range
Section 7: Leaving Hospital				
Q41. Thinking about any medicine you were to take at home, were you given any of the following?	4.6	4.6	4.6	3.6 - 6.2
Section 8: Feedback on the quality of your care				
Q49. During your hospital stay, were you ever asked to give your views on the quality of your care?	1.4	1.9	1.4	0.5 - 3.4

Table 9: Questions with scores 5.0 or below within the National Inpatient Survey 2021 results

Table 10 shows data for notably high scores, three questions had scores of 9.0 and above: this represents a decrease of five compared to the eight questions in the 2020 survey.

Question	MFT Score 2020	MFT Score 2021	National Average	National Range
Section 2: The Hospital and Ward				
Q15. During your time in hospital, did you get enough to drink?	9.5	9.1	9.4	8.6-9.9
Section 5: Your Care and Treatment				
Q28. Were you given enough privacy when being examined or treated?	9.6	9.3	9.4	9.0-9.9
Section 6. Operations and Procedures				
Q32. Beforehand, how well did hospital staff answer your questions about the operations or procedures?	9.0	9.0	8.9	8.2-9.7

Table 10: Questions with scores 9.0 or above within the National Inpatient Survey 2021 results

Development of Improvement Plans

Understanding the detailed results from the annual national patents surveys allow clinical areas to target improvement plans and improve patient experience. The 2021 survey results for MFT, show that all categories of questions, except for two, scored 'about the same' than the previous year. Two categories that did show deterioration compared to the previous year include 'Your care and treatment' and 'Operations and procedures'. The two areas that have deteriorated within these categories, were 'pain management' and 'communication post operation/procedure'.

A key focus area for 2023/24 is to consider how patients can be encouraged to provide feedback and participate in surveys, and then how these results are published and shared with our staff, patients, and the public. The teams within Corporate Patient Services are currently developing ways to enhance Trust engagement with its patients and service users.

To ensure continual improvement in patient experience and considering the 2021 national survey results, the Corporate Patient Services team have developed an action plan. Examples of actions include:

Improvement plans across the Trust have focussed on Nutrition and Hydration whereby snack rounds and additional drinks have been provided. Emergency Departments have incorporated drinks and snack into their Nurse in Charge rounding.

6.2. National Maternity Survey 2022

A postal questionnaire was sent to eligible women, aged 16 and over, who had a live birth during February 2022. The Maternity Survey is published in three sections aligning to different aspects of the Maternity Pathway: antenatal care, labour and birth and postnatal care.

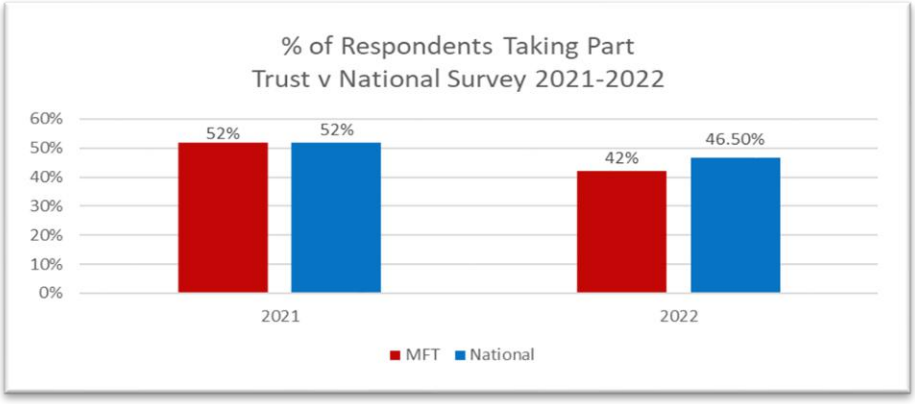
Respondents are required to indicate the standard of care they received by providing a score out of 10. A higher score is positive and indicates a more encouraging patient experience. **Table 11** below describes how the survey is structured into specific categories relating to the Maternal Pathway:

Antenatal Care	Labour and Birth	Postnatal Care
• The start of your care during pregnancy	• Your labour and birth	• Feeding your baby
• Antenatal check ups	• Staff caring for you	• Care at home after the birth
• During your pregnancy	• Care in hospital after birth	

Table 11: Structure of Maternity Services Survey

6.3. Maternity Survey 2022 Results

The response rate for the National Maternity Survey 2022 was 42% (473 respondents). This shows a decrease of 10% (46 respondents) in comparison to 519 respondents in 2021. **Graph 8** below shows MFT's response rate against the 2021 and 2022 national response rate of 52% and 46.5% respectively.



Graph 8: MFT response rate 2021/2022 compared to the national averages.

Survey Analysis

Whilst there is an overall score for each of the categories, there is no question relating to overall experience. Each survey question is categorised as **'***better', 'about the same'* or '*worse'* based on comparison to other organisations scores.

Notably High Scores

Of note there are two highest scoring areas for the Trust: Section 3 'During your Pregnancy' with a score of 8.2 and Section 7 'Feeding' with a score of 8.6. The score for 'Feeding' is consistent with the scoring from 2019 (8.6), however the score for 'During your Pregnancy' has dropped to 8.2 when compared to the 2019 score of 8.5. There are no results for 2020 as the survey was suspended due to the COVID-19 pandemic.

Positively, nine questions indicated specifically high scores (a score of 9.0 and above) **(Table 12),** this is an increase when compared to eight questions in 2021.

Question	MFT Score 2022	MFT Score 2021
Antenatal Care		
B10: During your antenatal check-up, did your midwives listen to you?	7.8	9
B14: Thinking about your antenatal care, were you spoken to in a way you could understand?	9.3	9.3
B18: Thinking about your antenatal care, were you treated with respect and dignity?	9.2	0
Labour and Birth		
C12: if your partner or someone close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted to?	9.2	9.4
C14: Did the staff treating and examining you introduce themselves?	9.1	8.9
C19: Thinking about your care during labour and birth, were you spoken to in a way you could understand?	9.2	9.2
C21: Thinking about your care during labour and birth, were you treated with respect and dignity?	9.1	9.1
Postnatal Care		
E2: Were your decisions about how you wanted to feed your baby respected by midwives?	9	9.3
F12: Did a midwife or health visitor ask you about your mental health?	9.5	9.7

Table 12: Maternity Survey Questions with Scores 9 out of 10

Notably Low scores

The results of two questions, compared to three questions in the 2021 survey, indicated specifically low scores (a score of 5.0 or below). Further detail is provided in **Table 13**, below.

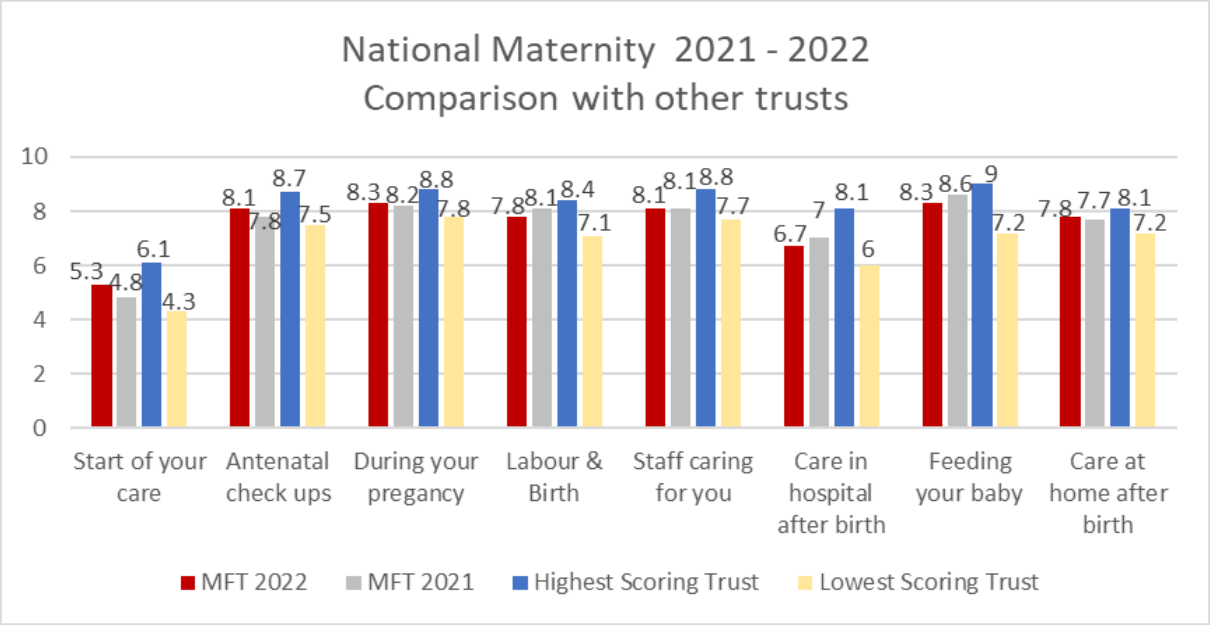
As in previous surveys, the low scoring questions have a similar theme relating to 'Choice of Care Provision'. As Saint Mary's Hospital (SMH) Managed Clinical Services (MCS) is a tertiary centre with specialist care services many women may not have had the option to choose their preferred choice of care provision.

Question	MFT Score 2022	MFT Score 2021
Antenatal Care		
B3: Were you offered a choice about where to have your baby?	3.3	3.2
Postnatal Care		
D7: Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?	4.3	4.4

Table 13: Maternity Survey Questions with under 5 score out of 10

National Benchmarking

Graph 9 compares the Trust's 2021 and 2022 results for each of the eight key themes alongside the highest and lowest scores achieved nationally.

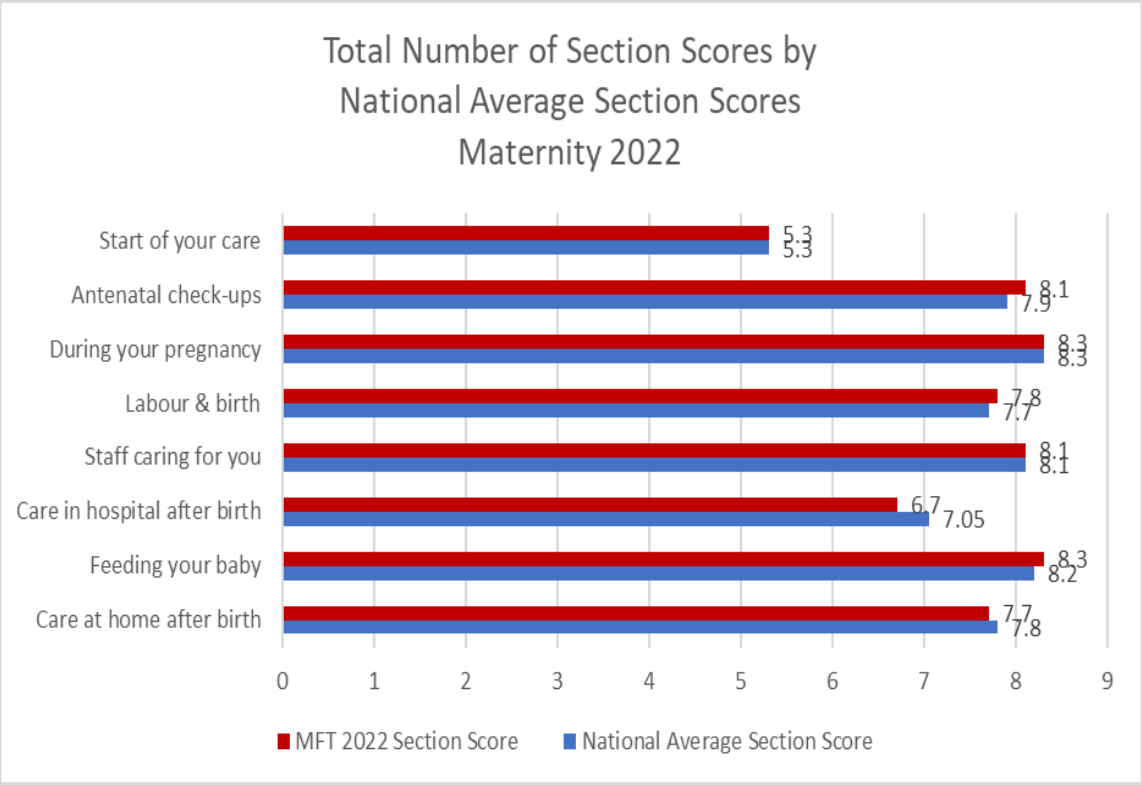


Graph 9: MFT 2021/2022 scores compared to national highest and lowest scoring Trusts.

Comparison with the Shelford Group

The National Maternity Survey does not include an overall question relating to patient experience, which prevents overall comparison with the other Shelford Group hospital trusts.

Of the eight sections, the Trust was in the top three sections for 'Care at home after birth' and in the top 5 for 'Antenatal check-ups', 'During your pregnancy', 'Labour and Birth', 'Staff caring for you', 'Care in hospital after birth', 'Feeding your baby'. The Trust was in the average range for six sections: 'Antenatal check-ups', 'During your pregnancy', Labour and Birth', 'Staff caring for you', 'Feeding your baby', and 'Care at home after birth'. 'Start of your care during pregnancy' and 'Care in hospital after birth' did not feature in the average range. **Appendix 12** provides a comparison of MFT with other Shelford Group hospital trusts for all eight categories.



Graph 10: MFT scores compared to National Average Section Score

Overall, and of the eight sections, the Trust was noted to be above the average score in four (50%) sections (Antenatal check-ups, Labour and birth, Feeding your baby, Care at home after birth), equal to the average score in three (37.5%) sections and below the overall average score in one (12.5 %) section. Further detail is provided in **Graph 10** below. **Appendix 12** provides a comparison of MFT with other trusts in the region for all eight categories.

Summary

The National Maternity Survey (2022) demonstrates that the results are predominantly about the same' as other NHS Trusts. However, it must be noted that improvement across two areas has been demonstrated.

MFT wide and local improvement plans have been developed with specific focus on the notably low scoring questions as detailed within the report. Examples are provided within the specific hospital/MCS/LCO reports at Section 14 of this report.

Section 7

7. Patient Experience Activity

This section of the report provides an overview of the range of activities aimed at providing a positive patient experience for all. Updates are provided from:

The Corporate Patient Experience Team activity, including:

- Bee Brilliant

- Small Change Big Difference
- Proud to Care on Camera
- Voluntary Services
- Spiritual Care and Chaplaincy Services
- Interpretation and Translation Services
- MyMFT

7.1. **Bee Brilliant**

Bee Brilliant is a MFT quality initiative, embedded into the culture of MFT since its introduction in 2013. The innovative style of education and teaching is both creative and interactive and uses a collective approach to improvements in healthcare that resonate with healthcare professions.

It provides staff with opportunities to celebrate and share good practice. The Bee Brilliant initiative updates staff on best practice, reminds staff of the fundamentals of care and can fill knowledge gaps. It empowers and engages staff to want to improve practice in their area for their patients and uses the social movement concept to drive large scale improvements with a Trust wide call to action.

The Bee Brilliant programme is delivered quarterly throughout the financial year. Each quarter has an overarching principal philosophy and is closely aligned to the Trust's Nursing, Midwifery and Allied Health Professional Strategy, and the Trusts Values & Behaviours framework. Each themed quarter aims to make improvements to patient care, based on themes identified through our approaches to seeking patients views of their experience, and clinical quality by inspiring and motivating staff and sharing good practice.

Quarter 1 – Communication
Quarter 2 - Leadership and Culture
Quarter 3 - Professional Excellence
Quarter 4 - Staff Wellbeing, Our staff matter

Table 14: Bee Brilliant Topics by Quarter

Each event is interactive, engaging, fun and current, a wide range of media tools are utilised to communicate event themes, including videos, sketches, role play, and social media such as Twitter. Events involves guest speakers, quizzes, music, and patient stories.

An integral and essential part of the event is the sharing of good practice with the inclusion of patient stories from within the Trust. This demonstrates the staffs' commitment to achieving the best possible patient experience.

At the end of the session there is a ***'****Call to Action'* for all staff to make a personal and team commitment. This requires the development of a quality improvement initiative based on the theme of the session and bespoke to the individual area.

Clinical areas have a Bee Brilliant display board, promoting how the '*Call to Action'* has been adopted and what changes have been made. The Bee Brilliant boards are then reviewed as part of the Clinical Accreditation assessment to provide assurance the 'Call to Action' has been implemented.

Bee Brilliant events are coordinated by the Quality Improvement Team and led and presented by a Hospital Director of Nursing/Midwifery/HCP. Bee Brilliant events are available on the MFT learning hub to improve access for all staff.

The relaunch of the first face to face, Bee Brilliant event since 2020 was held in April 2022. It was a successful event led by the Corporate Director of Nursing, Quality & Patient Experience. It received good attendance across all sites and focused on the importance of effective communication throughout the patient journey, with an opportunity to share some inspirational examples of effective communication from different clinical areas across MFT.

The event highlighted national and local data, focusing on

- the triangulation of national data
- WMTM data
- Patient Advice and Liaison Service (PALS) data
- Formal Complaints data in relation to the patient experience.

The event highlighted themes from PALS and Formal Complaints and explained 1.9 out of every 10 complaints are due to communication. A patient story in relation to poor communication was shared during the event to highlight the impact of poor communication on patients and their families.

Staff were 'call(ed) to action' to consider how they and their teams can communicate more effectively, how staff can promote civility and kindness in their workplace and finally how staff can utilise WMTM to achieve an excellent patient experience.

Slide 1: 'Call to Action' Slide shown during Q1 Bee Brilliant event

The live events were held on three dates over three sites, capturing 466 staff, during April 2023 – ORC, Wythenshawe & NMGH **(Table 26).**

Staff were able to book on to the event for the first time by using the Eventbrite website which generated a QR code for registration. The Quality Improvement Team were able to scan the QR code on entry to the event, enabling the team to log attendance electronically for the first time.

Site	ORC	Wythenshawe	NMGH
No. of staff attended	181	168	117

Table 15: Demonstrates staff in attendance at BB events across sites.

Future Plans – Bee Brilliant

- To include all the QI Team in championing the live events to gain experience and confidence in the event management skills and delivery of the event.
- To continue to address themes and issues from MFT data through the Bee Brilliant event to challenge staff with a 'call to action' to address the themes and triangulate the message.
- To explore opportunities to Live stream the events across all hospital sites in multiple rooms, to widen and enable the event to be seen by a greater staff audience.

7.2. Small Change Big Difference

The Small Change Big Difference programme (SCBD) is a key component of the Trust's 'What Matters to Me' patient experience initiative. The principles are around a small change making a big difference to patients and/or staff experience. It is overseen by the Corporate Director of Nursing and managed by the Quality Improvement Team (QI Team).

The programme is a rolling 12-month initiative that permits all ward areas to submit applications for up to £5,000 in funding for projects that are not covered by the ward's own budget.

Additionally bids to support patient experience for patients with a Learning Disability/Difficulties are considered for extra funding of up to £2,000 per application.

Applications are based on patient, family, and staff feedback, and must support the 'What Matters to Me' themes to improve patient and staff experience.

To meet the criteria for SCBD all applications must be supported by the Hospital/MCS/LCO Director of Nursing prior to applying. Staff are requested to complete an application form signed by their Director/Deputy Director of Nursing/ Midwifery/ AHP before submission.

During 2022/23 SCBD panels increased from quarterly to monthly to accommodate the increase in applications to the SCBD programme.

The SCBD panels take place monthly over Microsoft Teams. Panels are chaired by the Corporate Director of Nursing, Lead Nurse for Quality, Corporate Quality Matron and/or Matron for Professional Practice, a Quality Improvement Manager from the Corporate Quality Improvement Team and the Director of Nursing or Midwifery from the Hospital/MCS/LCO whose areas have submitted applications.

SCBD 2022/23 outcomes

A total of 47 applications were received, of which 34 applications were successful. The programme does include staff in that criterion but with the focus on patient experience. Of the successful applications 19 were to improve patient experience, 9 to improve staff experience and 18 to improve both patient and staff experience.

Applications	Approved	34
	Declined	13
	Total	47
Who will benefit	Staff	9
	Patients	19
	Patients & Staff	19
Hospitals submitted	ORC	14
	Wythenshawe	17
	Trafford/Altrincham	4
	LCO	4
	North Manchester	8

Table 16: Total SCBD successful applications & costs across MFT sites

Feedback posters have been provided to successful applicants to gain an understanding of how the funding they have received has improved their patient and/or staff experience (see **Diagram 1**). This will provide valuable feedback on how the patient and staff experience has been improved and allow opportunities to share good practice.

Diagram 1: Feedback poster provided to all successful SCBD applicants.

Examples of successful SCBD bids and Feedback

The environment for delivering Oncology results to patients was very clinical and cold, on looking at patient feedback we wanted to create a more welcoming area.	We spoke to patients about what they felt would make the area more welcoming, we decided that better seating for the patient and the family member to sit together to enable physical support if needed.	Patients have provided feedback that the seating area provides a warmer more personal feeling, it also allows patients and families to spend time together with the team and our Macmillan colleagues discussing next steps to treatment
Patient information is key in helping reduce the stress and anxiety when receiving hospital treatment.	A series of videos to offer advice to patients before, during and after orthopaedic treatment.	Videos are one easy & convenient way to disseminate knowledge to our patients. There is so much work to do in this area & there are many future projects possible.
MRI received several PALS and complaints about lost property, particularly phone chargers, IPads and glasses.	They invested in property boxes which were big enough to store patients' smaller items, making it harder for them to be left or misplaced.	Theatres and day case use these for patients going to theatre as they are a great way for the patient to store dentures, phones, chargers etc when in theatres as they can follow the patient through their journey.
Being an inpatient can be quite boring. We want our intermediate care environment to be as stimulating as possible.	A GT Tech Interactive table which is height adjustable and is pre-loaded with a vast amount of touch screen activities.	Patients found the day quite long and wanted expanded activities. Staff also wanted to explore more options to stimulate our patients.

Table 17: Examples of successful applications and feedback received from the improvements.

Future Plans – for SCBD

- To introduce quarterly SCBD newsletter to provide feedback on successful funding projects across MFT via MFT Comms.
- To implement a new celebratory SCBD event held at the end of the financial year to help the sharing of quality improvements and celebrate success.
- To involve all Quality Improvement Managers in process to improve reliability and sustainability of process.
- The QI team will promote the SCBD program in Accreditations, IQP training and Bee Brilliant to increase the applications and in so doing improve the patient experience.

7.3. Proud to Care on Camera

The Proud to Care on Camera competition 2022 provided the opportunity for MFT staff to submit photographs / images of MFT healthcare professionals delivering high quality, patient centred care to the Corporate Patient Experience Team.

The team received 40 excellent submissions that reflected one or more of the 6 key themes of the **What Matters to Me** initiative. The 6 key themes are:

- Professional Excellence
- Organisational Culture
- Positive Communication
- Leadership
- Environment
- Staff Wellbeing

The entries were judged by a corporate panel, the winning entry for 2022/23 was Phebe Bhaskar, Aspiring Lung Cancer Clinical Nurse Specialist in the Positive Communication category.

7.4. Voluntary Services Activity

Volunteers play an important part in supporting the Trust to deliver a positive patient experience. At the start of 2023/24 there were **203** volunteers working across all hospital sites, and by the end of the year, this number had risen to **388** active volunteers following dedicated recruitment campaigns.

This number includes volunteers who had previously paused their volunteering during the pandemic and now returned, as well as volunteers from the Trust's partnership with national and local charitable organisations, such as:

- The League of Friends
- Radio Lollipop
- The Ticker Club
- Northern Air Radio,
- Refuah Care and EZRA Care,
- Those with Pets as Therapy.

Our volunteers ranged in age from 16 to over 65 years and came from a wide variety of backgrounds.

As **Tables 18 and 19** below illustrate, MFT ended the year with 388 active volunteers, across all hospital sites.

	Oxford Road Campus (ORC)	Wythenshawe, Altrincham, Withington and Trafford (WTWA)	North Manchester General Hospital (NMGH)
TOTAL	**90**	**88**	**25**

Table 18: Number of active volunteers by site as of 1st April 2022

	Oxford Road Campus (ORC)	Wythenshawe, Altrincham, Withington and Trafford (WTWA)	North Manchester General Hospital (NMGH)
TOTAL	**134**	**176**	**78**

Table 19: Number of active volunteers by site as of 31st March 2023

Over the course of the year our volunteers, provided over **25,000 hours** of their time to supporting the Trust in our goal of ensuring patients receive a positive patient experience when they access our services.

Our MFT Voluntary Services Strategy 2022-2025.

Launched during National Volunteers Week, 1st - 7th June 2022, the MFT Voluntary Services Strategy 2022-2025 is aimed at further developing our Voluntary Services.

"Our Voluntary Services mission is simple, we want to make MFT one of the best organisations in which to volunteer and in doing so, ensure we provide the safest, highest quality, compassionate support for our patients and their families and staff." (*MFT Volunteer Strategy 2022-25*).

Throughout 2022/2023 the service continued to grow in response to the strategy and to the needs of patients. The Voluntary Services web site was updated and now includes the provision of an “easy read” layout. Following valuable feedback from new volunteer members, the team have reviewed the induction process following recruitment in 2022. In addition to the above workstreams, online resources and a volunteer’s handbook is being developed. Throughout 2023/2024, the service will continue to grow and develop.

Investing in Volunteers

Investing in Volunteers (IiV) was first awarded to MFT in 2019. It is the UK quality standard for good practice in volunteer management. Following re-assessment, MFT was re- accredited in November 2022 for a further three years. Achieving this award for a further three years, underpins the objectives of our Voluntary Services Strategy, which is to “Grow, Support, Diversify, Meaningful and Develop” the service.

The Volunteering Futures Programme

Supported by NHS Charities Together in conjunction with the Department of Digital Media, Culture, and Sport. The programme supported the recruitment of volunteers aged 16-18 years from historically excluded groups and built on the success of earlier projects. In total 93 were recruited, 81 of whom continue to volunteer.

Below are two quotes from Young Volunteers, who outline how the benefits of the programme for them and for our patients:

“Before I started volunteering, I didn’t feel so confident because I struggled to give clear instructions. However, watching my fellow colleagues give instruction I’ve gotten more confident with it. I’m proud of the fact that I’ve helped so many people and their little praises just make my day. One advice I would give is not to worry about how little experience or knowledge you have about the hospital, just be humble and approachable and everything will be fine! It won’t take you long to remember certain places because you’ll get used to it. Volunteering has helped get the interaction between myself and patients already which I will need as a doctor in the future.”

“I get the opportunity to interact with different people, my fellow volunteering colleagues and with the visitors. What I am most proud of as a volunteer is that I get to impact people’s lives by helping them find out where they need to be, this allows to me take away their stress a bit when they come to the hospital. visit. My advice would be to really just go for it and to not hesitate to apply, being a volunteer at North Manchester General Hospital has helped me a lot with my medical school application and it has also helped me to grow more confident in engaging in conversations with people and also pushed me to step out of my comfort zone. As a volunteer I also got to build my teamwork and communication skills.”

National Volunteering Certificate (NVC)

MFT continued to deliver the National Volunteering Certificate (NVC). Available to all volunteers, the NVC consists of six core standards based on statutory and mandatory

topics linked to the NHS Core Skills Training Framework and the Care Certificate[2]. The six modules of the certificate consist of:

- Roles and responsibilities
- Communication
- Safeguarding
- Health and safety
- Respect for everyone
- Mental health/dementia/learning disabilities

The modules aim to enhance the learning that volunteers will have gained and provides a formal qualification related to healthcare for Trust volunteers. In addition to their mandatory training, volunteers are required to contribute a minimum of 30 hours volunteering over 12 months. The benefits to volunteers completing the certificate are that:

- It demonstrates to others (internal and external) that the volunteer has undertaken quality assured theoretical training and completed a period of practice to be able to volunteer safely in health and care.
- It is nationally recognised (aligned to Care Certificate) meaning that the volunteer can include course completion in their CV or job/course applications.
- It is potentially transferable to other trusts/volunteering opportunities.

By the 31st of March 2023, 28 volunteers had been awarded the certificate and 26 are working towards achieving the award.

Volunteer Recruitment

It is extremely important that the team continue to focus their efforts on encouraging and motivating volunteers to join and stay at MFT. In support of the MFT Volunteering Strategy 22-25 and the recommendations of the IiV re-accreditation in November 2022 the team will be reaching out to people to recruit more volunteers. Detailed below are the team's steps to improving their recruitment strategy:

16-18 years.

- Embed the learning from the NHS Charities Together and DMCS Volunteer Futures Programme - link in with career leads for local schools and colleges and attend career events.

19+ years

- Attend Job Centre events
- Link in with local community leads for supermarkets for each of the hospital sites; local NHS Retirement Fellowship and other retirement community groups;
- Contact previous NCA volunteers to see if they now wish to return to volunteering
- Enhance links with Manchester University.
- Promote MFT Voluntary Services through MFTV; social media platforms; articles in MFT Team times; Patient Stories e.g. PAT Dogs; Re-fresh MFT Voluntary Services Web Page

- Work with Widening Participation Team St John's Ambulance NHS Cadets, St Johns Ambulance volunteers, Walking with the Wounded.
- Recruitment of additional PAT Dogs
- Link in with local community groups and charities e.g. Ezra Care, Radio Lollipop; Breast Feeding Peer Support Volunteers
- Review of current Volunteer Policy to reflect the learning from recent projects and to embed this into future recruitment.
- Review of Mandatory Training modules - delivery of and courses to be covered. This will be done in conjunction with the Learning and Development Team.
- Review of Volunteer role descriptions and roles available with MFT e.g. Patient Dining Companion
- Local site action plans- with Matrons/ Lead Nurse for Quality and Patient Experience.

Awards and Nominations

Helpforce Champion Awards

Fortunee Broha, HelpForce Champion Award Nominee

Helpforce are a charity with a mission to accelerate the growth and impact of volunteering in health and care. The Helpforce Champions Awards are the perfect opportunity to celebrate and share the amazing contributions made by volunteers and teams across the UK. Fortunee Broha, a Volunteer from Oxford Road Campus was nominated by MFT in the category of Volunteer to Career for the 2022 Helpforce Champions Awards.

Fortunee commenced as a volunteer in April 2021, feeling that volunteering would improve her wellbeing as society slowly "opened up", during the second year of the pandemic. Alongside her Meet & Greet Role, Fortunee helped out in the Eye Hospital, and with extra training, learnt how to navigate visually impaired patients across the hospital site for scans and treatment.

In September 2021, she joined other volunteers on the pilot for the Complex Patient Programme. The Programme provided a structure to identify complex patients and support care delivered to this diverse patient group.

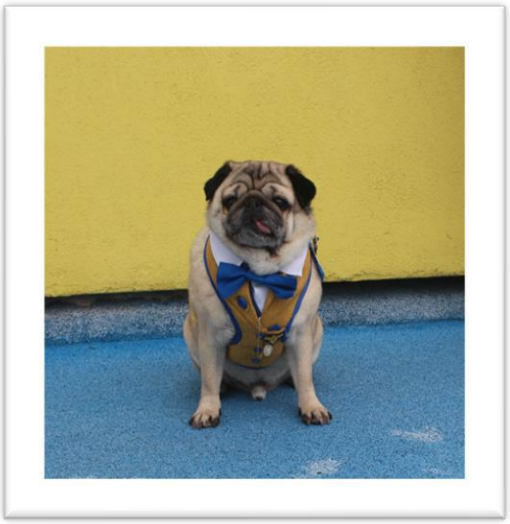
In February 2022 Fortunee was successful in her application for an administrative role within the Trust and in September 2022, commenced a Nursing Degree at Salford University, whilst continuing to volunteer on the Paediatric wards to support her nursing qualification.

Pets As Therapy (PAT) dogs

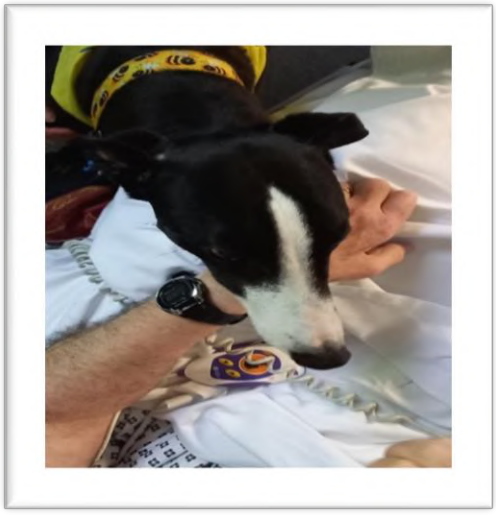
Voluntary Services currently has four registered Pets as Therapy Dogs (PAT Dogs). Together with their owners Voluntary Services conducted over 40 visits at WTWA, ORC and NMGH during 2020/23. These visits included both medical and surgical wards, Paediatrics and Staff Employee Health and Wellbeing days.

"Lovely meeting you and Scruffy. You made my day. He brightened me up so much after a traumatic week……"

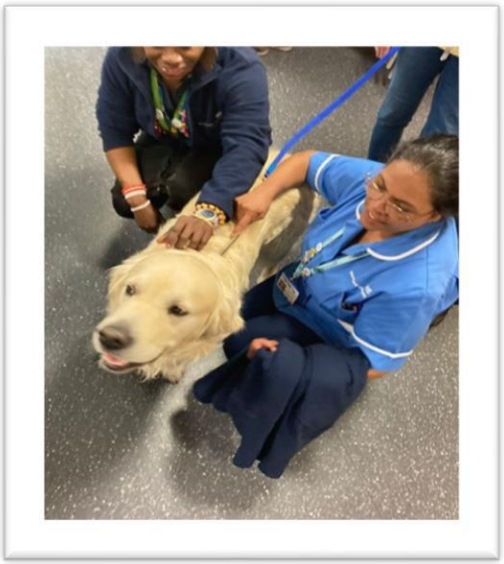
Feedback from patient on Jim Quick Ward, Wythenshawe Hospital, following a PAT Visit



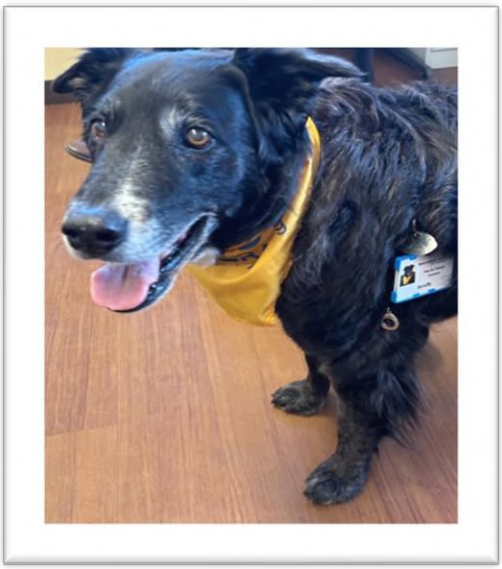
Meet Alfie



Meet Ellie



Meet George



Meet Scruffy

Plans for 2023-24 within Voluntary Services, is to “recruit” additional PAT dogs to enable this service to expand.

Celebrations

MFT has a long and established tradition of celebrating and saying ‘thank you’ to all its volunteers. During National Volunteers Week in 2022 the Trust Chairman, Kathy Cowell OBE DL, hosted celebration events across MFT. As the service returned to normality post pandemic, this was the first time it was possible to celebrate in person and say a big “Thank You” to all MFT’s volunteers, including to our Pet as Therapy dogs.

Significant events within the Voluntary Services “family” during the past year have included:

- Radio Wishing Well based at Trafford General Hospital (TGH) who celebrated their Ruby Anniversary in April 2022
- The League of Friends also based at TGH, founded in 1972, who celebrated their Golden Anniversary.

Planned Activity April 2023 - March 2024

- MFT Voluntary Services Strategy 2022-2025 will deliver on Year 2 actions which are to engage with services to identify new volunteer opportunities; school and college Roadshows to support volunteer recruitment, and to embed policy changes.
- Embed the learning from the Volunteer Futures Programme, to support the recruitment of volunteers and strengthening of the service. This will include attending community, educational and job centre events to strengthen the diversity of volunteer recruitment.
- MFT Voluntary Services Policy review to commence September / October 2023

- Continue to grow the service by supporting the St John's Ambulance, (SJA) NHS Cadet Scheme and as part of the MFT Armed Services Covenant- work with "Walking with the Wounded"- supporting veterans into volunteering.
- Continue to work with national organisations, such as 'Helpforce', National Association of Voluntary Services Managers (NAVSM) and NHS England
- Explore partnerships in community health and social care to support the recruitment of volunteers.
- To recruit to additional PAT dogs, and increase the pets as therapy volunteer service.

7.5. Spiritual Care and Chaplaincy Service

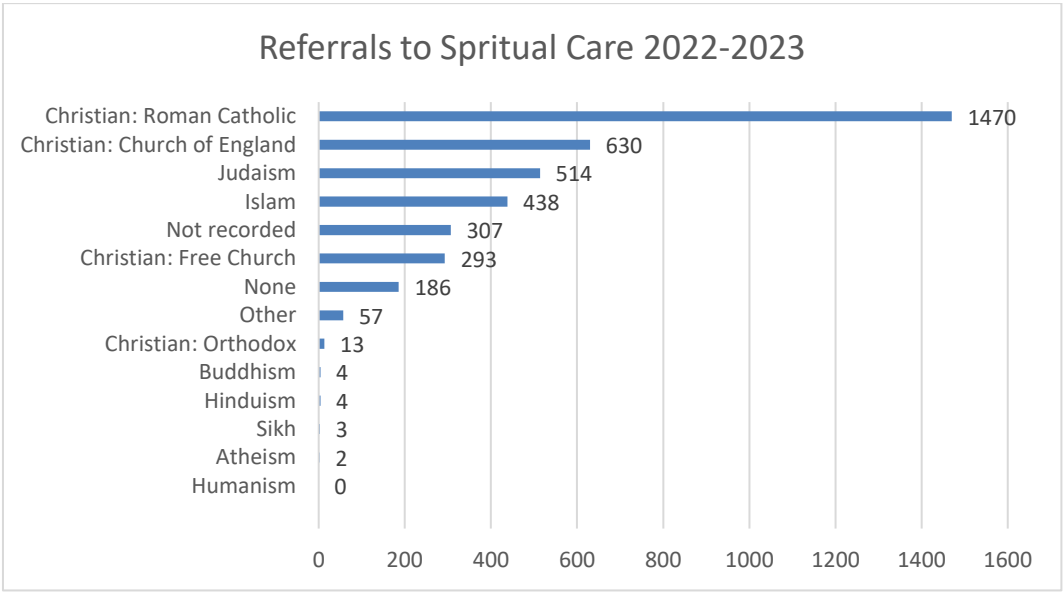
Throughout 2022/2023 the Spiritual Care and Chaplaincy Service (SCCS) provided high quality spiritual care across the Trust. SCCS is a vital part of the holistic care of patients, families and staff. The service is important in supporting compassionate, whole-person-centred care, ensuring the delivery of a positive, enriching patient and staff experience.

Activity Data – Referrals to Chaplaincy & Spiritual Care Service

During 2022/23 the CSCS moved from Ulysses database to the Trust's major clinical transformation programme Hive, in September 2022. Transferring from Ulysses to recording chaplaincy activity on Hive has been a significant improvement for CSCS, as it integrates the service much more closely with clinical teams. Using Hive, communication between care teams and CSCS has become much more efficient, with benefits to patients apparent. The benefits include a more rapid response to a referral,

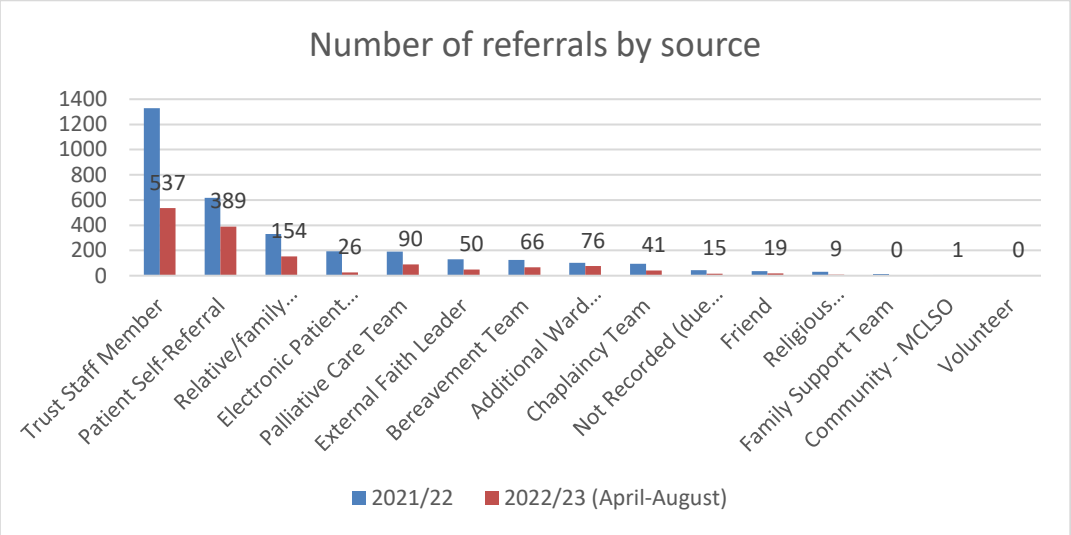
Graph 11 below illustrates the total number of referrals received by each faith tradition (3,921). This shows a marked increase of 21.4% (693) in comparison to the 3,228 received in 2021/22.

Of the 3,921 referrals received Roman Catholic (RC) faith received the greatest number of referrals in 2022/23, with 1,470 (37.5%) being received during 2022/23. This represents an increase of 303 RC referrals being received when compared to 1,167 (26.0%) in 2021/22.



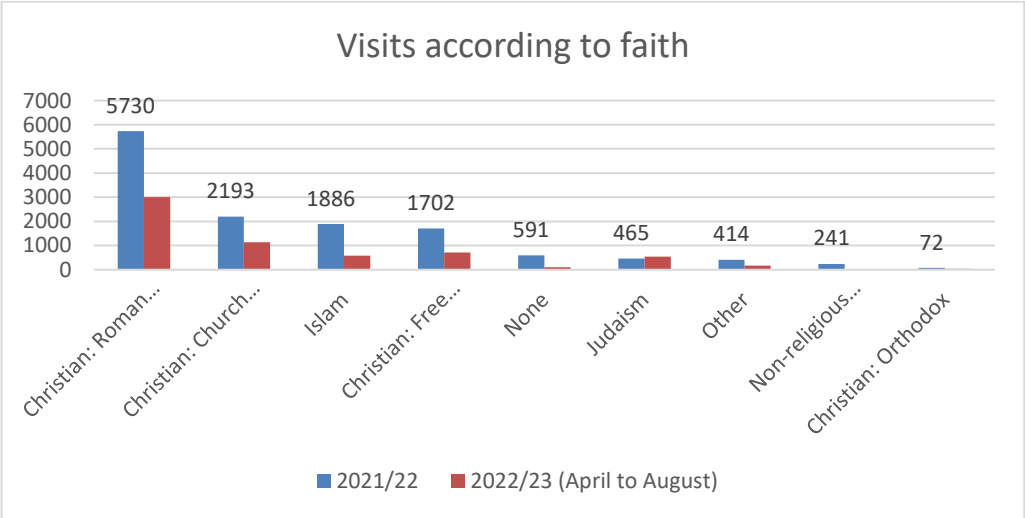
Graph 11: Number of Referrals received by each Faith Tradition in 2022/23

The mapping and tracking of the source of referrals continued during 2022/23, however, as described above data recording moved from Ulysses to Hive which meant that only the first five months of data for 2022/23 are available without manual trawl. **Graph 12** below shows that the frequency of the source of referrals is broadly in line with the previous year, with the referrals from Trust members of staff still being CSCS's most frequent source of referral. As detailed above CSCS currently have a manual system in place which has enabled the team to recommence reporting this data whilst we await the implementation of 'reporting functions' in the Hive system to be available.



Graph 12: Number of Referrals by Source

Graph **13** below provides the number of chaplaincy visits to patients by faith tradition received for April to August 2022. The proportions are broadly similar, although it is noteworthy that there is a significant reduction in those declaring themselves to be not religious. Roman Catholic faith patients received the highest number of visits.



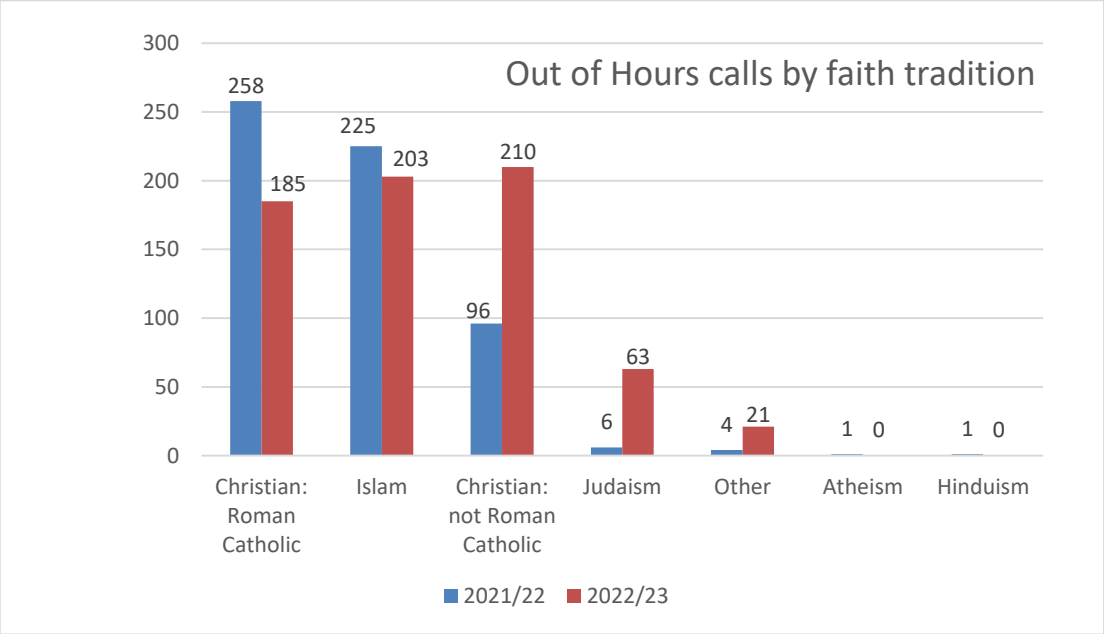
Graph 13: Number of Chaplaincy Visits to patients by Faith Tradition

Out of Hours

The Trust provides a Chaplaincy and Spiritual Care out of hours service from 16:00 until 08:00 hours the following day, including during weekends and Bank Holidays.

Graph 14 below shows the number of out of hours calls by faith for 2022/23. Please note that the faith recorded is that of the patient, not of the chaplain responding. Muslim faith specific support is provided Friday evening to Monday morning only.

At other times the on-call chaplain will respond accordingly. Christian faith excluding Roman Catholic received the greatest number of out of hours calls, with 210 calls.



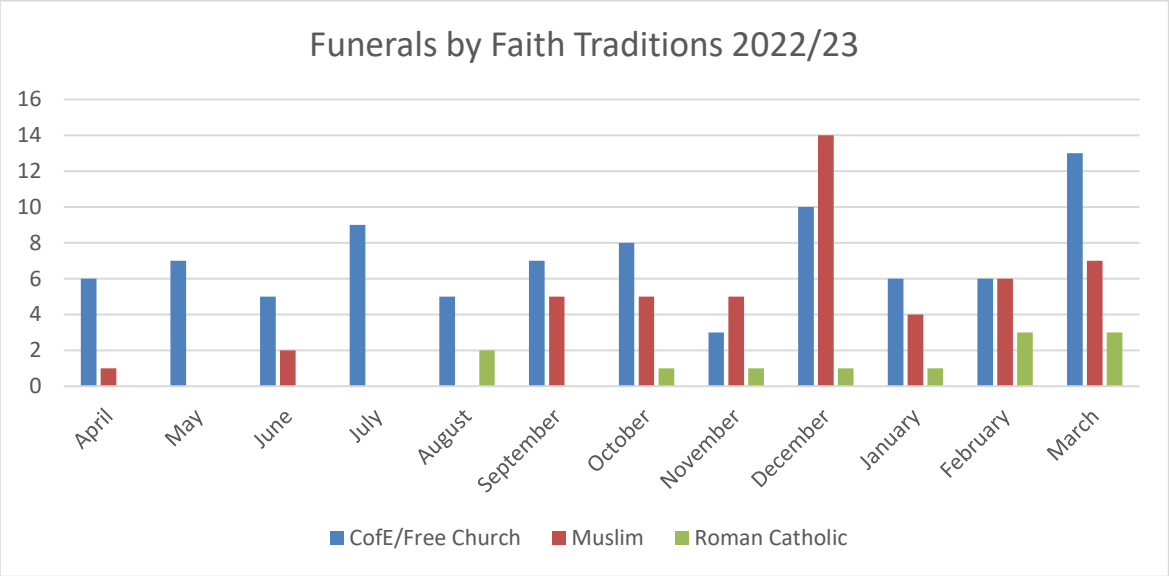
Graph 14: Out of Hours Visits

In order to support Muslim patients receiving a visit from a Muslim chaplain during out of hours periods, a review of the Trust's Chaplaincy Out of Hours on Call Services is planned for early 2023/24. Overall there was an increase in visits out of hours across all faiths, except for Roman Catholic, where there was an decrease of 28.2%.

Funerals

The Trust's Chaplaincy and Spiritual care team provides welfare funerals. These are conducted according to faith and circumstances and provide support to those patients with no next of kin, or relatives or friends available to arrange a funeral. In addition to this the team also provide Multi-faith funerals, these tend to be for faith traditions where burial is required to take place within 24 hours (Jewish and Muslim). This provision also provides support in circumstances where there is a continuation of care, and no support network or family is available.

In 2022/23 the Trust saw an increase in funerals from 2021/22 with 156 funerals. **Graph 15** below shows the number of Welfare and Multi-faith funerals by faith tradition. The greatest number of funerals were held in the Church of England/Free Church faith tradition.



Graph 15: Number of Welfare and Multi-faith funerals by faith tradition.

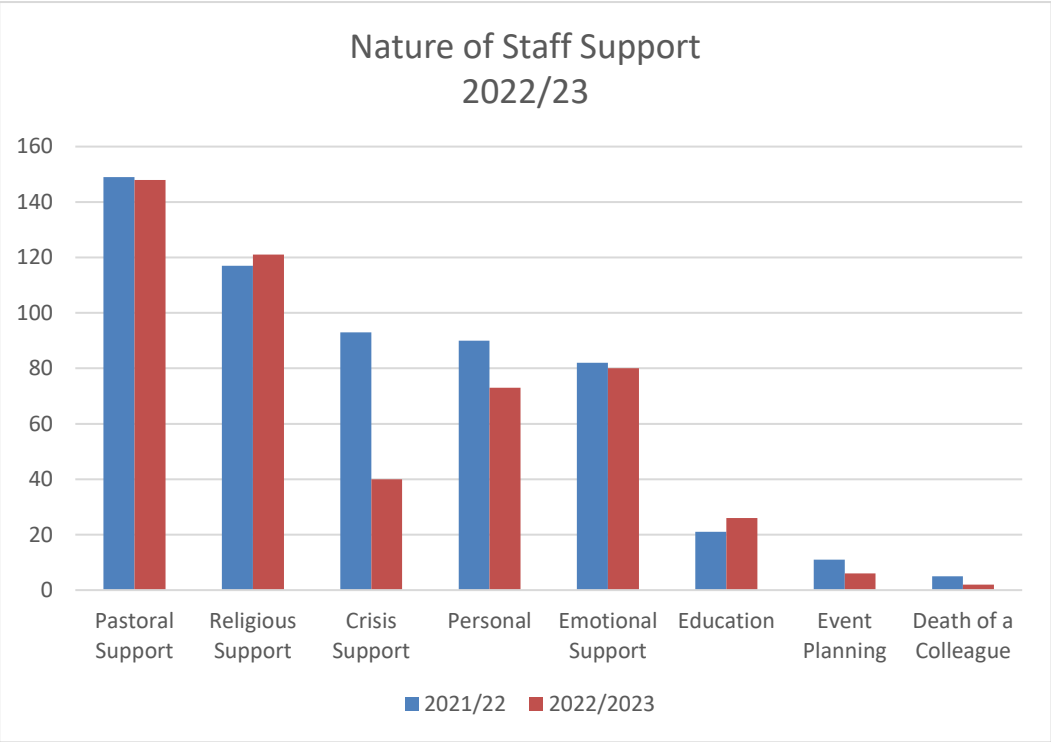
Weddings

The Trust's Chaplaincy and Spiritual care team gives support to emergency hospital weddings. Normally the Local Authority Registrar will be called upon to register the wedding, but if the family have specific religious requirements, the team are able to provide appropriate religious rituals. During 2022/2023, CSCS assisted with three weddings; a Roman Catholic wedding at Wythenshawe, a Muslim wedding at NMGH, and a Christian wedding blessing in the RMCH, where the child was unable to leave the hospital to attend their parent's wedding.

Staff Support

MFT's Chaplaincy and Spiritual Care Service also provides support to all MFT staff. Staff are able to access support in person, or via telephone and through Microsoft Teams. During this period, 2022/23 there were 311 separate recorded occasions of staff support. **Graph 16** below shows the nature of the support offered. 'Pastoral support' received the greatest number of referrals with 148. This shows a decrease of 0.67% (1) compared to

2021/22. Overall, the greatest increase in staff support was in 'religious support' with a 3.41% (4) increase being noted compared to 2021/22



Graph 16: Staff Support 2022/23

Commemorations

Commemorations are held to remember a person or event. In 2022/23 the Trust's Chaplaincy and Spiritual Care team assisted in a number of events, some examples are provided below:

- **Armistice Day**
  The SCSC supported patients and staff in the observation of the minute's silence. The Trust has recently employed a staff member to support veterans, and during November the team worked closely with the Veterans Integrated Hospital Care Programme Manager, to provide services at each of our hospital sites. In memory and to honour the veterans who served in the war the Trust marked the occasion by lighting up its hospitals red at Trafford General and Cobbett House, Trust Headquarters.

- **National Holocaust Memorial Day**
  National Holocaust Memorial Day is a national commemoration day in the UK held in remembrance of those who died during the Holocaust. It is held each year and to mark the occasion this year the Chaplaincy Volunteers set up a display board providing information about the Holocaust at Wythenshawe Hospital Multifaith Centre.

- **Valentine's Day**
  St Valentine's Day is a time when people celebrate their love for each other. To celebrate Valentine's Day this year and to show the Trust's appreciation on Tuesday 14th February 2023, the Chaplaincy and Spiritual Care team visited the wards and

departments across the Trust distributing ‘Remember, You Are Loved!’ cards and sweets to patients and staff.

- **Ash Wednesday**
  Ash Wednesday marks the beginning of Lent and is always 46 days before Easter Sunday. Lent is marked by repentance, fasting, reflection and ultimate celebration. During 2023, the Chaplaincy & Spiritual team Chaplains provided Ash Wednesday services at each of the hospital sites, below are photos from Oxford Road and Wythenshawe Multifaith Centres.

- **Ramadan.**
  Ramadan is the ninth month of the Islamic calendar, observed by Muslims worldwide as a month of fasting, prayer, reflection, and community. It is considered one of the holiest months for Muslims and the Islamic holy month of Ramadan began on Wednesday March 22nd, 2023, and lasted into April 2023. During Ramadan this year Chaplaincy & Spiritual Care provided dates and water at each of the main sites for Muslim colleagues who were working, to break their fast after sunset. The team also gave support and guidance to managers around the Muslim fast. This was on the Trust intranet and highlighted to managers in MFT Time to help support staff providing care to Muslim patients and their families.

- **Early Pregnancy Loss Service**
  The End of Month Early Pregnancy Loss service is held each month at Southern Cemetery, Manchester and led by MFT Chaplains. This is a service which is co-produced with the Bereavement Midwives, Family Support team, Co-op Funeralcare Directors and the staff at Southern Crematorium. Led by our Christian Chaplains, the service gives families an opportunity to acknowledge their loss in the early stage of pregnancy (babies born less than 22 weeks gestation).

- **Other Memorial Services**
  The CSCS supported patients, their families and carers through many other memorial services during 2022/23 as below:

  - **The Macmillan Memorial Service;** held four times a year at Wythenshawe Hospital Chapel.
  - **RMCH Memorial Service;** July 2022
  - **Candle Services:** held at NMGH and ORC for babies who have died.
  - **Renal Memorial Service:** normally takes place in the Autumn and is arranged by the trust’s Renal Department at Oxford Road with input from Chaplaincy. It is normally held at The Lowry Manchester.

Chaplaincy Volunteers

Volunteers greatly assist the Chaplaincy Team across the Trust. They help promote the work of Chaplaincy as well as providing support to patients. In 2023/24 CSCS will be exploring, with the trust’s Voluntary Services teams, ways to recruit new volunteers.

Feedback

During 2023/24 the CSCS team plan on further enhancing its collection of feedback from patients, relatives, carers and staff, to help plan future improvements. The following are examples of feedback received during 2022/23.

Figure 2: Chaplaincy feedback 2022/23

Routine Activity

In addition to the activity described above the Spiritual Care Service Chaplains were also involved in the following regular activities during in 2022/23.

- Friday prayers for Muslim staff and patients.
- Sunday Services for Roman Catholic and other Christian staff and patients.
- Daily prayers across traditions
- Providing dignified spiritual care at the end of life, and honouring patients and staff who have died.

Planned Improvements April 23- March 24

Continued areas for improvement and development for the Trust's Chaplaincy and Spiritual Care team throughout 2023/24 include:

- Development and introduction of Chaplaincy and Spiritual Care Trust Policy
- Implementation of the Chaplaincy and Spiritual Care Strategy
- Implementation of Chaplaincy Volunteer Standing Operating Procedure
- Staff development and training
- Enhancing the development of the evidence base for the activities that are provided

- Collection of service user feedback and active sharing of learning and service improvement
- Equitable out of hours on-call service across all faith traditions
- Re-instate the Adult Memorial Services, held four times per year in the Multi Faith Centre in conjunction with the Bereavement Service prior to COVID-19 pandemic.

7.6. Interpretation and Translation Services

MFT's Interpretation and Translation Service (ITS) provides a wide range of interpretation (spoken word or British Sign Language (BSL) and translation (written word or braille transcription) support to staff, patients, carers and family members across all the Hospitals/MCSs/LCO.

Interpretation and Translation Services Activity

During 2022/23 the service noted an increase in activity. The total number of referrals received in 2022/23 was 80,633. This is an increase of 20.92% when compared with the 66,684 received in 2021/22. **Table 19** below illustrates the Interpretation referrals received by each contact. Telephone interpreting is the method with the highest level of activity and received the highest number of referrals in 2022/23, with 53,579 (66.45% of requests). This represents an increase of 8.24% when compared to 49,498 referrals received in 2021/22.

Contact	2021/22	2022/23
Face to Face/ Virtual (Exc. BSL)	15,781	25,479
BSL (Face to Face/Virtual)	1,405	1,575
Telephone	49,498	53,579
Grand Total	**66,684**	**80,633**

Table 19: Breakdown of Interpretation requests by method and BSL

In 2022/23 referrals were received for Interpretation to 115 languages or dialects. **Table 20** below illustrates the referrals received for the top 12 languages. Urdu is the language with the highest activity and received the highest number of referrals in 2022/23, with 16,815 (20.85% of all language requests). This represents an increase of 15.81% when compared to 14,520 referrals received in 2021/22.

Language	2021/22	Language	2022/23
Urdu	14,520	Urdu	16,815
Arabic	14,081	Arabic	16,288
Bengali (Sylheti & Non-Sylheti)	3,266	Cantonese	4,137
Polish	2,567	Kurdish / Kurdish (Sorani)	3,945
Romanian	2,567	Bengali (Sylheti & Non-Sylheti)	3,758
Cantonese	2,529	Farsi (Persian)	3,492

Kurdish / Kurdish (Sorani)	2,408	Polish	3,031
Farsi (Persian)	2,347	Romanian	2,831
Tigrinya	2,131	Tigrinya	2,747
Portuguese	1,421	Mandarin	2,442
BSL Sign	1,381	Punjabi	2,225
Punjabi	834	Somali	2,024

Table 20: Number of Interpretation Referrals for Top 12 Languages via Face-to-Face, Video and Telephone

Table 21 below illustrates the Translation referrals received. Of noting one Request can count as multiple Translations as some requests are for one document to be translated into various languages. In 2022/23, 459 Translation Requests were received. This represents an increase of 7.24% when compared to 428 referrals received in 2021/22.

Contact	2021/22	2022/23
Requests	428	459
Translations	552	521

Table 21: Breakdown of Translation requests by number of requests, and translations

In 2022/23 referrals were received for Translations into 42 languages. **Table 22** below illustrates the referrals received for the top 10 languages. Urdu is the language with the highest activity and received the highest number of referrals in 2022/23, with 119 (22.84% of all language requests). This represents a decrease of 5.56% when compared to 126 referrals received in 2021/22.

Language	2021/22	Language	2022/23
Urdu	126	Urdu	119
Arabic	93	Arabic	70
Polish	59	Polish	49
Bengali	29	Kurdish	29
Kurdish	24	Bengali	26
Farsi (Persian)	22	Romanian	24
Traditional Chinese (Cantonese)	21	Traditional Chinese (Cantonese)	23
Simplified Chinese (Mandarin)	19	Farsi (Persian)	20
Portuguese	16	Punjabi	19
Spanish	16	Portuguese	16

Table 22: Number of Translation Referrals for Top 10 Languages

New Agency Provider

In October 2022 the Trust moved to a new "One Stop Shop" Agency provider DA Languages as part of a Greater Manchester (GM) initiative. This changed the process from four agencies accessed to one and included BSL translation. The service arranges interpreters for over 100 Languages. Having the one provider supports partnership working between MFT and DA Languages increases flexibility to react to unexpected events and improved quality of service.

Aligning the Service across the Trust

As the North Manchester General Hospital language provision has moved from Northern Care Alliance to the ITS from the 1st April 2023. Wythenshawe Hospital and Withington Community Hospital whose language provision was processed directly through to DA Languages will come through the ITS from 1st April 2023.

Between January & March 2023, ITS provided 25 teaching sessions to the three hospitals via Microsoft Teams. A total of 201 staff were reached. Feedback was positive, leading to further training being delivered at Audit Clinical Effectiveness Days (ACE) days.

Planned Improvements 2023/24

- Training for Service Users - To improve the efficiency saving for the service. ITS is planning to reduce costs such cancellation fees and promote alternative methods of interpretation. For example, telephone or video verses face to face (f2f).

- Text Service – Texts reminders are sent out to patients to remind them of their appointment. ITS is planning to carry out a project using the top three most used language to see if sending the messages in the patient's language increases the attendance rate for appointments of a particular service.

- Feedback – Currently feedback only involves interpreters. ITS is planning to develop feedback process from staff using the service to inform service development.

- Appointment to a BSL interpreter to ensure MFT are representing their deaf community. The appointment will provide a professional, accurate and effective interpretation service for our patients and their significant others whose first language is British Sign Language (BSL) who access MFT Hospitals, Services and MLCO.

7.7. MyMFT

As part of the HIVE implementation, the patient portal MyMFT went live on the 6th September 2023.

My MFT allows patients to view aspects of their health information and participate in their healthcare through a web browser or mobile app giving more control to patients over their care than ever before. It is fully integrated with HIVE and the core features available to all patients for all services consist of:

- View upcoming and recent appointment details, letters and After Visit Summaries.
- Appointment cancellation up to 48 hours before.
- Appointment reminders.
- View documents clinical staff choose to share.
- View current medications, allergies and health conditions.
- Pre-appointment check in allows patients to suggest changes or additions where required.
- Proxy access for relatives or carers who assist with a patients care.
- View released results.
- Clinician initiated messaging.
- View and update demographic information.

There are currently 25,000 patients signed up to MyMFT, with a further 4,400 people using proxy access. Improvements are noticeable in patients experience through having their own information available without unnecessary waiting, and through having choices specifically relating to outpatient appointments. For example, we have seen the DNA rate improve from an average of 9.7% to 4.4% in the cohort of MyMFT users.

Section 8

8. The Annual Clinical Accreditation Report

The Clinical Accreditation programme is part of MFT's assurance mechanism for ensuring high-quality care and the best possible patient experience.

The Clinical Accreditation Programme demonstrates that MFT has undergone a rigorous process to ensure patients, families and carers are receiving high quality services, delivered by competent staff, in safe environments, whilst providing assurance from frontline to Board.

The programme is underpinned by all our approaches to receiving patient experience feedback that has been outlined within this report. The programme is enabled by:

- The Improving Quality Programme (IQP)
- MFT's Values and Behaviors Framework
- 'What Matters to Me' (WMTM) Patient Experience Programme
- The Nursing Midwifery and Allied Health Professional (AHP) Strategy.
- The Clinical Accreditation programme across MFT is aligned to the Care Quality Commission's (CQC) Key Line of Enquiry Standards (Safe, Effective, Responsive, Caring and Well Led).

8.1. Overview of the 2022 - 2023 Clinical Accreditation Programme

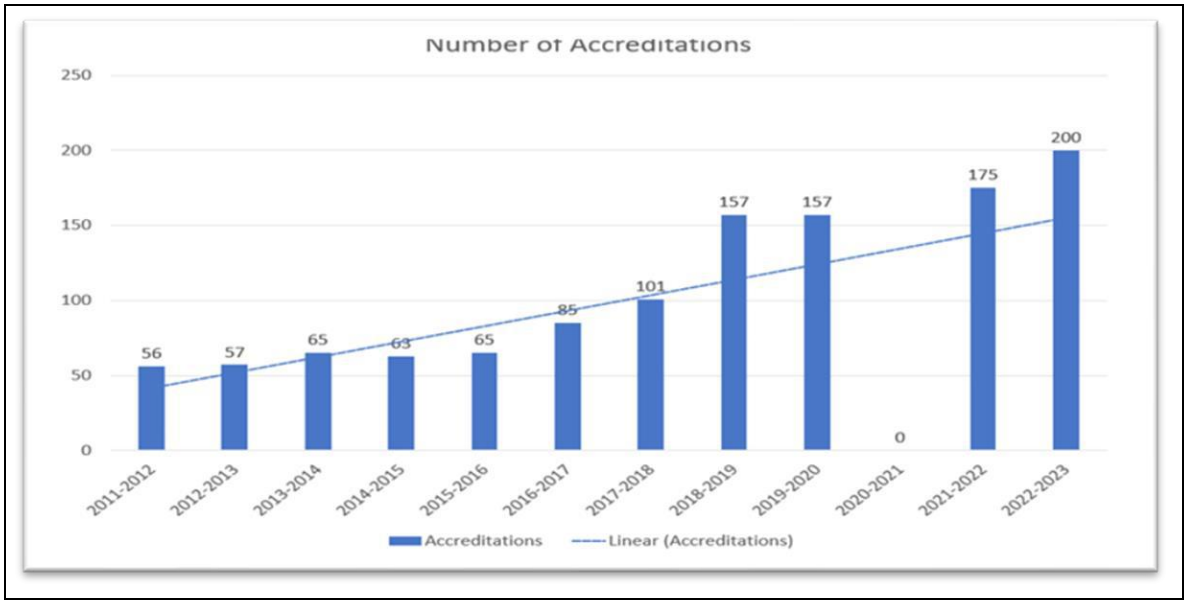
Since the introduction of the Accreditation Programme in 2011, there has been a year-on-year increase in areas being accredited (**Graphs 17 & 18**). During 2022 - 2023 a total of two hundred areas were accredited, which was an increase of twenty-five areas from the previous year.

During the 2021 - 2022 Accreditation Programme, due to COVID restrictions, a conscious decision was made to reduce the volume of people allocated to undertake an Accreditation to a minimum of three. During 2022 - 2023 the minimum number of people allocated to undertake an Accreditation was increased to four.

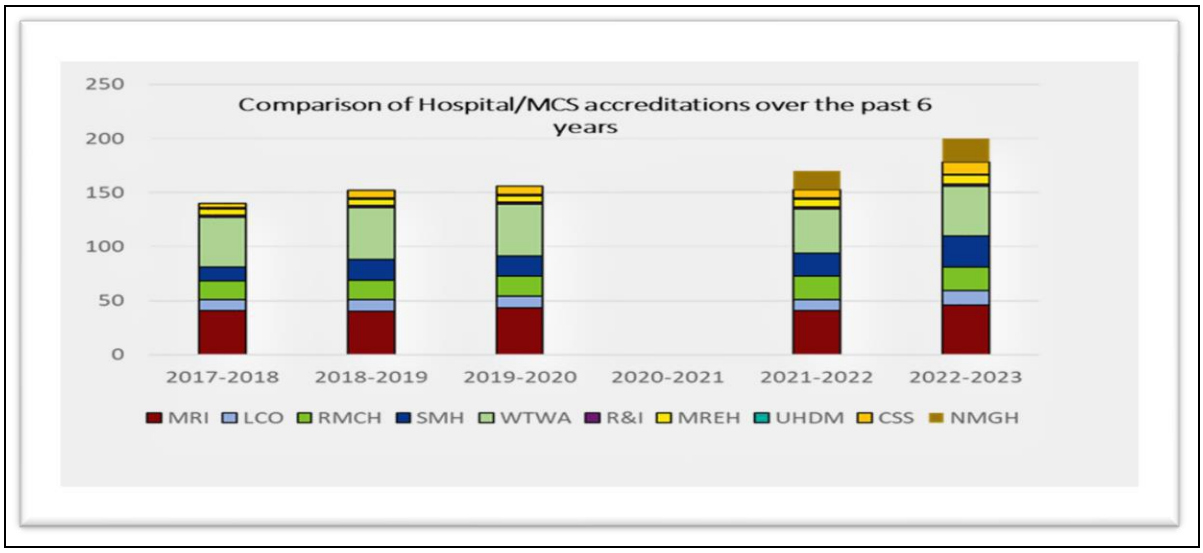
Each Accreditation undertaken, was led by a Head or Nursing / Midwifery, Deputy Director of Nursing or Director of Nursing / Midwifery.

After greater flexibility was realised following use of Microsoft Teams during the 2021 - 2022 programme, the Accreditation team continued to use the platform, to support the Accreditation process with data packs, communications and meetings.

The Accreditations completed represented areas from all Hospitals, Managed Clinical Services (MCS) and Local Care Organisations (LCO) including, adult and children's In-patient areas, Out-patient areas, Emergency Departments, Theatres and Community Locations.



Graph 17: The increase in Accreditations since 2011 (No Accreditations occurred in 2020 – 2021 due to the COVID-19 pandemic)



Graph 18: Demonstrates the comparison of Hospital / MCS/ LCO Accreditations over the last six years.

8.2. Accreditation Outcomes for 2022-2023

Of the 200 areas accredited, four areas were preliminary awarded a white score. Following their re-accreditation, the distribution of final awards demonstrated 58 areas (29%) achieved Bronze, 98 areas (49%) achieved Silver and 44 areas (22%) achieved Gold (**Table 23**).

	2022 – 2023 preliminary		2022 – 2023 Final	
	Number	Percentage	Number	Percentage
Gold	44	22%	44	22%
Silver	98	49%	98	49%
Bronze	54	27%	58	29%
White	4	2%	0	0%
Total	200	100%	200	100%

Table 23: The distribution of Bronze, Silver and Gold during the 2022-2023 Accreditation Programme

28 areas were accredited for the first time, 29 areas improved their award, 61 areas deteriorated in their award and 82 areas maintained the same award (**Table 24**). Further analysis can be found in the thematic analysis section which suggests concerns with leadership and safety being a reason for deterioration in overall scores.

Total 2022-23	
Number of areas that improved	29
Number of areas that deteriorated	61
Number of areas that stayed the same	82
Number of new areas	28

Table 24: The number of areas that improved, deteriorated, or maintained their Accreditation Award in 2022-23

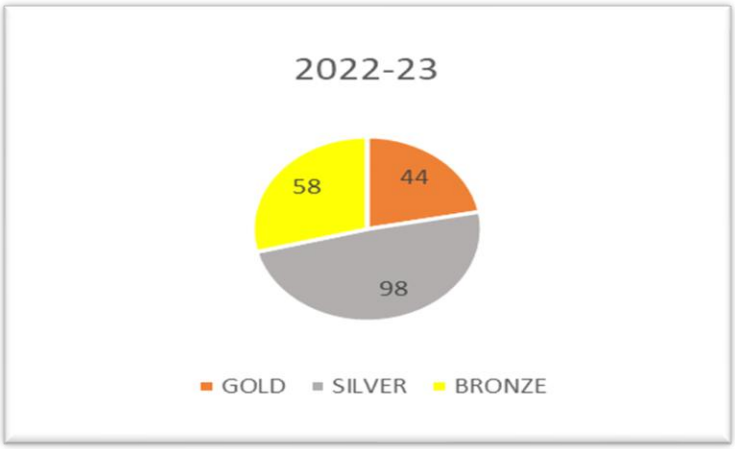
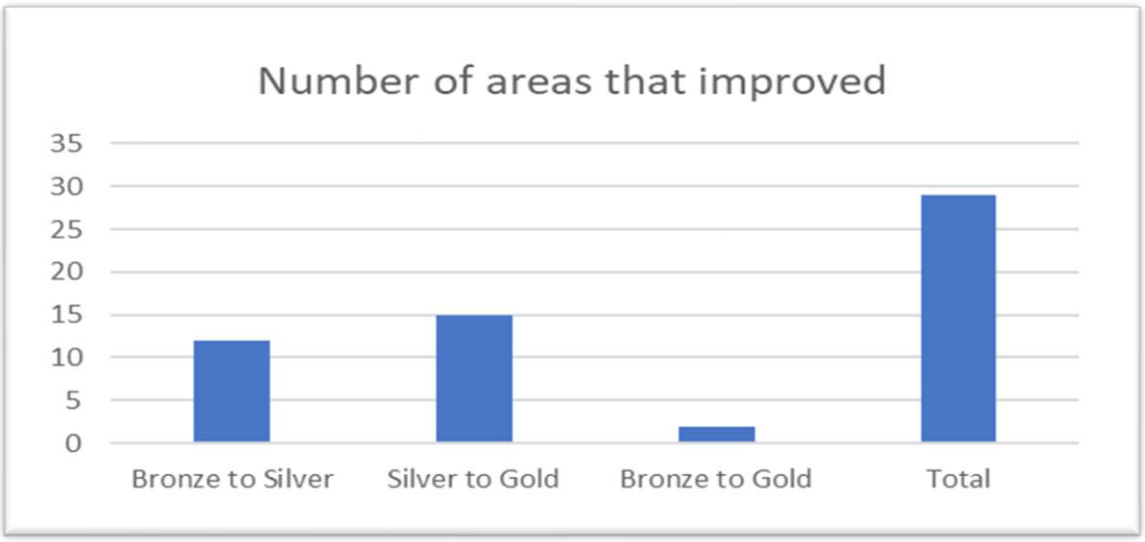


Chart 1: The distribution of bronze, silver and gold outcomes during the 2022-2023 Accreditation Programme

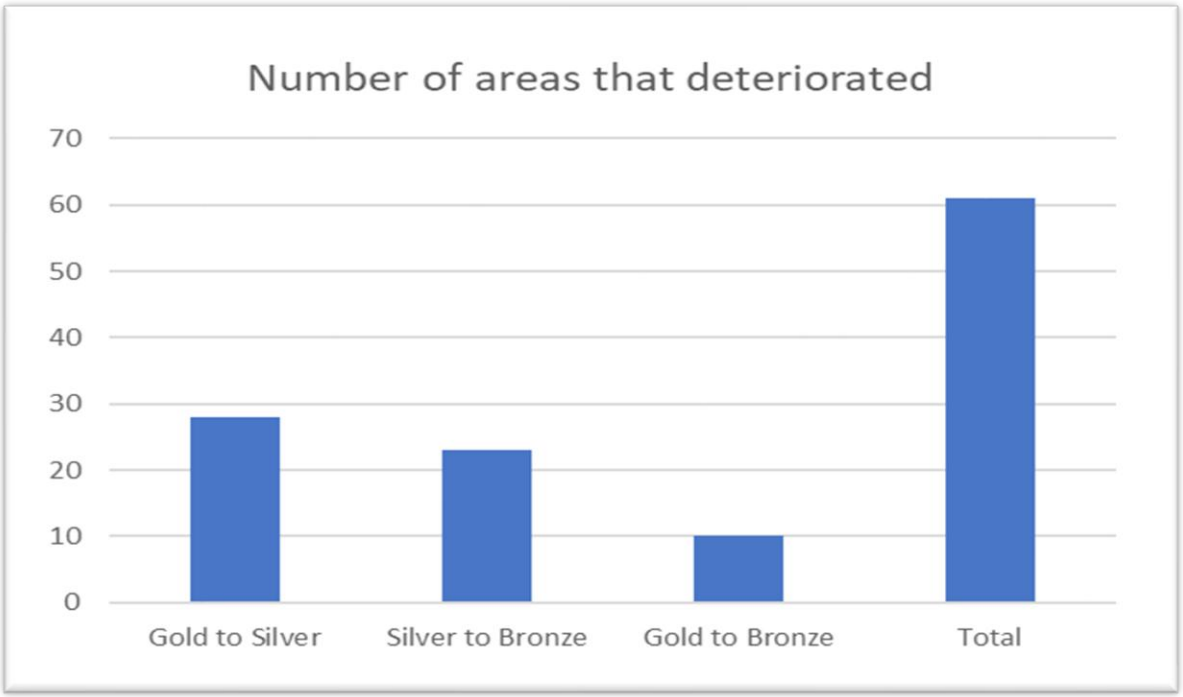
The number of areas that retained or improved their Accreditation Award was 111 (55.5%) compared with 115 (78%) in the 2021-2022 Accreditation Programme.

Of the 29 areas (14.5%) that improved, 12 areas (6%) improved their award from Bronze to Silver, 15 areas (7.5%) improved their award to from Silver to Gold and 2 areas (1%) improved their award from Bronze to Gold (**Graph 19**).



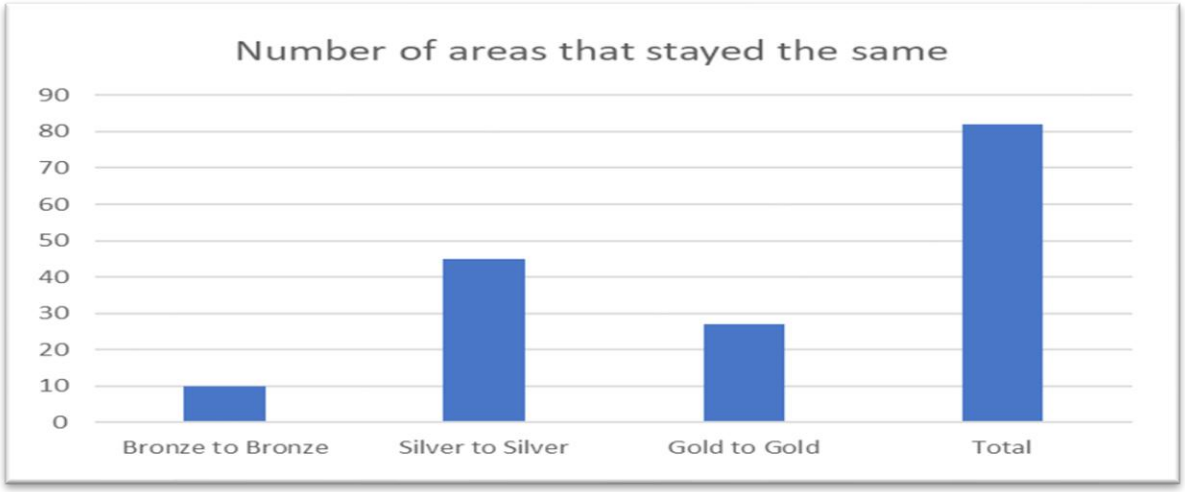
Graph 19: The shift in areas that improved their Accreditation Award 2022-2023**.**

Of the 61 areas (30.5%) that deteriorated, 28 areas (14%) showed a deterioration from Gold to Silver, 23 areas (11.5%) deteriorated from Silver to Bronze and 10 areas (5%) deteriorated from Gold to Bronze (**Graph 20**)



Graph 20: The shift in areas that deteriorated their Accreditation Award.

Of the 82 areas (41%) that maintained the same award as the previous year, 10 areas (5%) retained a Bronze, 45 areas (22.5%) retained a Silver Award, and 27 areas (13.5%) retained a gold award **(Graph 21).**



Graph 21: The proportion of areas that maintained their Accreditation Award 2022-2023.

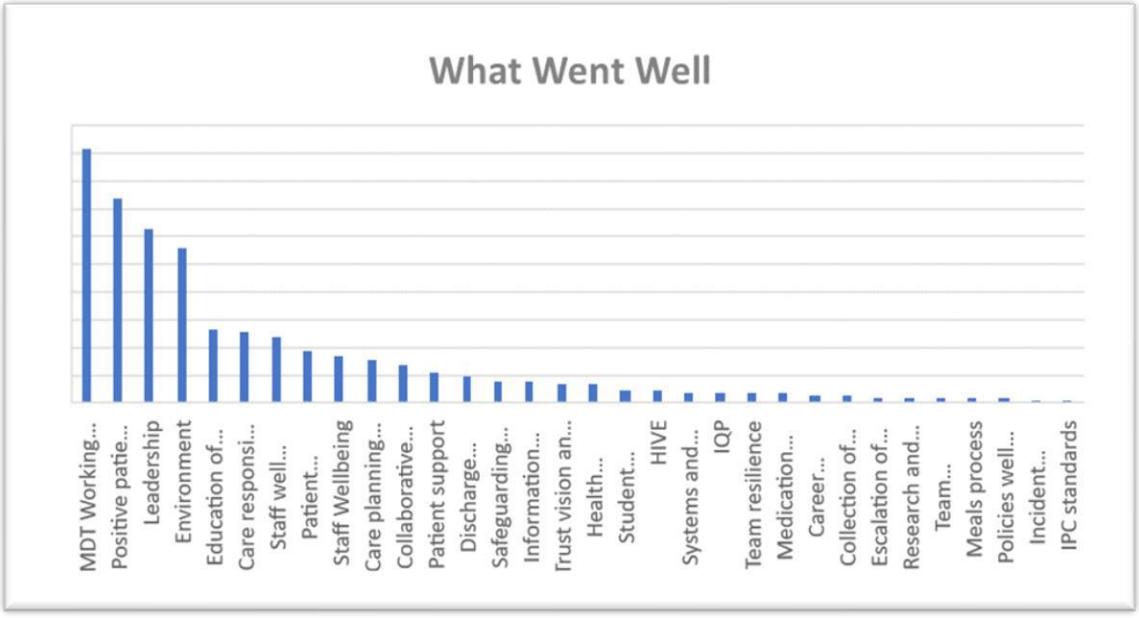
8.3. **Thematic Analysis of the findings of the 2022-23 Accreditation Programme**

Integral to the Accreditation process is the provision of initial feedback to the area being Accredited. At the end of the visit, the Accreditation team identify three areas of success and three areas for improvement. The aim of this is to celebrate what is going well and provide focus for areas of improvement.

Where appropriate, immediate actions may be identified during the visit in response to issues seen on the day that can be simply rectified or issues that relate to safety.

Themes of Areas of Success 2022-2023

From the 'areas of success' documented, thirty-two themes were recognised, with Multidisciplinary Team (MDT) working, positive patient feedback and leadership being identified as the three main area of success (**Graph 22**). Slightly different to the top three themes identified in 2021-2022: leadership, environment, and compassionate care.



Graph 22: Themes identified as Areas of Success in the Accreditation Programme 2022-2023.

88% of areas who demonstrated that the Trust's improvement methodology was embedded were awarded a gold score (**Table 24**)**.**

75% of areas who were awarded gold when "lessons are learned, and improvements made when things go wrong" in standard 5 of the Safe KLOE, were awarded gold overall (**Table 24**).

69% of areas who were awarded gold where "care is high quality and sustainable, this is reflected in the team's visions and values" in standard 1 of the Well Led KLOE were awarded gold overall (**Table 24**).

This is a direct opposite of the scores where an area was preliminarily given a white award.

KLOE	Standard	No of Golds awarded within standard	Gold score
Well Led Standard 5	The trusts' improvement methodology is embedded across the team	16	88%
Safe Standard 5	Lessons are learned and improvements made when things go wrong	36	75%
Well Led Standard 1	Care is high-quality and sustainable; this is reflected in the team's vision and values	62	69%

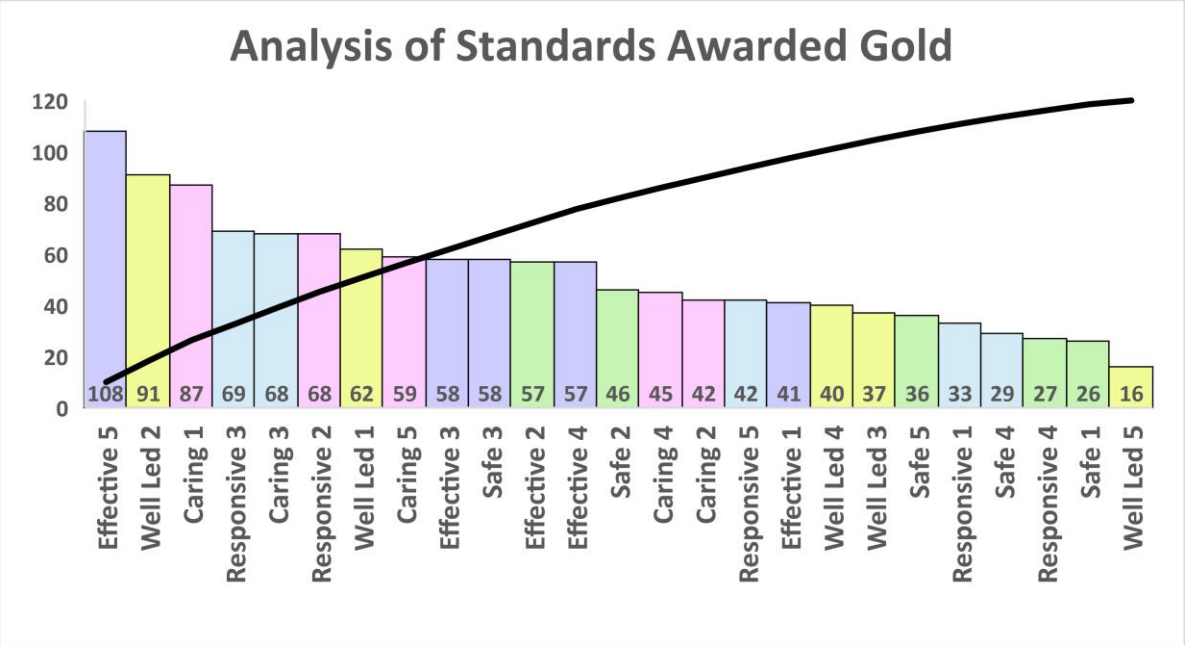
Table 24: The volume of golds awarded in a standard and the transition to a gold score**.**

	No of Golds	No of Silvers	No of Bronzes	No of Whites	Breakdown of standards receiving a 'white score'
'White' area 1	0	0	17	8	Caring standard 4 Responsive standard 4 **Well Led standard 1** Well Led standard 3 **Well Led standard 5** Safe standard 1, Safe standard 4, **Safe standard 5**
'White' area 2	0	0	20	5	**Well Led standard 1** Well Led 2 Well Led 3 Well Led 4 **Well Led standard 5**

'White' area 3	0	2	13	10	Responsive standard 3 **Well Led standard 1** Well Led standard 2 Well Led standard 3 Well Led standard 4 **Well Led standard 5** Safe standard 1 Safe standard 2 Safe standard 3 **Safe standard 5**
'White' area 4	0	4	17	4	Safe standard 1 Safe standard 2 Safe standard 3 Safe standard 4

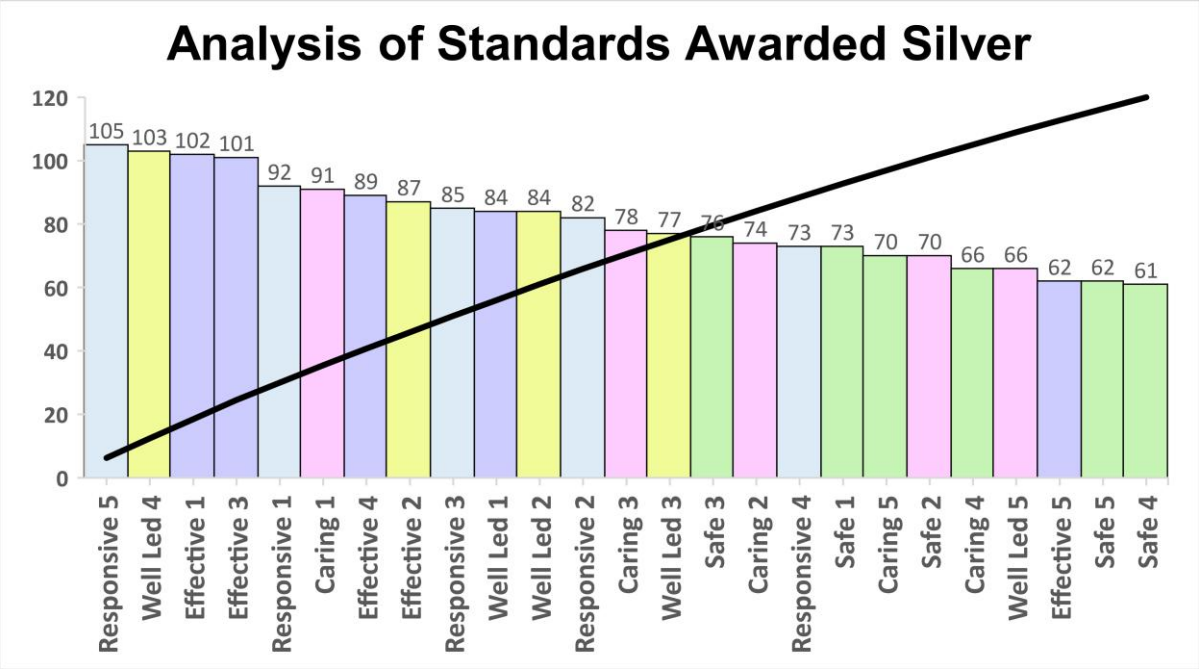
Table 25: The preliminary white areas, KLOE standards that were scored white highlighted in bold.

The three standards that were most frequently awarded a gold result were, 'Consent to care and treatment is sought in line with legislation and guidance' (Effective, standard 5), 'There is a positive team culture' (Well led, standard 2) and 'The service treats people with kindness, respect and compassion' (Caring, standard 1) (**Graph 23**).



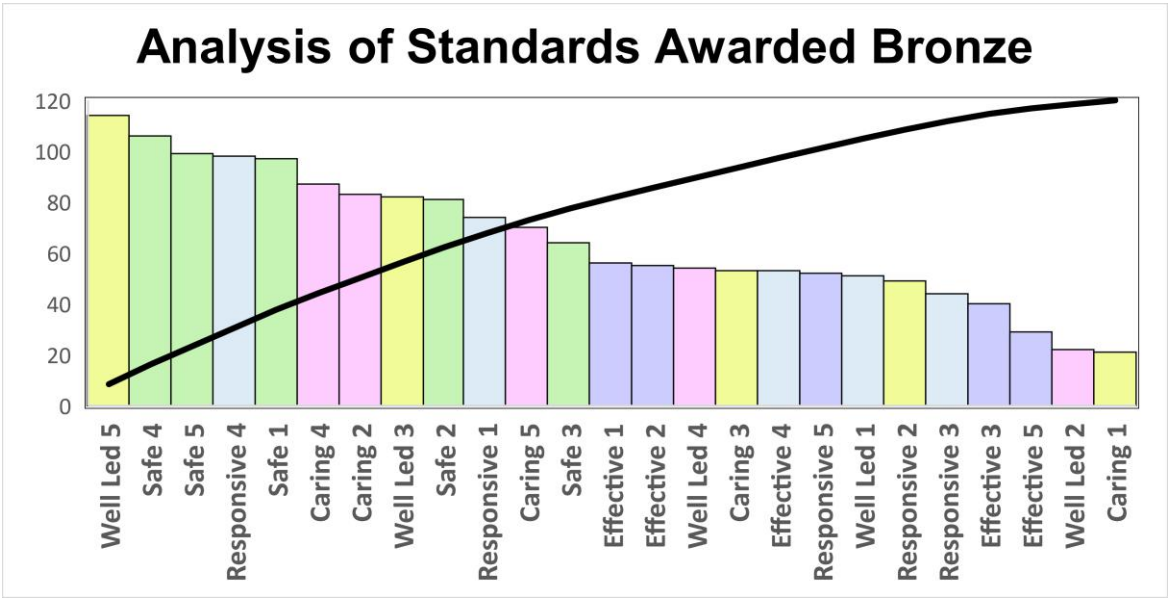
Graph 23: Number of golds awarded to each standard ranked in order.

The three standards that were most frequently awarded a silver result were, 'the service facilitates responsive communication' (Responsive, standard 5), 'Continuous professional development within the team' (Well led, standard 4) and 'People's care and treatment outcomes are assessed and monitored' (Effective, standard 1) (**Graph 24**).



Graph 24: Number of Silver awarded to each standard ranked in order.

The three standards that were most frequently awarded bronze were “Trust’s improvement methodology was embedded” (Well led, standard 5), “Medication is administered, monitored, and stored correctly) (Safe, standard 4) and “lessons are learned, and improvements made when things go wrong” (Safe, standard 5) (**Graph 25**).

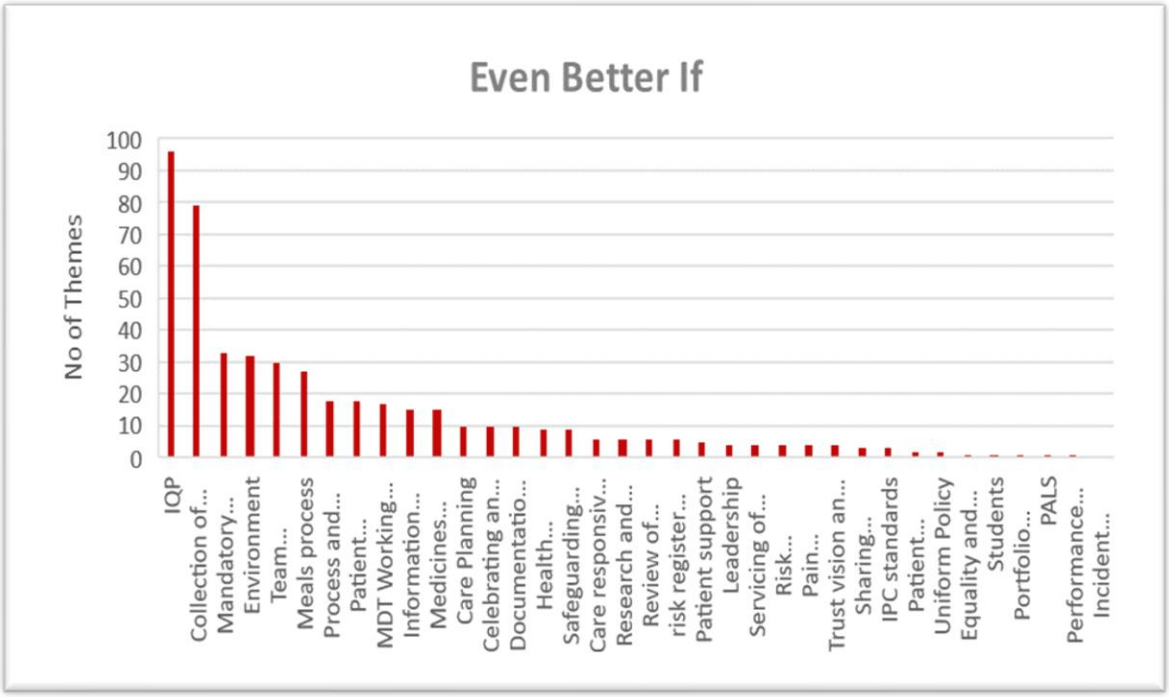


Graph 25: Number of Bronzes awarded to each standard ranked in order.

Themes of Areas for Improvement 2022-2023

The top three themes identified from the ‘areas for improvement’ documented, were implementing, and driving quality improvement, collection, and analysis of Quality Care Round (QCR) / What Matters to Me (WMTM) data and Mandatory Training compliance

(**Graph 26**). For reference the top three themes identified in 2021-2022 Patient feedback, documentation and feeding back to staff.

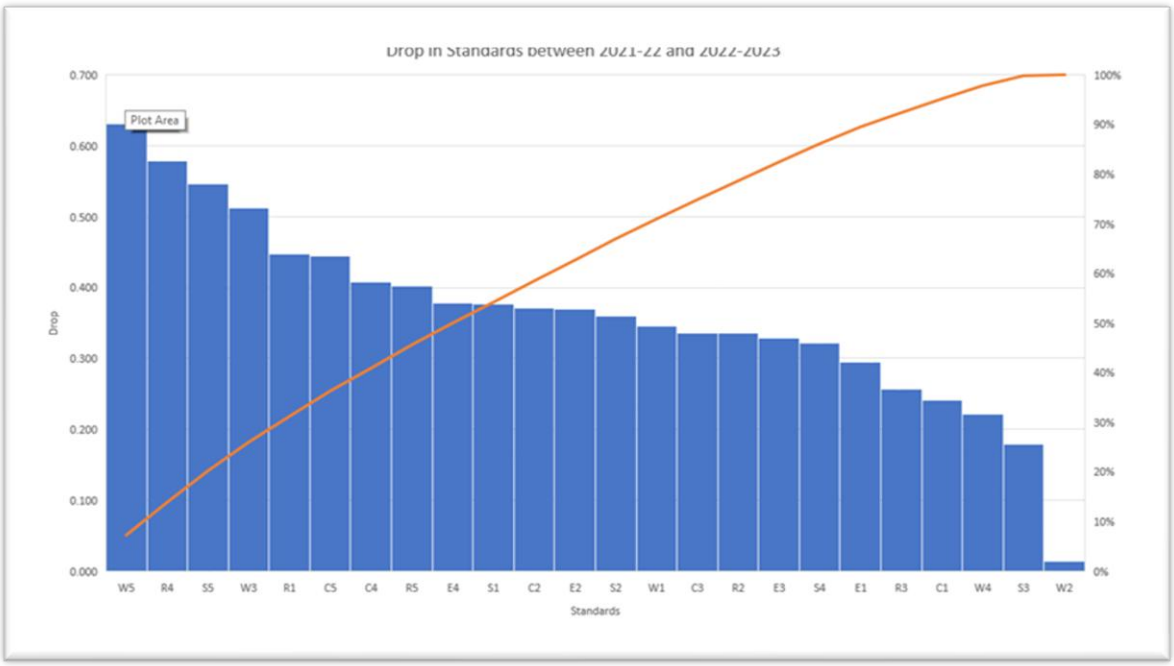


Graph 26: Themes identified as areas for improvement in the Accreditation Programme 2022-2023

During the 2022/23 accreditation process there has been a significant drop in many of the accreditation standards (**Graph 27**), Well led Standard 5 (IQP), Responsive standard 4 (people's complaints being listened to), Safe standard 5 (lessons learnt), Well Led standard 3 (managing risks and complaints) Responsive standard 1 (personalised care).

This correlates with the reduction in overall gold accreditation results during 2022/23 and the theory that Well Led standard 1,5 and Safe standard 5 are key factors in gaining an overall Gold accreditation result.

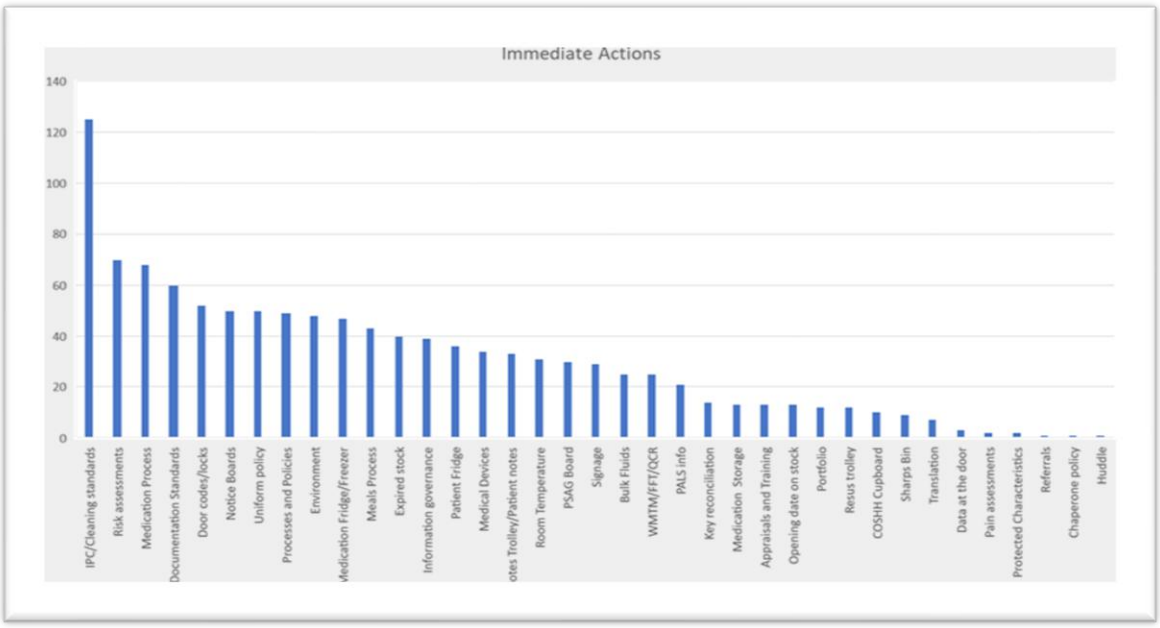
Conversely, there was only one standard that improved during the 2022/23 accreditations, Effective 5 (Consent sought for treatment). In addition, Well Led standard 2 (positive team culture) shows only a small drop in standards.



Graph 27: Demonstrates in order the KLOE standards that have dropped during the Accreditation Programme 2022-2023

Themes from Immediate Actions 2022-2023

During the Accreditation, actions identified that could be addressed immediately or within 72 hours were provided in the form of an immediate action plan. The top three immediate action themes were, Infection Prevention Control (IPC) / Cleaning standards not being adhered too, risk assessments not being completed or updated and medication processes not following trust standards (**Graph 28**). For reference the top three themes identified in 2021-2022 were meals process, environment cleanliness and incomplete documentation.



Graph 28: Demonstrates the themes identified as Immediate Actions in the Accreditation Programme 2022-2023.

8.4. Overview of White Wards

A white area indicates the area accredited is not achieving minimum standards and has no identifiable evidence of active improvement within one or more standards. During the Accreditation process, four areas received a preliminary white score, at Wythenshawe Hospital, MRI, and two at NMGH.

As per MFTs Standard operation Policy (Manchester University NHS Foundation Trust (MFT) Accreditation Standard Operating Procedure 2022/2023), any area identified as 'White' will receive an appropriate package of support and be reassessed no later than six months.

Within each of the four areas, thematic analysis of the domains where white was identified, were across 'Well Led' and 'Safety'.

In the 'Well Led' domain, the themes identified were leadership, team culture, process for managing risk and performance, and no continuous improvement identified or implemented.

Within the 'Safety' domain, themes identified were, safe storage and administration of medication, identification of lessons learned, and improvement work implemented.

Along with the hospital based quality improvement team, each area received support from the Corporate Quality Improvement team, and a bespoke action plan was developed based on the findings during the accreditation. Action plans were developed by the areas senior team around the key themes of well led and safety.

Regular meetings and visits to the areas were conducted by both hospital and corporate teams, to offer support and assist with localised action plans.

Each area was re-accredited within six months and showed significant improvement within the areas that had been identified, and each were awarded a Bronze as a final outcome.

8.5. Challenges of 2022-2023 Accreditation Programme

In response to the increase in the volume of Accreditations to be undertaken, and the volume that were postponed in 2021-2022 due to members of the team being unavailable, Matrons were added to the rota.

To mitigate any variation and subjectivity, the QI team undertook a rigorous process of standardising the narrative which was given prior to an Accreditation being undertaken. The QI team also provided additional training for members of the team who were underconfident or new to the process. Furthermore, the validation meetings were often extended to ensure the right information was sought to ensure the correct outcome was awarded in line with other areas.

It was also noted during the Clinical Accreditation process that following the COVID pandemic, implementation of the CIVICA platform for collecting QCR, WMTM and FFT, and the implementation of HIVE, many areas were collecting very little or no data from patient feedback which made evidencing improvements to areas subjective.

Due to variable Wi-Fi connectivity, the introduction of iPads to complete the Accreditation documentation presented a challenge during the 2021-2022 programme. This continued to present challenges; therefore, the Accreditation teams were encouraged to use their Trust laptops to complete documentation on the day of Accreditation.

The implementation of HIVE in September 2022 saw the Clinical Accreditation Programme pause for six weeks to allow all areas time to adapt to a new way of working. This saw an increase in Accreditations at the beginning of the year to ensure the programme was completed on time and with a degree of consistency.

After the launch of HIVE, additional time was required for education to understand how technology could complement the Accreditation process. It was identified that additional time was required during Accreditations to assess documentation compliance within the system e.g., care plans, risk assessments and flow sheets.

The patient experience platform, CIVICA, was launched in April 2022 for the completion of QCR, WMTM and FFT. Due to issues within the external platform, areas who undertook the surveys were unable to view and display data until July 2022. This presented a challenge as teams struggled to obtain data to drive improvement work based on the Trust minimum target of 85%.

8.6. Validation

Validation is an integral part of the Clinical Accreditation process in ensuring consistency of results awarded. The meetings are chaired by the Corporate Director of Nursing for Quality and Patient Experience, the Deputy Chief Nurse or Corporate Director of Nursing for Workforce and Education.

All preliminary validations were completed by February 2023, and the final validation following a re-accreditation occurred on the 23 May 2023.

There was an average of twenty-three days from the Clinical Accreditation to validation, which is a variance of nine days from the recommended time within the SOP which is fourteen days.

On average, areas received their accreditation result within three days of the validation.

The overall timeframe from Clinical Accreditation to areas receiving feedback was 66 days compared to the recommendation of 28 days (**Table 26**).

	SOP Standard	Average number of days	Met the SOP Standard
Accreditation to Validation	14	23	34.8%
Validation to area receiving their result	14	3	94.5%
Accreditation to Area receiving Feedback	28	45	19.4%

Table 26: Demonstrates the time taken from Accreditation to validation to feedback in relation to the SOP.

To ensure consistency of outcomes, many validation sessions exceeded their allocated time. This resulted in sessions exceeding their allocated timeslot and areas being postponed.

Sessions that were postponed were rescheduled to a later date, thus impacting on time taken for areas to receive their feedback. (**Table 27)**

Issue	Number of times
Ran out of time	11
Technical issues	4
Not enough narrative	3
Not quorate (i.e., illness/annual leave unaware of)	4
TOTAL	22

Table 27: Demonstrates reasons for validations being adjourned.

8.7. Review of the Accreditation process

Engagement

Utilising Improving Quality Programme (IQP) methodology, the Corporate Nursing and QI Team, reviewed the 2022-2023 Clinical Accreditation process based on observations and feedback from numerous stakeholders.

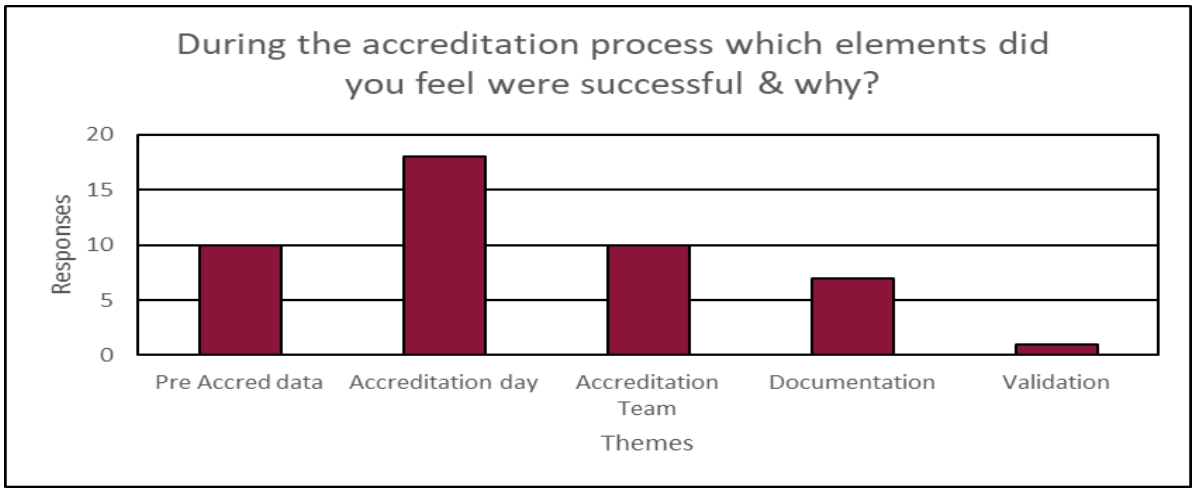
The QI Team used a survey monkey to engage further with subject matter experts and all members of the Accreditation team to gain further feedback on their experience and areas for improvement.

Key themes indicate that Clinical Accreditation teams valued the Accreditation visit and narrative being completed on the same day. Additionally, feedback gained suggested Accreditation teams valued the expert knowledge provided by the structure of the teams and the support that was provided by the QI team and the data being available prior to the Accreditation (**Graph 29 & 30**).

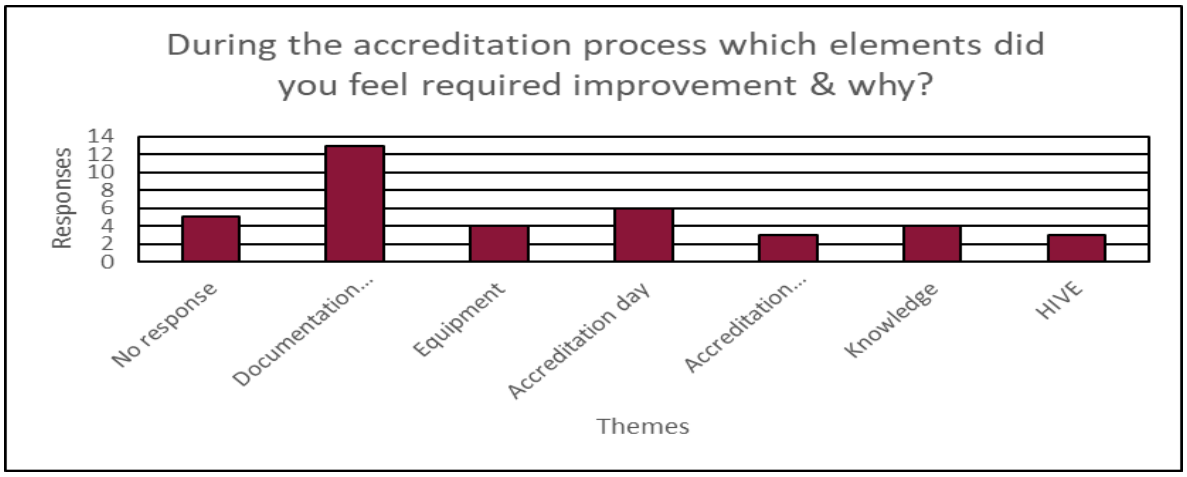
The QI team also visited wards and asked a variety of patients what they felt would be appropriate for the teams to focus on during Clinical Accreditations.

Stakeholder engagement sessions took place with subject matter experts to ensure all specialities were represented.

8.8. Clinical Accreditation Stakeholder Feedback Themes



Graph 29: Demonstrates feedback gained from stakeholders



Graph 30: Demonstrates feedback gained from stakeholders

The QI team worked with the HIVE team to understand how the system can best support the Accreditation process with relevant dashboards for the team to use during Accreditations.

The Corporate Director of Nursing for Quality and Patient Experience met with Directors of Nursing and Midwifery across the Trust to receive feedback and recommendations based on experiences.

In February 2023, the Chief Nurse held a session facilitated by the Corporate Director of Nursing for Quality and Patient Experience and Head of Nursing for Quality and Patient Experience, and supported by the Chief Nursing Informatics Officer and the Digital NMAHP Team to explore areas of success and drill down into further areas for improvement. During the session, next steps were discussed to offer stakeholders the opportunity to contribute to the 2023-2024 programme based on their experiences.

Considering the expanding programme and the feedback received, Directors of Nursing and Midwifery were asked to review their areas to decide which areas should be Accredited, which areas could be merged, and which required a different approach to provide assurance.

Wordle 1. Demonstrates the key themes generated from the survey monkey sent to members of the 2022-2023 Accreditation team. “During the Accreditation process which elements did you feel were successful and what areas were unsuccessful and why?”.

8.9. Changes to the Clinical Accreditation Programme

Following analysis of the data obtained from all participating stakeholders and the introduction of HIVE, changes were made to the Accreditation process in readiness for the 2023-2024 Accreditation Programme

The QI team reviewed and revised the documentation to ensure it was less subjective, less repetitive, more patient centred and incorporated data.

It was agreed in Professional Board that in-patient and outpatient areas would continue to be part of the Accreditation Programme. However due to the growing volume of areas being added into the programme, and in recognition of the different operating hours, standards and expectations, it was agreed that out-patient areas would receive a ‘Quality Assurance Review’. The Quality Assurance Review process is still being developed with key stakeholders to ensure equity and that it provides the correct oversight of assurance.

In line with MFTs services evolving and becoming single site or merged teams, a number of areas have been amalgamated.

A pilot of the updated paperwork and standards was undertaken by the QI team on a variety of wards within different Hospitals and MCSs to ensure the scoring system was effective, standardised and that sufficient time was allowed to complete the paperwork during the day.

The Accreditation SOP was updated to reflect the changes made to the Accreditation process.

Following agreement from each Director of Nursing / Midwifery, 139 Accreditations will be undertaken within the 2023-2024 Accreditation Programme. This will encompass 171 of the previous areas following amalgamation in line with service delivery.

There are currently 45 areas identified to receive a Quality Assurance Review which will be confirmed in line with the co-design of the process.

Table 28 summarises the changes implemented following review of the 2022-2023 Accreditation Programme.

Process	Change
Rota	• Staff were able to submit their availabilities for the 2023-2024 rota via a Microsoft Teams channel to provide visibility for teams to co-ordinate. • It was agreed that all dates required out of those provided would be release for the year opposed to month-on-month. • Two rotas were introduced to split Accreditations from Quality Assurance Review
Accreditation Team	• The core number of each team will be a minimum of four unless visiting a larger area. • Accreditations will be led by Assistant Chief Nurse, Deputy Directors of Nursing and Directors of Nursing and Midwifery. • Heads of Nursing or Lead Nurses will form part of the team. • Every Accreditation will have a Quality Improvement Manager. • Matrons will be included in the team where necessary as subject matter experts. • Notification of the location of an Accreditation and the team composition will be provided 24 hours before the visit.
Documentation	• Accreditation prompts were reviewed to reduce subjectivity. • Access to data on a Microsoft Teams channel is available 24 hours prior to the planned Accreditation to support timely review by the team member before the planned visit. • A HIVE Accreditation dashboard has been introduced to support the team on the day.
Education & Training	• New staff will be given the opportunity to shadow an Accreditation before becoming a full member of the team.

Table 28: Summary of the changes implemented following review of the 2022-23 Accreditation Programme.

The analysis of the 2022-2023 Accreditation outcomes has provided an overview on where to focus support for teaching and training.

The QI Team are currently working with the Organisational Development team to develop a Continuing Professional Development (CPD) accredited e-learning IQP package. This will enable a wider audience to access training at a time more convenient to the learner. The learning package will be a valuable resource for new people to the Trust as well as the wider MDT such as AHPs and clinicians and to further embed the Trust's methodology.

The QI Team have linked with Quality leads across the Hospitals / MCS and LCOs to be able to offer support and the introduction of an Operational Quality Leads Forum has facilitated collaborative working.

White Areas

In response to the learning from areas having a preliminary score of white, a White Ward Support Package has been developed. This package is included in the SOP to provide assurance to the Board that areas performing below the expected standard are supported by their Hospital/MCS/LCO as well as the Corporate Nursing Team.

Planning for 2023/24

- In response to the data suggesting that there is a clear correlation between the knowledge of IQP methodology, leadership, and the Accreditation outcome, the IQP team plan to continue to deliver IQP training to wards and departments to ensure the methodology is disseminated to address areas for improvement identified during the programme.
- The QI Team will address accreditation themes, in Bee Brilliant and bespoke IQP training to empower staff to undertake quality improvement projects to address the themes.
- The QI Team plan to collaborate with Professional Practice and Patient Experience teams to address themes and triangulate the approach to quality improvement.
- In addition to identifying areas for improvement, the Accreditation Programme offers opportunities to celebrate and share success in the form of "Sparkles of excellence" to highlight areas of exemplary practice.

8.10. **Summary**

The Clinical Accreditation Programme for 2022-2023 successfully reviewed 200 clinical areas amidst the challenges of the launch of HIVE Go Live and COVID.

The Accreditation programme has built on the successes of previous years, with the introduction of a robust scoring mechanism to ensure consistent and standardised scoring throughout.

In total, of the 200 areas accredited, 111 (55.5%) retained or improved their score from the previous assessment. 28 (14%) areas were accredited for the first time, providing a baseline for future success.

Extensive stakeholder engagement during the 2022-2023 programme has further developed the Accreditation Programme going forward into 2023-2024. Thus providing the Trust Board with an effective quality assurance mechanism, whilst also providing a vehicle for continued service improvement.

Section 9

9. Improving Quality Programme (IQP)

The Improving Quality Programme (IQP) is MFT's methodology for continuous improvement and has been an embedded improvement methodology across MFT and legacy CMFT since 2011. It is designed to empower staff to make local improvements based on their quality metrics and WMTM patient feedback data. IQP teaches staff to identify areas of concern on which to focus their improvements, align these to current best practice, evidenced based, and implement change.

The IQP methodology teaches staff to follow a structured approach using a problem identification tool (SUDA) designed and developed by MFT, followed by the Model for Improvement to ensure that changes are evidence based, measurable, embedded and sustained in practice.

IQP enables teams to improve their ward environment and processes, which is intended to 'release time', that can be reinvested in improving quality, safety, and the patient experience.

The Quality Improvement team teach and deliver the IQP methodology in different formats and forums including masterclasses, staff away days, team training days, action learning sets, one to one's and full roll outs across MFT.

The Quality Improvement team delivered 482 IQP training sessions during 2022/2023. This involved many different sessions with all grades of staff.

Following the 2021-22 accreditation feedback it was recognised that well led standard 5 continuous improvement and the use of the IQP methodology was predominantly scored Bronze. In response to this the Quality Improvement team designed and planned IQP training to educate and train staff on quality improvement across MFT.

Directors of Nursing/Midwifery, Deputy Directors of Nursing requested direction of training towards band 7/ team leaders initially due to the increased number in position which may not have received IQP training previously.

IQP relaunched in November 2022, training commenced with band 7/team leaders, 138 band 7/team leaders were trained across MFT**.**

Following the initial Band 7/team leader invitations to training, the invitation to the IQP training was opened to all staff.

In recognition of staff roles changing and many new ward managers/team leaders a new Portfolio training guide has been developed via an audio PowerPoint, providing staff with valuable advice and guidance on the portfolio content and expectations. For ease of access this has been provided in an MS Teams folder and sent to all matrons to ensure

matrons are familiar with these expectations and can signpost their new staff towards the training.

The Quality Improvement Team have provided useful advice and liaised with team working on projects such as Well Organised Area, Meals Process and Medication Administration. Electronic Resource Files (ERF) can be provided by the team to display and disseminate project findings and ultimately improvements.

9.1. **Future Plans 2023/24**

- The analysis of the 2022-23 Accreditation outcomes has provided an overview on where to focus support for teaching and training.
- To review accreditation feedback data monthly to understand themes and areas of focus for education and training.
- The QI team will be developing bespoke training in areas identified by triangulation of data from accreditations and themes from immediate actions and What Matters to Me data.
- The QI team will commence IQP clinics to support staff with quality improvement projects, IQP and the development of Electronic Resource Files (ERF) to evidence improvement projects.
- The QI Team continue to work with the trust's Organisational, Development and Training (OD&T) to develop a Continuing Professional Development (CPD) accredited e-learning IQP package which will enable a wider audience to access training at a time more convenient to the learner. This package once developed will be a pre-requisite to attendance at a 'Quality Clinic' where staff will be able to explore their QI project with a QI Manager.
- The QI Team continues to connect and work with the Quality leads across the Hospitals/MCSs and LCO to offer support and work collaboratively to improve patient care and identify areas in need of extra support.
- The QI Team will continue to link with teams within Corporate Patient Services, particularly Professional Practice and the Patient Experience Team to support and triangulate the services we provide to staff including education and training.
- The QI team have recently connected with the Sustainability team to promote sustainability in improvement work and plan to include this in future masterclasses for staff recognition and understanding of the Trusts Net Zero plan and how improvements can help to deliver this.

9.2. **Improving Quality Programme (IQP) and Accreditation 12 Week Support Programme for NMGH**

A request for additional IQP support for NMGH by the Director of Nursing was agreed in January 2023 and additional capacity from Group Corporate Nursing and Patient Services was identified.

In collaboration with the Senior team at NMGH, the following was agreed to support 23 in-patient wards to further embed IQP:

- Develop a 12-week ward-based support programme for Matrons and Ward Managers and their ward teams to further embed IQP Methodology as part of their continuous improvement journey.
- To ensure fundamentals of care are embedded; improve the patient experience of care and improve overall accreditation scores over time.

- Increase the number of WMTM and FFT surveys and improve the data analysis expertise of staff using CIVICA, the trust's Patient Experience platform.
- Build sustainability into the programme by involving Matrons in the training from the start.
- Defining the Matron role and responsibility in supporting Ward Managers and their team to sustain momentum, continue to embed IQP and improve Ward Accreditation scores.
- Provide access to tools, resources and guidance by developing an IQP and Accreditation Resources Toolkit.
- Increase the understanding of the Key Lines of Enquiry (KLOE), Accreditation standards which are based on Care Quality Commission's (CQC) domains and provide examples of what Gold Accreditation standards look like.

Evaluation of programme

There has been a significant pace of change that NMGH staff have embraced since merging with MFT in April 2021. Amid COVID-19, the challenges to align MFT policy and practice and the massive success implementing the digital Hive system as well as introducing front line staff to the IQP and Accreditation process.

Section 10

10. Hospital/MCS/LCO specific Patient Experience Improvement Activity

Each Hospital/MCS/LCO have provided an overview of their patient experience and quality improvement activity in 2022/23 to include in the Annual Patient Experience Board Report 2022/23. The Appendices provide many examples of improvement work, undertaken across the organisation to improve patient experience.

Section 11

11. Governance: Monitoring and Assurance

Professional forums and operational groups are in place to monitor the actions described through this report. These include:

Quality and Patient Experience Forum (sub-group of Professional Board)
Each Hospital/MCS/LCO feeds into the Quality and Patient Experience Forum, which is constituted as a sub-group of the Professional Board, to set the strategic direction for patient experience for the nursing, midwifery and AHP workforce. The overall purpose of the group is to provide the corporate strategic direction in relation to quality and patient experience, ensuring patients and families are at the core of all we do. This forum supports the collaboration of services, shares best practice, and provides a clear link to triangulate themes across the Trust. Reports are received to demonstrate the delivery of the Improving Quality
Programme and "**What Matters to Me**" Framework

MFT Complaints Review Scrutiny Group

In addition to this the MFT Complaints Review Scrutiny Group, which is chaired by the Corporate Director of Nursing for Quality and Patient Experience. The main purpose of the group is to review the Trust's complaints processes in a systematic and detailed way to ascertain what can be learnt about the overall quality of complaints management and to indicate changes that might lead to future improvements in the management of

complaints within the Trust. This will enhance the Hospital/MCS/LCO performance and improve patient experience.

Hospital/MCS/LCO local quality structures
All hospitals/MCS/LCOs have established quality governance structures, which report to the Group Quality and Safety Committee. It is important that local performance continues to be monitored and addressed through these routes.

Section 12

12. Summary

Underpinning this report is the wealth of national, organisational and local patient experience feedback, including incidents and complaints captured during 2022/23, allows for the triangulation of the results for key questions contained within the National Adult Inpatient Survey (2021) with the Trust's local 'What Matters to Me' Patient Experience and FFT survey results. The findings inform improvement activity at both strategic and local levels.

Key areas where improvements are required have been identified, and improvement plans are underway within Hospitals/MCS's/LCO and are presented at Section 14 of this report.

Examples of 'What Matters to Me' initiatives across MFT have demonstrated how the Trust continues to focus on delivering a personalised approach to care.

The Trust will continue to focus on further improving patient communication and ensure it actively listens and acts on feedback provided.

A framework for continuous improvement, informed by external and internal patient experience feedback, continues to be is embedded across the Trust, supported by MFT Improving Quality Programme (IQP) methodology and monitored through the Trust's clinical accreditation programme.

Section 13

13. Recommendations

The Board of Directors is asked to note the content of this report, recognise the achievements during 2022/23 and continue to support and prioritise the Trust's WMTM patient experience work programme.

Section 14 Appendices

Appendix 1

Adult National Inpatient Survey 2021

Comparison of hospital score against overall MFT score. If fewer than 30 responses were received an asterix (*) is shown.

Question	Trust Score 2020	Trust Score 2021	MRI	Wyth	NMGH
Admission to Hospital					
Q2. How did you feel about the length of time you were on the waiting list before your admission to hospital?	8.2	7.1	*	6.5	*
Q3. How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital?	7.2	6.4	5.9	6.7	5.0
The Hospital and Ward					
Q4. Did you get help from staff to keep in touch with your family and friends?	7.7	7.6	6.8	7.8	8.1
Q5. Were you ever prevented from sleeping at night by noise from other patients?	6.3	5.6	5.2	5.8	5.9
Q5. Were you ever prevented from sleeping at night by noise from staff?	8.1	8.1	7.9	8.0	7.9
Q5. Were you prevented from sleeping at night by hospital lighting?	8.7	8.1	8.7	7.9	8.1
Q7. Did the hospital staff explain the reasons for changing wards during the night in a way you could understand?	6.7	6.1	4.9	*	*
Q8. How clean was the hospital room or ward that you were in?	8.9	8.9	8.7	8.9	9.1
Q9. Did you get enough help form staff to wash or keep yourself clean?	8.2	7.6	7.4	7.4	7.9
Q10. If you brought medication with you to hospital, were you able to take it when you needed to?	8.3	8.1	7.6	8.4	7.7
Q11. Were you offered food that met any dietary needs or requirements you had?	7.7	7.8	7.3	7.9	*
Q12. How would you rate the hospital food?	6.2	6.5	6.3	6.2	6.9
Q13. Did you get enough help from staff to eat your meals?	7.2	7.3	6.9	7.3	*
Q14. Were you able to get hospital food outside of set mealtimes?	*	5.4	4.7	5.7	*
Q15. During your time in hospital, did you get enough to drink?	9.5	9.1	8.9	9.1	9.5

Doctors					
Q16. When you asked doctors questions, did you get answers you could understand?	9.0	8.7	8.4	8.9	8.0
Q17. Did you have confidence and trust in the doctors treating you?	9.3	8.9	8.5	9.1	9.0
Q18. When doctors spoke about your care in front of you, were you included in conversations?	8.8	8.3	8.1	8.5	7.9
Nurses					
Q19. When you asked nurses questions, did you get answers you could understand?	8.8	8.5	8.2	8.5	9.1
Q20. Did you have confidence and trust in the nurses treating you?	9.0	8.7	8.5	8.6	9.1
Q21. When nurses spoke about your care in front of you, were you included in the conversation?	8.8	8.4	8.2	8.4	8.4
Q22. In your opinion, were there enough nurses on duty to care for you in hospital?	7.8	7.3	6.5	7.2	7.6
Your Care and Treatment					
Q23. Thinking about your care and treatment, were you told something by a member of staff that was different to what you had been told by another member of staff?	7.9	7.7	7.1	7.6	8.7
Q24. To what extent did staff looking after you involve you in decisions about your care and treatment?	7.3	7.1	7.0	6.9	6.9
Q25. How much information about your condition or treatment was given to you?	9.2	8.8	8.8	8.8	8.4
Q26. Did you feel able to talk to members of hospital about your worries and fears?	7.7	7.4	7.3	7.3	8.0
Q27. Were you able to discuss your condition or treatment with hospital staff without being overheard?	6.9	6.2	5.7	6.5	7.0
Q28. Were you given enough privacy when being examined or treated?	9.6	9.3	9.2	9.4	9.3
Q29. Do you think the hospital staff did everything they could to help you control your pain?	8.9	8.5	8.5	8.5	8.6
Q30. Were you able to get a member of staff to help you when you needed attention?	8.2	7.9	7.7	7.7	8.5
Operations and Procedures					
Q32. Beforehand, how well did hospital staff answer your questions about the operations or procedures?	9.0	9.0	8.6	9.0	*

Q33. Beforehand, how well did hospital staff explain how you might feel after you had the operations or procedures?	7.8	7.6	7.0	7.7	*
Q34. After the operations or procedures, how well did hospital staff explain how the operation or procedure went?	8.3	7.3	6.9	7.3	*
Leaving Hospital					
Q35. To what extent did staff involve you in decisions about you leaving hospital?	7.2	6.8	6.3	6.9	7.1
Q36. To what extent did hospital staff take your family or home situation into account when planning for you to leave hospital?	7.2	7.2	6.7	7.3	7.6
Q37. Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital?	7.9	8.0	8.4	8.0	*
Q38. Were you given enough notice about when you were going to leave hospital?	7.1	6.9	6.6	7.0	6.8
Q39. Before you left hospital, were you given any information about what you should or should not do after leaving hospital?	6.6	7.6	6.5	7.8	7.7
Q40. To what extent did you understand the information you were given about what you should or should not do after leaving hospital?	*	8.8	8.8	8.9	8.9
Q41. Thinking about any medicine you were to take at home were you given any of the following?	4.6	4.6	4.4	4.5	4.5
Q42. Before you left hospital, did you know what would happen next with your care?	6.6	6.2	5.7	6.3	6.3
Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	7.7	7.4	7.1	7.5	7.6
Q44. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	8.6	7.7	8.0	7.3	7.9
Q46. After leaving hospital, did you get enough support from health or social care services to help you recover or manage your condition?	6.6	5.9	5.6	5.4	*
Feedback on Care					
Q49. During your hospital stay, were you ever asked to give your views on the quality of your care?	1.4	1.9	1.9	2.1	1.1
Respect and Dignity					
Q47. Overall, did you feel you were treated with respect and dignity while you were in the hospital?	9.2	8.9	8.6	9.0	9.1

Overall Experience					
Q48. Overall, how was your experience while you were in the hospital?	8.2	7.9	7.5	7.9	8.0

Table 29: Survey Questions by Trust and site-specific scores for 2021

Appendix 2

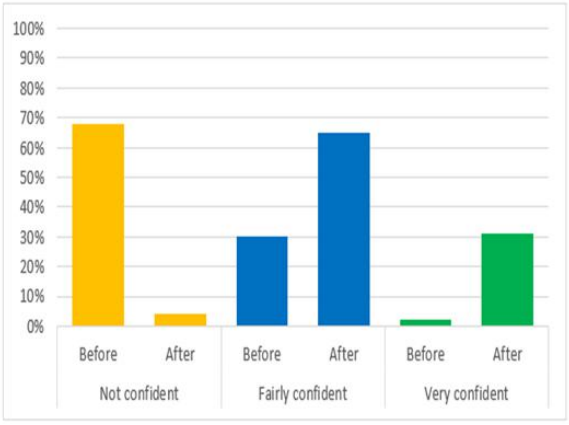
Wythenshawe, Trafford, Withington, and Altrincham (WTWA)

A monthly Patient Experience report has been developed by the WTWA Matron for Quality Improvement and Patient Experience to provide a progress update for WTWA on aspects of quality and patient experience (QCR, WMTM, FFT). The report identifies key areas of success, priorities for further development and shared learning as well as providing clear visibility of divisional data for the WTWA Heads of Nursing.

The WTWA IQP Masterclass Programme commenced in August 2022 for nursing colleagues. In January 2023, the invite was extended to all nursing, allied health care professional, and administrative and clerical colleagues across WTWA, with the aim of improving the confidence levels of participants in utilising:

- The Sense, Understanding, Define, Action (SUDA) problem defining tool
- The Plan, Do, Study, Act (PSDA) improvement methodology
- Data to measure improvement

During the 2022/23 financial year, 23 WTWA IQP Masterclasses have been facilitated across WTWA with 185 participants attending overall. Participants have engaged from teams across all the WTWA divisions. Session evaluation data is collected to support regular review and improvement of programme content. In Quarter 4 2022/23 the Masterclass format was refreshed to include group work related to 'what data can be used'.



Well Structured With Good Information.
Content, Easy Going With Time To Ask Questions
The Whole Presentation Was Relevant And Well Communicated. Really Useful.
I Am More Aware Of The Iqp Projects Aims And I Am Looking Forward To Supporting The Wards Displaying The Improvements Made.
It Was A Good Length For You To Absorb The Information And Understand Without Feeling Overwhelmed.
Knowing The Models That Can Be Used And The Resources Available To Get Data
SUDA, LEAN, PDSA models, the use of CIVICA and assurance frameworks to collect data
Claire Was Brilliant. I Really Enjoyed This Session. Very Informative But In A Simpler Way, Fantastic Trainer, Very Approachable And She Has Made Herself Available If Any Problems. What More Can You Ask For!
Learning About Different Projects That Could Be Undertaken And How To Measure/Evaluate These
The Whole Session Was Engaging And Answered All My Many Questions. I May Still Be Unsure In Areas But I Feel I Now Can Action These
Very Helpful To See Visuals On What To Do Step-By-Step
The Examples Given Helped In Better Understanding

Graph 31: Confidence Level and Positive Feedback Post WTWA IQP Masterclass Attendance

Over the last 12 months a total of 19 departments across WTWA have been supported with quality improvement projects. The support has been far reaching from the creation of electronic resource files and audits to understand the issues and demonstrate improvements to regular contact supporting colleagues through each step of the IQP Methodology.

Below is a sample of the high standard of quality improvement projects undertaken across the divisions of WTWA to positively impact our patients' experiences during 2022/23:

- In Quarter 4 2022/23, Ward A4 commenced an IQP project to improve their mealtime service. The project has been split into three cycles to ensure embedding of knowledge and alignment to normal business. The team are introducing pre-mealtime rounding, Registered Nurse meal lead and a Nutritional 'Patient Status at a Glance' Board. The aim of the project is to improve patients experience of the meal service, improve patient safety and release nursing time to care by providing an efficient service.
- Acute Medical Unit at Trafford General Hospital undertook improvement work which aimed at improving patient safety and individualised care. The project involved staff education around Safeguarding and Deprivation of Liberty Safeguards to improve staff confidence, enabling appropriate care assessment, planning and referral of patients to be undertaken.
- Northwest Ventilation Unit undertook improvement work to reduce hospital acquired pressure ulcers. Their improvement work involved staff education in relation to the changes within HIVE.
- Acute Coronary Care Unit commenced an IQP project to ensure all patients are asked WMTM on admission, embracing HIVE to capture this information and share amongst the team.

WTWA Corporate Nursing Team facilitated a 'Back to Basics Quarterly Focus Campaign Programme' working collaboratively with specialist teams, utilising themes from Section 42's, incidents, complaints and QCR/WMTM results to further support teams to undertake meaningful IQP projects. The programme launched in Quarter 4 2022/23 focussed on pain management and the Quarter 1 2023/24 focus will be pressure ulcer prevention due to an increase in hospital acquired pressure ulcers. A bespoke quality improvement programme will include:

- Health promotion
- HIVE teaching
- Roadshows
- Promotional resources

The WTWA Corporate Nursing Team launched the WTWA Quality and Patient Experience Forum and the following workstreams will form core agenda items:

- IQP and Accreditation themes
- National Inpatient Survey
- Pain
- Environment
- Complaints / PALS
- PLACE
- Sustainability
- Accessible Information Standards

A WTWA Band 6 Development programme has been established for WTWA to support with the upskilling and succession planning of the ward/department leadership teams. The first Band 6 day was facilitated on in January 2023 by the WTWA Workforce and Quality Improvement and Patient Experience Matron's. During the day, there was an

informative session held on complaints looking at local resolution and analysis of quality data to support improvement in patient experience following IQP methodology.

The WTWA Quality Improvement and Patient Experience Team were successful in obtaining a grant from the MFT Sustainability Team to explore opportunities to reduce food waste and improve patients' experiences of dining within WTWA. Project planning commenced in March 2023 and will provide further data to support our understanding of patient nutrition in WTWA and will enable review of the current meal service provision for individual departments to support improvement in patient experience data.

The WTWA mealtime peer audit programme was launched in December 2023. The themes identified supported the focus during nutrition and hydration week and will form the basis of the WTWA Back to Basics Focus in Quarter 2, 2023/24, supporting colleagues and patients' knowledge in relation to the benefits of good nutrition and hydration.

The WTWA Outpatient Departments (OPD) teams successfully won their bid when applying for MFT Small Change Big Difference funds to purchase grab boxes to launch the Hidden Disabilities Sunflower Scheme for patients with a Learning Disability and/or Autism accessing OPD services. This is part of a larger project to standardise the care received in the OPD's. The Department Managers will measure the impact of the grab box initiative and present their findings at a future WTWA Nursing and Allied Health Professionals Forum.

The WTWA Dementia Team were instrumental in the development of the Strategy as integral members of the stakeholder planning event. The Strategy Commitments are providing a structure to support Dementia care delivery across WTWA with the aim of ensuring that patients living with Dementia have access to high-quality, equitable, and safe care provision, in line with the MFT Vision and Values and the Dementia Care Policy (2018). The WTWA Dementia Team will be holding an event in June 2023 with the Fabulous Forgetful Friends where colleagues will hear first-hand accounts from people living with Dementia and their carers about their experiences. This event is also the official WTWA launch of the MFT Dementia Strategy 2023 – 2026.

Appendix 3

MRI Patient Experience Activity 2022-23

Launch of the Dementia Strategy

The MFT NMAHP conference was held in March 2023 and included on the day was the launch of Dementia strategy by Deputy Director of Nursing for MRI. The Corporate team also delivered the Strategy to the ward areas and raised awareness of the Strategy.

Figure 3: MRI staff raising awareness of the Dementia Strategy at the MFT NMAHP Conference 2023

World Delirium Day

The MRI Corporate Team went into the clinical areas to raise awareness of the Dementia Screening Questionnaire for Individuals with Intellectual Disabilities (DSQUID) question and awareness.

Nutrition and Hydration Week

Nutrition and Hydration week – having a focus on breakfast delivery, patient feedback and food chart compliance. Staff were also encouraged to make pledges to “Making a Difference Everyday” in terms of delivering the best patient experience in terms of patient dining.

Malnutrition Awareness Week

October 2022– Malnutrition Awareness Week – focused on embedding the Mealtime standards. All inpatient areas had a baseline meal audit undertaken and results and support shared with the clinical teams.

Time for tea, time for me

Figure 4: The MRI Corporate Team visit wards for Time for Tea

Time for Tea - Time for Me – staff wellbeing walk rounds occurred on a monthly basis during 2022/23 where the MRI Corporate Team visit wards and give staff the chance to take some time out for a cup of tea, biscuits and some time for reflection.

Stop the Pressure Week

Figure 5: November 2022 – Stop the pressure week – the teams supported the Tissue Viability teams raising awareness of pressure ulcer grading.

Mouthcare Matters

Figure 6: The MRI Mouth Care Head Simulator & Students attending Mouth Care Matters Training

Mouth Care Matters – the mouth care head simulator was acquired via a Small Change Big Difference bid to support the Education team with teaching of good oral hygiene. The Education team provided teaching sessions during 2022/23 explaining the importance of good oral hygiene for all staff and students.

Patient Property Initiative

Figure 8: A Patient Property Box

Patient property boxes were also supported via a Small Change Big Difference bid and rolled out to all admissions areas to ensure patient property e.g., dentures, glasses, phones etc are kept safe and secure on transfer.

Falls Awareness Week 19-25th September 2022.

Figure 9: Nicky, MRI Falls CNS, delivering key messages as part of Falls Prevention Month

The Community Falls service, Matron for Harm Free Care and the Falls Specialist Nurse held a stand in the Outpatients Department and Fracture Clinic and the wards were visited engaging therapy and nursing staff to promote mobility and activity for patients in hospital. Making movement count is one of the key priorities, aiming to reduce hospital deconditioning and promoting strength and balance. This work will continue over this financial year.

Learning Disability Awareness Week

Figure 10: The AJ Learning Disability Choir

Learning disability awareness week – all ward areas involved in promoting awareness of learning disabilities and engaging staff in thinking about how they can make reasonable adjustments for patients during their hospital stay. Ward 5 celebrated with singing, milkshake parlour, ice cream and flake, and manicures plus a hidden talents show by

their own staff. The AJ learning disability choir attended the main atrium to perform for all staff and patients.

Dementia Awareness Week

Figure 11: Therapeutic Activity Coordinator – Ward 32

Dementia Awareness Week – Staff on the ward celebrated dementia awareness week. Ward 32 pictured about celebrated with a little teas party led by the therapeutic activity coordinator.

Emergency Access and Assessment (EAA) Patient Experience Work

Figure 12: EAA (Fracture Clinic) held training to improve care for their patients within their services. Giving staff a true taste of the lived experience of patients requiring splints.

The Emergency Department (ED) have QR codes on display within their department to signpost service users to ongoing support services such as food banks and the Citizens Advice Bureau.

MRI Estates and Facilities Team worked collaboratively with ED to develop a food voucher initiative to support patients who are in the department for long periods of times to ensure they have access to hot food. Staff can distribute vouchers to patients who can in turn exchange these for hot meals in the on-site cafeteria.

As a direct response to patient feedback, the ED team have introduced additional snacks for patients that are in the department for any length of time.

There has been a review of the Housekeepers role in ED, and it has now has a stronger focus on patient facing activities. For example, ensuring there is a robust schedule in place to ensure that chairs in the patient waiting areas are cleaned.

A Small Change Big Difference bid was submitted for anti-ligature blankets and pillows to support patients with mental health needs who are in the Emergency Department for prolonged periods awaiting external mental health beds.

Introduction of the Complex Patient Programme

The Complex Patient Programme continues across MRI. The programme is a patient-assessment initiated programme which identifies patients with both very complex medical and social needs and assigns them a lead consultant and nurse for daily review and full oversight of their care. Working cohesively with the Patient Experience Team and Voluntary services, a bespoke survey and volunteer role profile was developed to capture the views of these individuals to improve the programme. This is now embedded across all ward areas within the MRI. The programme also aims to reduce the number of patient complaints and PALS enquiries regarding communication and delays by ensuring they have regular senior reviews by both the nursing and medical teams.

Appendix 4

Clinical Scientific Services

Outside space for patients/relatives and staff projects

The King's Fund report on gardens and health, found that the mental health benefits of gardening are broad and diverse, with reduction in depression and anxiety and improved social functioning, emotional well-being and physical health. Across all critical care areas, the vision is to have a dedicated space on each site to support the rehabilitation of patients, their families/friends/carers and staff.

Following last year's outside space update during 2022/2023 our critical care units continue to work with colleagues to create spaces outdoors for both patients, their families, and our staff.

The NMGH Critical Care Garden space was officially opened in November 2022 by Victor Lund who previously spent 64 days in the Critical Care Unit at NMGH. The garden was the vision inspired by both Victor and Allison Keegan, Advanced Critical Care Practitioner.

Figure 13: Victor with Allison Keegan with the scissors cutting the ribbon

Figure 14: Victor with Allison Keegan, Kathy Cowell and NMGH Critical Care team

Figure 15: Victor, far right, with Allison Keegan, Advanced Care Practitioner (centre) representatives of Novus, Morgan Sindall Group, Kathy Cowell

The outside space at NMGH has been completed and positive feedback has been received from patients, relatives, and staff.

Funding and development plans for the critical care units at Manchester Royal Infirmary and Wythenshawe Hospital are in progress.

Nutrition and Hydration- supporting our patients.

Teams from across CSS promoted the importance of nutrition and hydration during National Nutrition and Hydration week in March 2023. This included ward-based teaching and engagement sessions with staff and patients and auditing the Mealtime Standards to ensure these are reviewed and improvements made. During the week the Dietetics Team took to Twitter to promote their specialist roles.

This continued focus resulted in recognition for the Interventional Radiology Unit (MRI site) who won third place in the MFT Bee Brilliant quality initiative for their work. The Interventional Radiology team presented work on hydration to ensure patients have enough fluids to prevent Acute Kidney Injury following CT scans which required the administration of contrasts. The Interventional Radiology team were also acknowledged for auditing the time that patients were starved for the correct time period prior to their procedures.

Figure 16: Interventional Radiology Unit (MRI site)

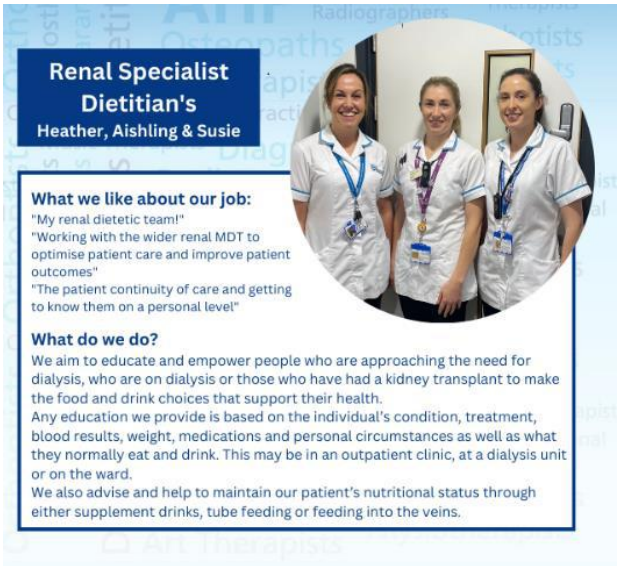


Figure 17: Renal Specialist Dietitian's, Heather, Aishling and Susie

Harmonisation of Practice and Collaborative working

To support staff with knowledge and skills for our patients' members of the Dietetic Team from North Manchester General Hospital (NMGH) and Trafford Hospital, developed the nutrition and hydration eLearning module which forms part of a larger 6-part programme on frailty and healthcare. The e-learning programme, developed with input from key nutrition stakeholders, is for all professionals across MFT who may be involved in the care of frail older adults.

With the launch of HIVE services across CSS, the team continue to review patient information leaflets with many now available on the MyMFT patient portal.

Therapists on all hospital sites have supported ward and service-based projects to improve patient experience, these have included therapy led exercise classes as part of falls awareness, palliative care, promoting the therapy role to achieve person centred goals. Supporting the 'back to basics' project focusing on getting home and reconditioning, rehabilitation of patients on Extracorporeal Membrane Oxygenation (ECMO) who are sitting, standing or mobilising when on ECMO.

To improve patient, experience the Muscular Skeletal Service (MSK) have worked collaboratively across each of our hospital sites and community services to standardise protocols and practices for patients undergoing elective procedures for knee or hip replacements. This project has included that all our patients receive a follow up referral to therapy services. In additional a 'My recovery at home' leaflet has been devised to provide guidance to patients regarding exercises and progression on walking aids.

The Bereavement Service team have updated the MFT Bereavement booklets for each hospital site to reflect changes to national guidance.

Music Therapy

Neurological Music Therapy (NMT)

A Neurological Music Therapy (NMT) pilot service took place on the Intermediate Neuro Rehabilitation Unit (INRU) at Trafford General Hospital. The pilot was run by Chiltern Music Therapy as part of their Northern Partnership with MusAbility. Sessions took place

one day each week, over a 12 week period, during May, June and July 2022. Dependent on specific patient needs, sessions were either one to one or group sessions.

NMT is an evidence-based, neuroscientific model of music therapy and features 20 standardised clinical techniques for speech & language training, cognitive training, and sensorimotor training. NMT can be combined with existing therapy goals with neuro rehabilitation patients.

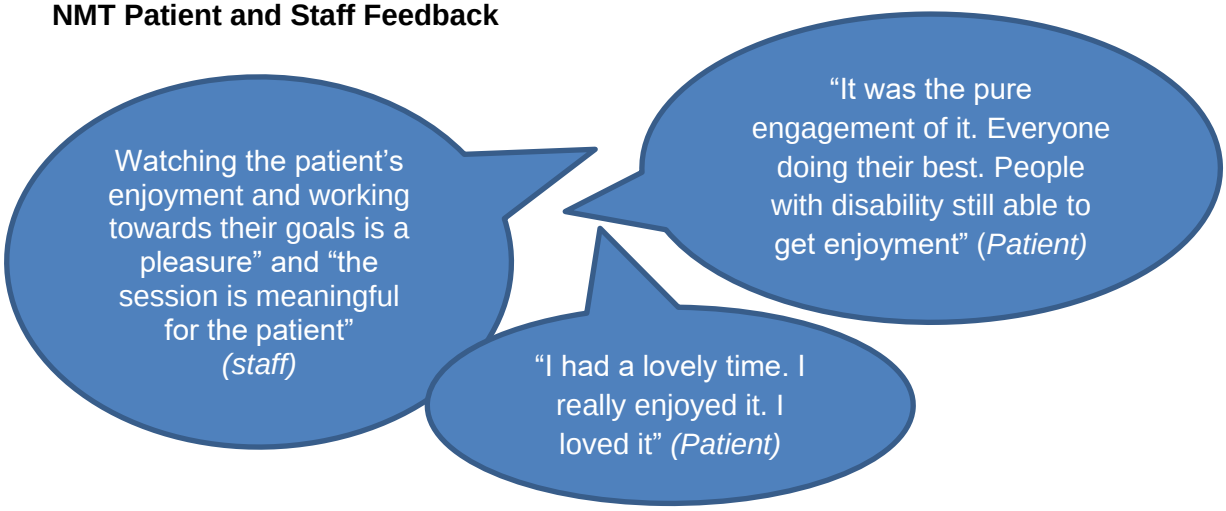
As part of the pilot the multidisciplinary team had training from Chiltern Music Therapy. The training explored how patients were referred to NMT by the MDT including Occupational Therapists, Physiotherapists, Speech and Language Therapists and Neuropsychology.

Highlights of the pilot reported the patients (21 patients took part)

- 95% improved in mood following NMT.
- 87% achieved their SMART goals in NMT sessions.

The pilot was funded by the "Small Change Big Difference" initiative and with the overwhelmingly positive impact it had on patient engagement as well as patient and staff well-being, the role of a permanent music therapist is being explored.

NMT Patient and Staff Feedback



Music in Hospitals

With COVID-19 visiting restrictions being reduced the patients, and staff, in the Critical Care Units on the MRI site have been able to reintroduce live music for patients. Live music is provided by musicians from the charity. The benefit of music in a critical care environment, which is busy and noisy, has been shown to support patients to reduce respiratory rates, feelings of pain and discomfort.

We are keen to bring Music in Hospitals to the critical care units on the North Manchester and Wythenshawe hospital site and plans have begun to introduce this during 2023.

Patient Information

Radiology Day Unit

Following feedback from patients, a wall mural was designed with information for patients on what to expect during their stay in Radiology Day Unit, in the Imaging Department, MRI site. The mural which is placed at the entrance of the department details information on the patients journey from admission, to during procedure, and post intervention care. This project was funded by MFT Small Change Big Difference initiative.

Figure 18: Photo- Wall Mural for patients in Radiology Day Unit, Imaging (MRI site)

Appendix 5

Royal Manchester Children's Hospital (RMCH)

Patient experience response rates - WMTM:

RMCH WMTM feedback response rates have significantly increased following the implementation of WMTM and FFT information posters containing a QR Code to enhance access to the survey has seen improved FFT scores.

Ward 77 have shared their improvement work with all divisions at the RMCH Managed Clinical Service (MCS) Quality Workshop about how they have explored roles within the team to capture feedback and support positive communication between staff and families, including early escalation of patient requests or concerns.

Figure 19: Overall WMTM completions for RMCH 2022/23

Experience of Care Week - 'You said, we did' responsiveness with patient survey feedback:

The Lead Nurse – Quality and Patient Experience, and Manager for Patient Experience, facilitated a Patient Experience of Care Week planner and a 'call to action' for teams.

The call to action was to use the Trust template to celebrate and display a current piece of improvement work they are undertaking in response to patient feedback. Impressively, all areas took part in the call to action and 3 winning areas were selected with reasons stated below.

Figure 20: Mealtimes Matter – Patient Dining, Nutrition and Hydration WMTM feedback:

RMCH MCS participated in a Paediatric focused Nutrition and Hydration week during March 2023.

Paediatric patient and parent engagement with meal service and hydration rounding – WMTM and incidents:

Ward 84 and Ward 81 facilitated Patient and Parent/Carer engagement sessions with food tasting and ‘What Matters To Me’ feedback.

Both areas have now moved to the two-week menu following feedback and have seen improvements in WMTM data:

WMTM Feedback 2022/23		
Ward 84	Q1 2022/3 – 62.5%	Q4 2022/3 – 77.9%
Ward 81	Q3 2022/3 – 64.5%	Q4 2022/3 – 75.2%

Table 30: Ward 84 and 85 WMTM Feedback 2022/23

Based on feedback, RMCH has also introduced drinks rounding to improve patient hydration and experience.

Food wastage review – responding to patient feedback
Ward 76 is currently undertaking a food wastage review to support the need for Saffron meal ordering system within the high-turnover department following a complaint and review of satisfaction scores. The plan is to have the team trained in Saffron meal ordering, HIVE diet orders and to reduce food wastage with an agreed bulk order top up which will be suitable for both short and long stay patients.

Paediatric Emergency Department (PED) – responding to feedback from accreditation/FFT:
Following feedback regarding increased attendance and waiting times from patients, parents (WMTM/FFT) and 2022 accreditation visit, PED have been working together with the catering team to stock non-perishable items and now have access to meal vouchers to ensure hot meals can be offered to patients to improve patient experience.

Communication; waiting times – responding to FFT feedback:
Paediatric Emergency Department have received feedback following ward accreditation and FFT responses regarding communication of waiting times. The team are working with Communication/MFTV team and HIVE to provide digital waiting time displays that update parents/patients with robust processes. The team will be linking with Adult A&E colleagues to share learning and roles within the teams to design this project and map clear processes.

Pain management – WMTM feedback:
The RMCH MCS Pain team have facilitated education sessions throughout departments with staff and parents regarding pain assessment and documentation. It is recommended that each department displays information in parent/patient facing areas to promote escalation of concerns regarding pain assessment and management in response to feedback. This will enable parents to advocate for their child if they feel improvements could be made, whilst educating staff regarding expected pain management assessment, monitoring and review in response to parents' feedback.

Figure 21: The RMCH MCS Pain Team

MFT Youth Worker Service

MFT Youth Worker Service opened in February 2022, it is situated in the TeenZone at Royal Manchester Children's Hospital. The yearlong funding for the pilot service has been raised by RMCH charities. The areas and specialist transition services that are benefiting from this are as follows: Haemoglobinopathy specialist services, at RMCH & Manchester Royal Infirmary (MRI), Endocrinology and Diabetes specialist services, at RMCH & MRI and Respiratory specialist services at RMCH & Wythenshawe. The clinical areas the youth workers support include those Inpatients & Outpatient areas that young people access as part of their healthcare transition pathway. Additionally, the youth service also provides a universal offer of social prescribing to any young person, or service from across MFT.

MFT Youth Service Residential 21st – 23rd April 2023

Outdoor adventure experiences, in particular for those in a group residential setting have long been seen as beneficial for children and young people. The background benefits gained by outdoor adventure, such as enhanced personal and social communication skills, increased physical health, enhanced mental and spiritual health, improved sensory and aesthetic awareness and the ability to assert personal control and increased sensitivity to one's own well-being, are all expected benefits that come from spending time in an outdoor setting[4].

Given the knowledge of the benefits, the addition of a residential programme was key in ensuring a holistic Youth Work offer for young people with long term health conditions and that MFT Youth Service provide engagement, support, and development opportunities. The service was successful in obtaining funding which would enable young people to benefit from residential experiences with a focus on the outdoors.

We know the background benefits of outdoor residentials and their positive effects. Youth work residentials focus on the planned benefits of outdoor group experiences that are determined by the service provider. MFT Youth Service expect the residentials will help young people with long term health conditions to:

- Build problem solving and team working skills.
- Develop a positive and knowledgeable response towards personal health and wellbeing.
- Expand their personal horizons and reach out of their comfort zones.
- Increase self-esteem and build confidence.
- Develop friendships with other young people and build a peer support system, that is young person led.
- Take personal responsibility for themselves and improve independence and life skills.
- Increase communication skills and the ability to advocate for themselves.

[4] Health, Well-Being and Open Space, Literature Review by Nina Morris, OPENspace Research Centre, 2003.

For our (MFT) first residential experience, we took 8 young people to Borwick Hall in Carnforth which is run by Lancashire County Council outdoor education service. Young people were selected by the youth workers from the diabetes, endocrinology and hemoglobinopathy services. The young people were selected because the youth workers felt they would benefit from the experience, engage well with others, and because they possibly would not have had the opportunity to otherwise bridge the poverty gap.

The Preparation

Prior to the weekend it was important that we were prepared and had accounted for all the important factors that could potentially impact the weekend in both a positive and negative way. This included; diabetes training from a specialist diabetes nurse and nutritionist; completing paperwork such as risk assessments and third party responsibilities; activity planning; choosing outdoor activities that all the young people could take part in taking their health conditions into account; medication trackers; ordering and designing the food and menus that incorporated young people's input, tastes and dietary requirements; designing the group work and reflection and organisation of the transport. A pre residential planning meeting was held which outlined the weekend and what was involved so young people and parents were fully informed prior to attending, ensuring that we could support all the young people to the best of the team and outdoor centre's ability.

The Responsibility

From the start, young people took responsibility for themselves and the tasks such as unpacking, making beds and setting up the kitchen and their rooms as they liked, ready for the weekend. It was evident and expected that some young people would know how to do this very well and for others it would be a challenge. The huge grins on their faces and the satisfaction of making their bed for the first time successfully was the first step in boosting confidence and self-esteem. The smallest steps are the foundation for the greatest achievements. Young people did all the cooking, preparation, laying the table, washing up, making their own packed lunches, taking their medication and managing their health condition responsibility themselves with the support of staff. The growth in the young people, being able to demonstrate their knowledge, share their experiences and advice with each other, was brilliant to see and provided a strong foundation for the group. Acknowledging and accepting that they are young people with long-term health conditions and that identity is stronger in a group than as an individual. The young people themselves termed this as solidarity referring to each other (with the same condition/department) as

'Sickle cell solidarity, Endo solidarity, Diabetes solidarity'

They all felt comfortable taking medication in front of each other, explaining their conditions to others and championed and encouraged each other if they were struggling a little with compliance. Peer support and the instinctive need to 'fit in' with peers is and was a driver for the members of the group to manage their conditions effectively.

The Activities

The activities undertaken were archery, canoeing, indoor caving, campfires and climbing. As a team we delivered team building and problem-solving activities throughout

the weekend. Young people also had the opportunity to lead activities of their choice in their downtime.

Communication and teamwork are key components of successful canoeing and one of the main predicted benefits we wanted the young people to achieve was to push themselves physically. Some young people with long term health conditions avoid, are discouraged, don't feel confident, or strong enough to take part in PE or any other physical activity. Canoeing was one of the most physical activities of the experience and they soon got over their fears. For some conditions, such as sickle cell, canoeing can be scary given the potential cold temperatures of the water and the impact this has on their condition. All of the young people took part, and as they paddled along the canal the camaraderie and competitiveness between the boats shone a bright light on the friendships and support developed over the weekend.

These benefits and outcomes ran throughout the weekend with all young people, discovering new skills, finding their confidence, their voice, and ways of communicating and developing a sense of teamwork and drive to solve problems. All of which they will take away from this experience and insert into their daily lives. Mastering how to manage their condition, taking medication such as insulin, glucose testing, dealing with hypoglycaemic episodes, monitoring devices failing whilst still being able to cook, clean, do personal care, take part in activities, support others and push themselves enabled them to be able to say:

"If I can do this, I can do anything, actually if we can do this, we can do anything."

(PN Young person with diabetes)

After a jam-packed day of activities and outdoor learning it was time for some down time and self-led discovery and learning. Following our evening meal of a full Eid banquet cooked from scratch by young people to celebrate the end of Ramadan for one of young people, which went down a treat with a very hungry group, we set off to the campfire for evening games and campfire treats which were very well deserved for the group.

Although the thought of Mars Bar hot chocolate may bring the feeling of fear and dread to those in the diabetes know, it was important that we enabled young people to see they don't need to miss out on things that others do, they just need to do it a little differently. So, we worked out the amount of carbs each young person would need to take to enjoy the deliciousness that is campfire cooked mars bar hot chocolate and marshmallows.

This is such an important part of living with a long-term health condition. All young people have a fear of standing out during the teenage years, when they just want to blend into the crowd. Feeling or being told that they're not able to do what their peers do, can have a significant impact on their self-worth and mental health. Youth work has a focus on enabling and supporting young people to find solutions.

The Reflection

All successful youth work encourages and is built on reflective practice for both youth work professionals and young people. The final day is a day of reflection, giving the young people an opportunity to realise achievements that may have passed them by, peer support and feedback from the group and individuals. Self-actualisation is fantastic to witness in young people, however, the positive feedback from peers for many is the pinnacle for them.

This was done through an exercise called positive petals where young people write in a petal of a flower, until the flowers petals are all completed by each person in the group.

They also decorated and completed scrapbooks where they could write messages and memories in each other's books as a memento to take away and for them to be able to look back on and remember those, thoughts, feelings, experiences, and relationships.

The group were also asked to feedback about what they have gained from the experience and their feedback from the weekend. Feedback included:

> *"This resi meant to me I engage with others, made new friends and have the best time ever!!!!"*
>
> *"It was such an amazing experience!! I've made so many new friends! I was really nervous at first but once I got to know everyone, I really enjoyed it. All the activities were great, and I would definitely want to go again."*
>
> *"It was everything to me, to come here and make new friends"*
>
> *"It was very fun, and I enjoyed it a lot because I learned how to do a lot of things for myself"*
>
> *"Having choice and being allowed to do activities and lead activities we wanted to do P.S Staff are great!"*
>
> *"I learned to talk to people, and realised I need to start more conversations"*
>
> *"An amazing experience, if you get the chance you have to go"*
>
> *"I learned how to tie my laces"*
>
> *"Cooking was really fun"*
>
> *"I was much more social than I have been in a very long time, thank you for the opportunity"*
>
> *"Loved meeting everyone, people were very friendly, I wish to do this again"*

The Impact

The impact and benefits of the residential experience for the young people is evident through the following achievements as set out in the planned benefits.

Confidence: Young people had the freedom, time, and space to learn and demonstrate independence, skills and responsibility for themselves and their long-term health condition.

Social skills: The group gained increased awareness of the consequences of their actions on their peers through team activities such as team building, canoeing, climbing and self-led activity.

Communication: language development was evident throughout and developing an understanding of how to communicate effectively with others through tasks and general socialisation.

Motivation: the exploration of the area tended to fascinate the group and they developed a keenness to participate and the ability to concentrate over longer periods of time and to try new things, including motivating and supporting each other in all aspects of the experience.

Physical skills: these improvements were characterised using physical stamina and gross and fine motor skills in the activities as well as pushing themselves out of their comfort zones in trying new skills that they found they had a real talent for.

Knowledge and understanding: the young people developed an interest in the outdoors, more knowledge and understanding of their condition and ways to manage it effectively. Half the group were found to manage their condition more successfully than they do at home which given the conditions just demonstrated that they can, and they did. This was in part due to hearing this from another young person with the same condition. Not a medical professional. A peer whose opinion they often value more. There was a drive not to say no because of their condition using the knowledge they have learned to adapt, and problem solve.

The group all want to stay in touch with each other, have exchanged details and would like to do more peer support sessions as a group achieving the self-led peer support. A gap is filled through continued independent contact with young people that have an increased understanding of their experiences. Collectively the experience achieved the goals of peer support youth work activity at MFT and was a resounding success.

Appendix 6

University Dental Hospital Manchester

Patient satisfaction Survey

April 2022- March 2023 UDHM have revised the patient satisfaction survey undertaken in 2021-2022 which focused on how safe patients felt during COVID and the recalibration of its services. The revised survey focuses on communication and environment and will be re-launch in June 2023.

Supporting patients with Learning Disabilities and Autism

Following on from the work undertaken in 2021-2022 with the LD Safeguarding Specialist Nurses to develop a Bespoke Dental Outpatient Care plan for patients with LD and Autism, further work has been undertaken by the UDHM team and HIVE colleagues to migrate this care plan onto HIVE. As at go live this functionality was not within the Wisdom build. This build has now been achieved and is due for launch in the live system by the end of Quarter 1, 2023/24.

The Special Care Dentistry Department is a specialised department that provides a service that is only available at this level in Dental hospitals managing patient with complex needs. The majority of complex needs patients referred to UDHM require a full assessment and prescribed a bespoke treatment plan from a Special Care Consultant. This service had previously been delivered by one consultant with a large proportion of the patients referred being accepted for treatment either with sedation or general anesthetic. The activity for this cohort of patients has increased significantly since during 2022-2023 and a review of this activity has been undertaken resulting in a successful business case for an additional Special Care Dentist, resulting in a second Special Care consultant being appointed in March 2023. This member of staff will be in post by Quarter 2 2023/24.

UDHM submitted a charity bid to implement the Sunflower hidden disability scheme. Following the successful bid in February 2023, all resources have been ordered and staff are in the process of being trained to implement this scheme across UDHM.

A review of demand for the Special Care Dentistry patients requiring a General Anaesthetic (GA) has led to the development of the Trafford Dental Special Care list. Supported by UDHM Dentist Nurses and Special Care Dentist within Trafford theatres, this initiative has significantly helped reduce the GA waiting list and improved patient access.

Engaging Children and Young People

In December 2022 members of the Youth Worker Forum undertook a walk round of UDHM and its services to highlight any recommendations for improvements. The changes the forum suggested were IPAD chargers, feedback wall with sticky notes of suggestions and a radio in waiting room, all of which have been implemented.

Following the successful implementation of the Adolescent Intravenous Sedation Service in 2021-2022, UDHM have developed an Oral Adolescent Surgery Service launched in January 2023. This service reduces the number of young people that would

have previously required a GA, who are now treated with conscious sedation within the safe environment at RMCH Dental Child Health Suite. Following the implementation of this service the waiting list for GA has reduced and patients requiring this treatment have had their pathway reduced due to the removal of the requirement of a GA.

Appendix 7

Manchester Royal Eye Hospital

Collaborative work with Henshaws

A Certificate of Visual Impairment (CVI) is a formal Consultant Ophthalmologist led recognition and registration of a patient's visual impairment. The threshold is determined by findings from visual acuity and visual fields testing that determines sight loss or severe sight loss. When a patient is given a CVI this formally registers their disability and opens a much wider range of support and benefits to patients, such as those offered by local authorities and charities. This is currently a paper-based system, that is time consuming due to the administrative demands for the process. To improve the compliance with CVI registration a CVI Task and Finish Working Group was established in January 2023, to review the process and specifically assess the capability of building this process into HIVE. This group consists of representatives from Henshaw's, Eye Clinic Liaison Officer, Hive support Matron, Orthoptics and Lead Nurse together with Director of Business and Innovation, MREH/ UDHM. The group is working with Hive colleagues to introduce an electronic version of the CVI form, that is a national document not owned by MFT. The work is of significant size that it will require multiple Hive Sprints to complete. It is envisioned that this process will drive efficiencies, improving timely access to services for patients through earlier CVI completion by way of Hive best practice advisory pop-ups for clinicians and reducing the administrative burden of the current processes.

Improved communication to patients in emergency and outpatient setting.

Communication Rounding in Outpatient settings and EED has been implemented across MREH and in EED by the introduction of communication rounding tool, which has been successful in communicating delays to clinic, identifying transport issues, patient queries and resolving issues locally.

Theatre Improvement Board to increase patient experience.

Theatre Board is an MDT board consisting of Lead Consultant, Consultant representatives, Director of Business and Innovation, Directorate Manager, Lead Nurse, Operational Managers, Matron and Team leaders. The board meets monthly with actions identified to improve patient experience and theatre efficiency.

Following the implementation of HIVE the process of the Golden Patient process did not continue. MREH Theatre Board identified this issue, and a request was made to HIVE colleagues to provide functionality in HIVE for the identification of a Golden Patient. The concept behind this was to support identification of the Golden Patient when listing and for the ward and surgical teams to identify and support work up on the day of surgery. Plans are for launch in HIVE in Quarter 1 2023. A further internal request has been made to identify subsequent list order after WHO to support the ward in ensuring the correct patients are ready for theatre on the day of surgery. This has been raised as a ticket with the Op Time Team.

Start times in theatre (and theatre data) is reviewed at the weekly 6-4-2 meetings. During these meetings the team reviews theatre utilisation, efficiency, review late starts and late finishes and provide solutions as they arise. Improving theatre efficiency will in turn

increase patient experience by reducing waiting lists. There has been a delay in the accuracy of the power bi data pulling the data the team are working closely with reps to improve this data reporting.

Pre-op improvement reviewing the service to improve patient flow and templates Stock and equipment - work has been undertaken with procurement to improve the identification of equipment needed, which has led to less theatre delays due the availability of equipment.

Outpatient Improvement Board

Re-established early 2023, an MDT approach with a Consultant lead, Outpatient Managers, Matron, Lead Nurse, Directorate Manager, Assistant Directorate Manager, as core members
Identified need for room utilisation review, to ensure clinics are running at full capacity to improve patient experience by reducing waiting times. Review began in March 2023, with an expected completion of June 2023 and includes a distinct patient flow element. Regular meetings with the Medical Records team have been set up to improve the availability of patient notes for clinic.

New process set up for appointment status and outcome monitoring.

Meeting memberships reviewed to streamline and free up time for other tasks.

Teaching clinics began on the 17th February 2023 at the University of Manchester School of Optometry. The relevant equipment was installed prior to this to ensure clinicians have access to HIVE and patients report a good experience. Paediatrics have also expressed an interest in using the space.

EED improvement Board

Following the successful trial of the Emergency Eye Department (EED) streaming process in 2021-2022, this service has now become embedded in EED patient flow. A Task and Finish group was created to ensure the streaming process was included in the Kaleidoscope ASAP build.

The Rapid Access Clinics have also been increased in frequency from 3 times per week to 5-day service, enabling patient streaming either to community services or to Rapid Access Clinic 5 days a week to reduce the patient activity and demand within EED.

Request submitted for changes made to powerBI to allow visibility of numbers of children in the department.

Redesigned an EED report by ADM reporting Key performance metrics into improvement board due for roll out Quarter 1, 2023/24.

Improving access for Learning Disability patients, dedicated orthoptic clinic for children with Autism

Relationships built with MCLO Community Orthoptists who work in the Special Education Needs (SEN) schools, enabling shared care and information. The community orthoptists undertake an assessment in the school, yet the child will still need to come to MREH for medical review. It is vital that information is shared to ensure the child does not have unnecessary repeated tests. The community orthoptists have a direct contact with the Advanced Orthoptist, Lead for LD & Autism to be able to liaise with individual cases.

Children who attend the Specialist Autism Clinic have now got a place at a SEN school and are ready to transition from MFT care to school. This relationship between MCLO community Orthoptists is key to provide the orthoptist going into school with relevant up to date information.

Autism fidget boxes introduced to all orthoptic clinics to help patients with Autism / LD.

MREH have implemented a dedicated orthoptic clinic designed for children with Autism who struggle with the busy environment of MREH. The team have received positive from parents and children attending this dedicated clinic at Altrincham.

Specific feedback cards for children with SEN have been created.

Database set up of all SEN school provision in Greater Manchester so that if a child is under MREH and attends one of these schools, ensure they have follow-up orthoptic appointments within school, improving patient experience.

This clinic was presented at the National British Irish and Orthoptic Society conference following a service review on the Autism clinic at AGH. This was well received and created interests from a number of other Trusts promoting learning.

Review of the need to create sensory room at AGH. Work currently under way scoping with Estates.

Designated Transition/ CYP and LD champions.

Identifying patients with depression following diagnosis

Patients with low vision are at risk of depression in view of their condition. In order to identify patients from the low vision clinic who are experiencing depression related symptoms and be able to direct them to the appropriate support services or to their GP, two NICE standard recommended questions have been included as part of the standard low vision assessment carried out by the optometrists. Should the patient respond positively to the depression questions, a pathway has been introduced to ensure the GP is informed and to ensure appropriate referral. This is aimed to improve patient experience and help provide support related to their wellbeing.

Training on ways to approach these questions with the patient and how to refer onwards was carried out as part of a teaching meeting for optometrists within the department and

appropriate “smart phrases” were developed to use within the HIVE to allow input into the patient record appropriately.

The use of the “smart phrases” is currently being evaluated in order to identify any further training requirements or barriers to asking the questions within the low vision assessment.

Supporting Transition patients

Paediatric patients who are about to reach the age at which they will be seen in the adult optometry clinics, should have a supported environment and journey to allow a smooth transition. In order to improve the experience, the optometry contact lens and low vision services are creating a specific “transition clinic”. This clinic will be held in a familiar clinic space with dedicated optometrists. Support can then be specific to the patients’ needs, whilst also including the relevant clinical assessments. When appropriate, the patients can be transferred into the adult contact lens or low vision service.

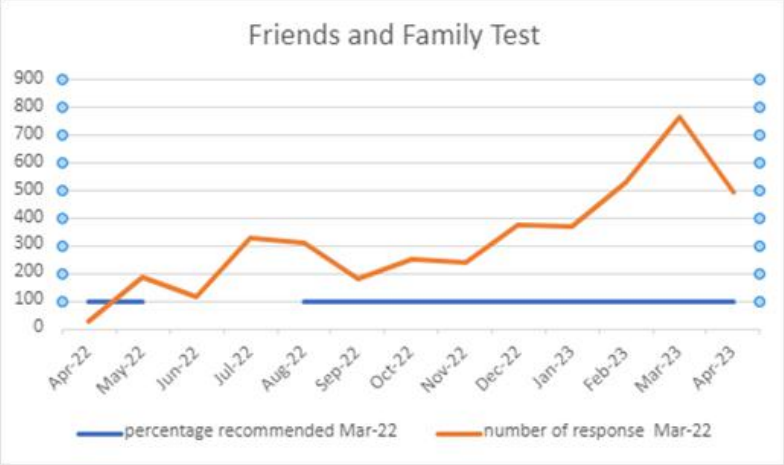
Appendix 8

Manchester/Trafford Local Care Organisations

All teams have now been introduced to the Community Accreditation Portfolio of Evidence with teams encouraged and supported to complete throughout North, South, Central Manchester, and Trafford. Teams are building on results and feedback to continuously improve treatments, outcome measures and patient experience.

Development of What Matters to Me surveys, and the QCR surveys, within the LCO has been ongoing. With the recently distributed iPads, these surveys are currently being launched across adult and children's services throughout the LCO with the aim that, by quarter three of 2023, they will be in full circulation. CIVICA training has been rolled out to all staff, alongside bespoke IQP training, and data is now becoming available for teams to analyse and give an assurance mechanism for ensuring safe and effective care. The data produced will help to inform our improvement projects.

LCO staff have reviewed processes to support effective collection of FFT information and have successfully increased the number of surveys completed.



Graph 32: Overall FFT Totals for LCO 2022/23

City wide review of induction for newly appointed Community Nurses and Nurse Associates was undertaken, and a new programme has been designed and implemented. Delivered by the Education and Development Practitioners from all directorates, and specialty practitioners, it covers a wide range of topics that are applicable to our new starters. Initial feedback is very positive. The programme includes ongoing support and peer group meetings for the preceptorship period and beyond and has been rolled out for all areas.

Community Nurses and Nurse Associates attending a Peer Group Meeting

MFT's continuing health care facility, Dermot Murphy Close, shared at recent Bee Brilliant events, the work they had undertaken with a patient, enabling him to communicate with state-of-the-art eye movement-controlled IT solution, this has revolutionised his communication and ability to express what matters to him.

Following patient engagement sessions, refurbishment of the Sickle Cell Centre is almost complete, and the newly renovated area has significantly improved staff and

patient experience. Space is now available for support group sessions and collaboration with Acute colleagues with space for them to hold clinics within the Centre. LCO Nutrition and Hydration (N&H) group has been established with representatives from community teams to give oversight of any N&H issues encountered and to look at improvement and work streams to ensure that incidents, training and improvement initiatives and opportunities are recognised and supported.

Children's Community Nursing

The Abbey Hey Health Visiting Team arranged a health promotion stall at Gorton Hub to promote the health visiting service and contemporary health issues impacting children under 5 years, these included immunisations, specifically the Measles, Mumps and Rubella, vitamin D, home safety and oral hygiene/dental care The event was facilitated by 2 community staff nurses and 2 nursery nurses. The event attracted several people from 0 -80 years, generating considerable interest and people not understanding the role of the health visitor and team. Following the event there has been an increased interest from partner agencies to be involved in the next event that the team were exploring.

Appendix 9

North Manchester General Hospital

Activities

All clinical areas now have activity boxes to support those living with dementia, which includes fidgets, colouring, books, music cubes/boxes. Dementia Specialist Nurse is working closely with a knitting club who continuously make and donate Twiddle mitts and blankets. This provides comfort and a feel of purpose for our patients whilst in hospital. Our TNAs have been supporting hand massage therapy across the hospital

End of Life Care

All clinical areas have EOL resources to support to support the management of EOL patients. During our recent Dying Matters Event led by our Head of Nursing for Palliative and End of Life Care, the focus was to engage staff in open conversation about dying and to explore thoughts and feeling on the subject. Resources were shared with managers to better equip them to support staff in their areas and were also signposted to services available.

Quality Initiatives

Our first quarter of the NMGH Quality initiative focused on Privacy and Dignity and saw the relaunch of “Hello my name is….”, options of how to keep patients’ property, and secure and sage were also explored. We have also begun to establish a patient clothing wardrobe, which is an ongoing project. Arrangements have been made for patients who present in ED who are homeless and can leave with a fresh set of clothes. The Alcohol Care Team are also working with local communities in supplying clothing and toiletries to support patients with no fixed abode.

Comfort

NMGH ED have replaced trolleys with a more comfortable model and additional beds have also been purchased to provide comfort and to support patients who may have extended periods in ED.

Environment

Ongoing work on site to improve on better signage to support patients navigate around the hospital and increased the number of wheelchairs to support patients round the hospital. We have also created outdoor spaces such as the ICU breathe easy garden and the postgrad garden to enable patients and their carers enjoy the outside.

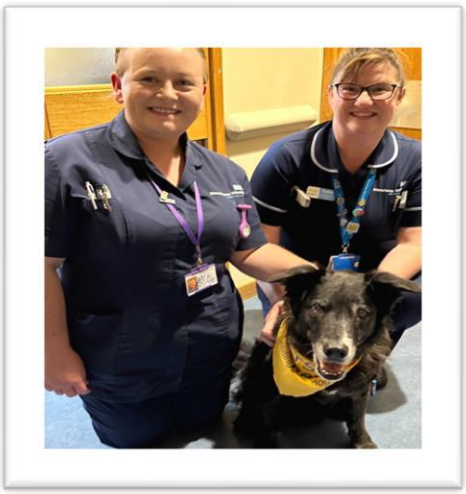
Learning Disability

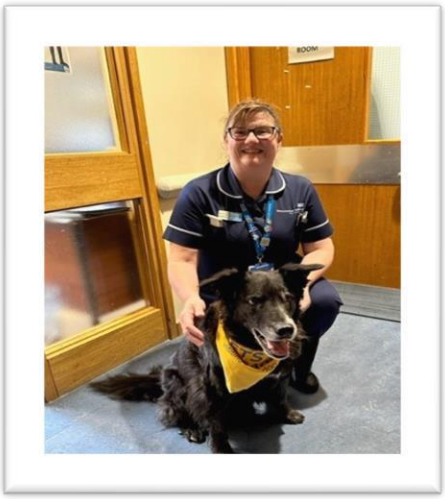
AJ’s Sing and Sign choir is a group of individuals who attend AJ’s day services who have a diagnosed learning disability and/or autism, the choir utilises Makaton to promote the alternative use of communication aids to support individuals with Learning Disabilities and/ or Autism.

The choir visited the hospitals to share their talent by signing and singing to a range of songs, they visit on Learning Disability Awareness Week and often attend the MRI and perform for staff and patients throughout the year.

PAT Therapy Dog

Our patients, families and cares have been enjoying a visit form Scruffy our therapy dog. Ongoing work with our volunteer's team to recruit another Dog to enable us to offer this wonderful service to all wards.





Celebrations

Patients, families, and carers have been supported in celebrating milestone birthdays and renewal of wedding vows. Patients participated in the celebration of the King's coronation and had the opportunity to watch the Queen's funeral. There have been several awareness weeks events across NMGH to raise the profile of carers, volunteers, and dementia.

Appendix 10

Saint Mary's Hospital

Patient and Public Involvement in Patient Safety

Ward managers review their FFT, WMTM, QCR and local Civica data monthly and draw up action plans to reflect on the issues raised and to put in local developments to mitigate the issues raised by the patients. As part of shared learning, each division provides feedback to the Professional Forum showcasing their IQP data, identifying areas that need action and sharing the action plan and the outcomes. By undertaking this across the MCS, the learning promotes equity and equality of the service provision and continuity of care across the MCS.

Service User forums in place: to promote coproduction of policies and practices to improve the patient experience. Within Maternity, 3 Maternity Voices Partnership groups are in place, the Newborn Services has a Parents forum and a Parental Advisory Group in place, Genomic Medicine has a Manchester Genomic Patient/public Involvement and Engagement (MAGPIE) Group, and a Youth Forum and regularly undertook specialist conditions focused away days. The Gynaecology Division has a Gynaecology / oncology group and is setting up a Gynae Voices Partnership with the Cradles Group.

Patient Experience feedback:

Poor Communication: Communication remains the overall key issue:

Access to Information and understanding of the care pathway: Saint Mary's Hospital is the largest user of the ITS service across MFT and complaints during 2022/23 were related to poor and ineffective interpretation and translation are referred to the ITS team and investigated. Several interpreters have been removed from the register due to inappropriate interpretation. The Antenatal Service have added posters related to Chaperone requests and how to ask for an interpreter in 10 languages in addition to the work already ongoing as part of the CMO 4 Equity Actions: Reaching out and reassuring pregnant Black, Asian and ethnic minority women with tailored communications. 13 translated languages available with QR code.
Access to service: Department managers to ensure departmental telephone contact details are correct and that there is a process for answering telephone messages in a timely manner. Staff have been allocated to ensure telephone enquiries are responded to in a timely manner and calls left on answering machines are actioned.

"*This was brilliant and created a lot less stress, this made the appointment have less of an impact mentally, being severely disabled and having to plan a journey out is very hard physically, emotionally and mentally. Creating less anxiety, this was actually a breath of fresh air. No horrible waiting rooms either, trying to find a disabled space, getting in and out of the car, getting up even earlier to get there in rush hour traffic. This is a fabulous idea and how I would like all future appointments for [redacted] and myself as her Carer/mum. I work full time so this helps so much. Thank you.*"

Feedback from patient within Genomic Medicine regarding Attend Anywhere Consultation

Access to Clinical Pathways: Delays due to capacity on the Induction of Labour pathway: Provision of accurate and concise information when booking women for an induction of labour to ensure they feel fully informed and prepared for the process and the potential delays. Inpatients on the Gynaecology ward had commented that they were not getting an opportunity to discuss personal worries and fears with nursing staff and not knowing the names of the nurses meant they were unable to put a face to a name. The ward had pictures of all staff taken which are put up daily by the bedside of the patients to improve communication. Staff are encouraged to meet and greet patients each morning.

Treatment and Procedures: Patient Safety

The standardisation of care pathways, SOP's, guidelines, and Patient Information leaflets across the MCS following the amalgamation of services at NMGH, Wythenshawe and Oxford Rd site to ensure continuity and consistency of care across the MCS has been ongoing during the harmonisation and merger of services. Each Division has a register of their guidelines with the renewal dates and monitor this activity through the Governance framework.

Staff competencies and Training: Following the implementation of new clinical assessment plans, a retraining programme led by the Education teams in each division has been implemented to ensure competence and confidence in care provision. Individual staff training and assessment of competencies are arranged and supervised on a 1-1 basis.

The undertaking of additional CTG assessment to allay maternal concerns. Staff were reminded that whilst CTG's are routinely undertaken twice daily, additional assessments are appropriate and should be seen as a priority.

Delays in provision of Discharge Medicines. Ensuring the medical staff understand the discharge letter process to reduce the delays in the provision of discharge medication
Within the theatre environment, the safety huddle and 'stop before you chop' actions are in place to ensure that all members of the team are cognisant of the patient, the procedure and how to escalate concerns.

Appointment delays:

Complaints related to Appointment delays and cancellations continue to be a pressure in Gynaecology.

Staff were reminded of the importance of regularly updating service users on delays in appointments, explanation of department acuity and offer drinks and signpost to canteens where appropriate.
Addressing backlog of new patients waiting longer than expected. Additional clinics, theatre sessions and weekend working has been implemented to reduce waiting times, this is a significant issue and one the Senior Leadership Team are fully focused on.

Clinical Assessment:

Poor pain management both post-delivery and post-surgery. The Postnatal Ward on the Wythenshawe site delivered a Quality Improvement programme through the Always Events programme to improve the timeliness of analgesia provision and the assessment

of effectiveness of treatment. This has been shared across the Postnatal wards on the Oxford Rd and NMGH campuses.

Accessible Information Standards / reduction of cultural / language barriers.

Across the MCS all services utilise the ITS service to support patient experience, understanding of the service and to ensure they are able to make informed decisions about their treatment. In addition to face to face, telephone and video calls, there is ongoing work providing patient information leaflets in Easy Read format and the top ten languages that have been identified for St Mary's MCS.

Chief Midwifery Officer (**CMO**) **4 Equity Actions**

In June 2020, in response to the emerging evidence from the UK Obstetric Surveillance System (UKOSS), Professor Jacqueline Dunkley-Bent, Chief Midwifery Officer (CMO) for NHS England, wrote to all maternity units in the country calling on them to increase the support for Black, Asian and minority ethnic women during the COVID – 19 Pandemic. Maternity Units were asked to take **four specific actions** which would minimise the additional risk of COVID-19 for Black, Asian and ethnic minority women and their babies.

- Increasing support for at-risk pregnant women
- Reaching out and reassuring pregnant Black, Asian and ethnic minority women with tailored communications.
- Minimise the risk of Vitamin D insufficiency.
- Gathering the correct data

The work the Maternity team commenced in 2020 continues in line with the AIS standards to mitigate against Communication barriers and support the patient experience. Kate Brintworth is the newly appointed CMO.

As part of the Chief Midwifery Officer (CMO) 4 Equity Actions: Reaching out and reassuring pregnant Black, Asian and ethnic minority women with tailored communications, leaflets in 13 translated languages have been available with QR code and printed copies for those patients with no digital access. Recently requests for chaperones and Interpretation services have been added and all Patient Information Leaflets are currently under review.

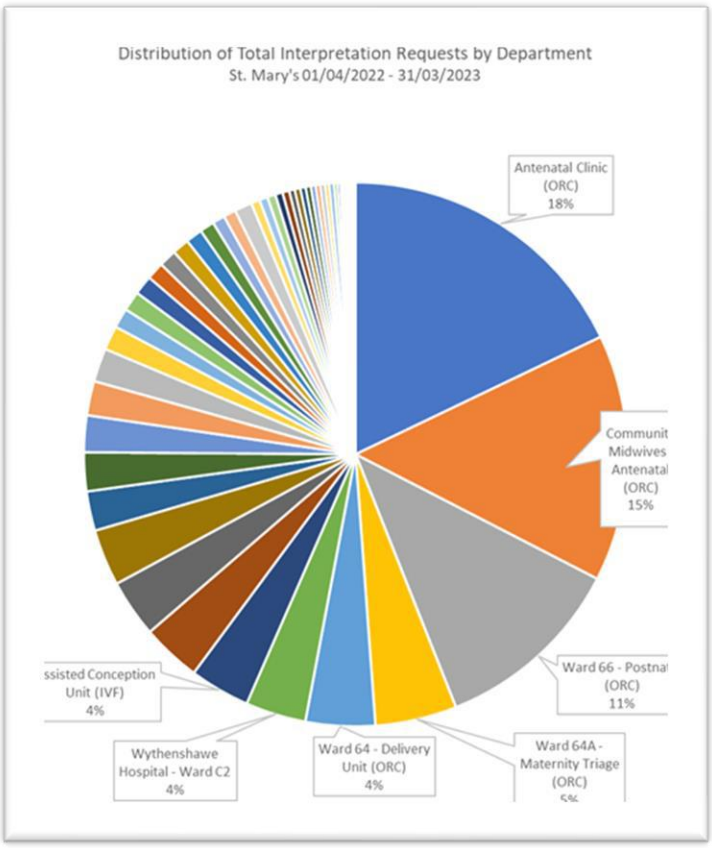


Chart 2: Distribution of the Total Interpretation Requests by Department SMH 2022/23

St. Mary's Hospital MCS				
Month	Face-to-Face Requests	Video Requests	Telephone Calls	Total
Apr-22	108	98	1790	1996
May-22	129	105	1851	2085
Jun-22	142	107	1824	2073
Jul-22	100	85	1812	1997
Aug-22	136	87	1917	2140
Sep-22	94	68	1528	1690
Oct-22	98	36	1663	1797
Nov-22	136	49	1715	1900
Dec-22	127	27	899	1053
Jan-23	153	31	1833	2017
Feb-23	180	42	1762	1984
Mar-23	193	37	2035	2265
Total	1596	772	20629	22997

Table 31: SMH Interpretation Requests 2022/23

Newborn Services:

Involvement:

Following feedback from the questionnaire, work has been ongoing on increasing Parental involvement in day-to-day care and understanding parental expectations of how much they wished to be involved. The FiCare Passports have been instrumental in this achievement.

Palliative care Service has been introduced to provide support and care for the infant and families following the Palliative care route both within the Hospital setting and at home in the community. Derian House are attending NICU weekly and Virtual visiting has been commenced for Outreach infants. The Bereavement team continue to work with the maternity and children's bereavement teams to provide continuity of care across the MCS.

The following Excellence report shares details where the Neonatal Team provided excellent care to a family who were undergoing conservative management and subsequent palliative care of their baby girl.

Excellence Report:

"The neonatal team treated the family with care and dignity throughout their stay in hospital and enabled the family to be able to spend two precious days with their daughter, for which they are eternally grateful. I witnessed some of the conversations and care plans on Friday over the weekend which were tailored perfectly to the family's specific needs and wishes, I was impressed by the sensitive conversations that were had and with the input from team to help ensure this baby was comfortable and cared for. Thankyou".

Newborn Services were delighted to be able to make progress in welcoming SPOONS across the MCS, who are a peer support charity, focusing upon those families who are in neonatal care and have left inpatient services. SPOONS lead the peer support recruitment process, prepare and facilitate parent forums, support families with their psychosocial well-being, in conjunction with the MCS Counselling service. Families are already able to join virtual support networks including the SPOONS Greater Manchester Dads group.

Delivery Room Cuddles: Quality improvement work had identified that only 16.7% of parents were having cuddles before admission. On the ORC site, a Registrar has been driving a new quality improvement project to ensure parents are having cuddles with their baby in the delivery room before admission to NICU. The change appears to be making a big improvement, with feedback from parents and staff being very positive.

Communication:

Website and Patient Information Leaflets enhanced to reflect the MCS and resources that are available to parents through a poster with QCR code that those with digital access can use. The service has developed a VCreate Platform to increase digital usage. A Vizbox Virtual tour has been filmed for all 3 sites.

Engagement:

Support for Siblings with play packs and resources, and the units were reopened to siblings following the shut down during the COVID Pandemic.

Feedback:

Bliss and FiCare Accreditation. FiCare Passports created with input from parents to encourage involvement of carer's / parents in all aspects of their baby's care.

The following case study relates to:

- Access to Infant Feeding Services / breastfeeding support

Neonatal infant feeding team received feedback that families who are transferred to areas in RMCH from NICU, ORC, are not receiving breastfeeding support and/ or facilities to store EBM. Some mothers had, as a result stopped expressing breast milk. The Neonatal infant feeding team across Newborn Services support mothers and prepare them for the transition over to RMCH, to be able to maintain expressing.

Maternity Services:

The Greater Manchester and Eastern Cheshire (GMEC) Local Maternity and Neonatal System (LMNS) developed the Maternity Equity and Equality Action Plan 2022-2027 following the publication of the MBRRACE-UK report, which has been codesigned and coproduced with the key stakeholders across the LMNS. 36 Interventions have been identified against 6 national priorities with 363 individual actions.

Dedicated Midwife for Styal Prison set up a weekly support and education group called PRAMS (as women cannot access other forms of antenatal and birth preparation classes) and runs a weekly Antenatal Class at Styal. The Midwife liaises with the maternity unit where the patient originates (as the women are not all local to Manchester). This ensures that the Midwife obtains a full history when women are admitted but also to support the plan of care once patients are released. One of the huge improvements she made was to accompany the women to their hospital ANC appointments.

During the Afghan evacuation, the Midwifery teams provided Clinics at Manchester Airport. Due to the crisis in Kabul, there was a desperate need for a Link Afghanistan Midwife which was a challenge as previously there has been no clinical footprint for this type of international crisis. The Link Afghanistan Midwives shared her experiences:

"I was more than happy to step forward for this role. I have developed a Standard Operating Procedure (SOP), liaised closely with our safeguarding team and the wider multi-disciplinary team. I have made contacts with the GTD City Health links and the Manchester City Council key workers for the two hotels within our geographical area. I have fostered close working relationships with our Antenatal Clinic and Ward Clerks and also with the refugee Midwife at St Mary's Oxford Road, the link Midwife at North Manchester General Hospital; we are constantly in touch trying to develop this service to the highest standard we can, creating a culture of intimate working across the Managed Clinical Services (MCS). I attend and actively participate in the TEAMS meetings as part of the Healthcare Huddle for the Bridging Hotels, for sharing

information. I have sign posted the women to services that will improve their wellbeing, for example to our Perinatal Mental Health Specialist Midwife, Improving Access to Psychological Therapies Programme (IAPTS) and overseen and ensured the women are on the correct care pathway. From booking, I provide the antenatal and postnatal care for the women and their families. Within this role I have worked with the voluntary sector from members of the Asian community who have sourced charitable donations which I have distributed and I have spent much of my own time shopping with donated money to purchase clothing when I realised there was an evident need. I feel extremely privileged and honoured to provide this service".

Patient Safety Framework Plan:

In January 2022 the MCS undertook a workshop reviewing how the MCS could increase patient engagement in improving patient safety. A T&F group was established, and each division submitted plans for their own specialty, work is ongoing to implement the plans.

Following the Workshop, 11 themes were identified as a focal point for the Divisions.

- Positive Communication and AIS,
- Positive Identification,
- Harmfree care,
- Environment of care,
- The Expert Patient,
- Discharge planning and Continuity of care,
- Nutrition and hydration,
- Pain Management,
- Safety and emergency responses,
- Patient Feedback / learning from events
- Safeguarding work plans.

A further workshop in January 2023 took place, learning the lessons from the East Kent report and the ongoing PSIRF work undertaken by the Trust to focus on coproduction in patient safety and optimalisation of safety and care.

Learning Disability Action Plan:

Patients/service users can access highly personalised care and achieve equality of outcomes. Learning Disability (LD) Champions in place across Emergency Gynaecology, Obstetrics and Gynaecology Elective and Emergency Theatres and Elective Inpatient Ward to empower patients and staff in care of patients with LD. Information and easy read material specific to gynaecology available, an example being an easy read cervical screening leaflet.
Mechanisms are in place to identify and flag patients/service users with LD and/or autism from the point of admission through to discharge so reasonable adjustments can be made.

Where appropriate, information will be shared as people move through wards / units / departments and between services.

Processes are in place to investigate the death of a person with LD and/or autism while using our services and learn lessons from the findings of these investigations.

Any restrictions or deprivations of liberty associated with the delivery of care and treatment to people with LD and/or autism are vigilantly monitored, e.g., sharing lessons learnt at Gynaecology Quality and Improvement Meeting monthly where a protected agenda item has been introduced for focused LD discussion. As part of transition process the Division of Genomic Medicine collaborates with adult services ensuring that reasonable adjustments are in place for LD patients.

Measures to promote anti-discriminatory practice in relation to people with LD and/or autism are in place across the MSC**.** SARC have appointed two ISVA with special focus on clients with Learning Disabilities, one for adults and one for children.

Appendix 11

Research and Innovation

During 2022, more than 17,000 participants were recruited to clinical studies taking place at MFT, with more than 1,400 studies active. Research at MFT takes place across our hospitals, community settings, and clinical specialties – often providing patients with opportunities to be the first in the UK, Europe, and the world, to take part in clinical research studies.

Despite the uptake of the COVID-19 vaccination, new variants meant it was critical to keep researching new ways to tackle the virus. Working in partnership with The University of Manchester and US pharmaceutical company, Gritstone bio, Inc., MFT was chosen as the chief study site to trial one of the world's first multivariant COVID-19 vaccines.

Our newly formed R&I Vaccine Team delivered the early phase trial – involving a small number of people to be the first in the world to be given the treatment – at the NIHR Manchester Clinical Research Facility (Manchester CRF) at Manchester Royal Infirmary.

The Pharmacogenetics to Avoid Loss of Hearing (PALoH) study, delivered at Saint Mary's Hospital and supported by the NIHR Manchester Biomedical Research Centre (Manchester BRC), was instrumental in developing a world-first bedside genetic test that could save the hearing of hundreds of newborn babies every year. Following a successful pilot, the NHS has begun rolling out of the test as part of the NHS Long Term Plan.

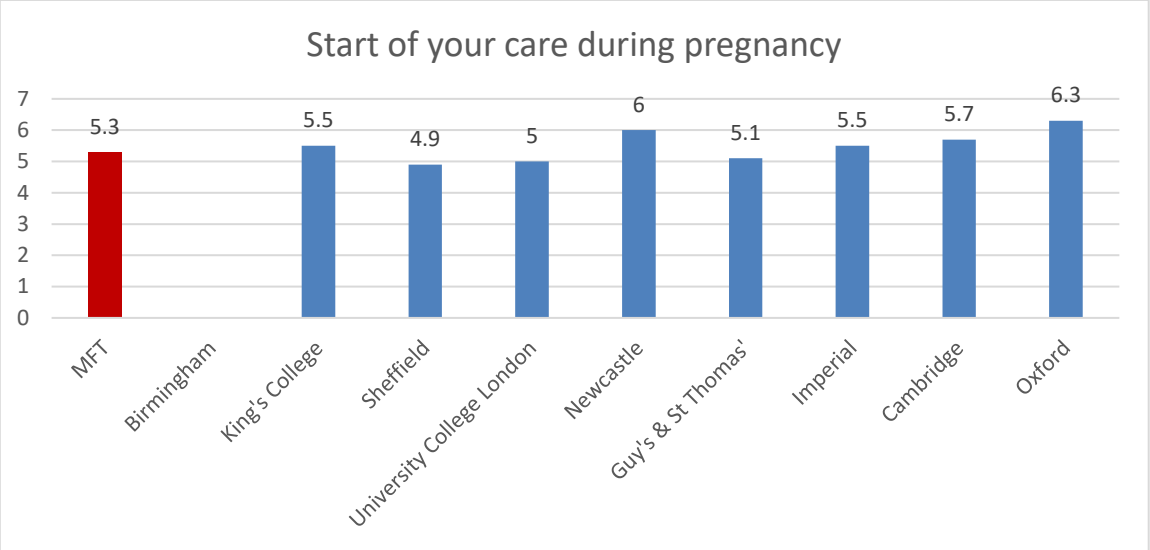
Due to the expertise of our researchers in gene therapy studies, MFT has been chosen as the only UK site, and one of only five across Europe, to deliver the revolutionary life-saving gene therapy, Libmeldy. With a reported list price of more than £2.8 million – making it the most expensive drug in the world – the treatment will become available on the NHS as a specialist service and will be delivered within Royal Manchester Children's Hospital (RMCH) in collaboration with Manchester's Centre for Genomic Medicine at Saint Mary's Hospital.

Following results from the Palisade (Peanut Allergy Oral Immunotherapy Study of AR101 for Desensitization) trial delivered at the Manchester CRF at RMCH, children in the UK will be able to receive Palforzia – a life-changing oral treatment for peanut allergies – as NHS standard of care following approval for use by the National Institute for Health and Care Excellence (NICE).

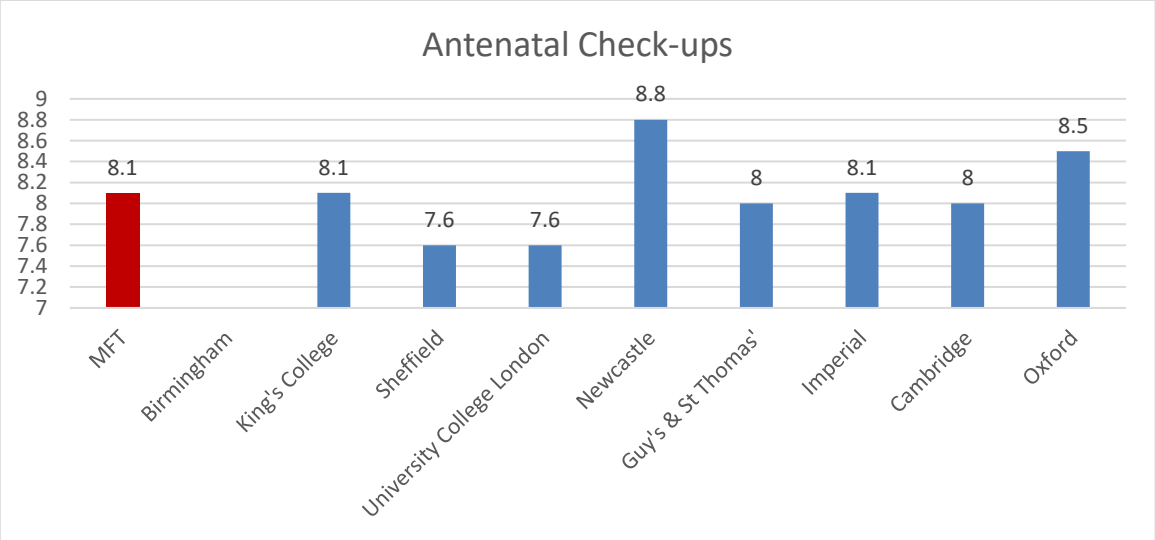
Finally, due to the arrival of our state-of-the-art Research Van in late 2021, we are now able to bring our ground-breaking research closer to our communities and widen opportunities to take part in research by visiting easy-to-reach locations such as community centres and supermarket car parks. The purpose-built one-stop mobile facility – only the second of its type in the country – includes a pharmacy and clinical area containing all equipment necessary to run vaccine programmes, clinical trials, and bespoke clinical projects out in the community.

Appendix 12

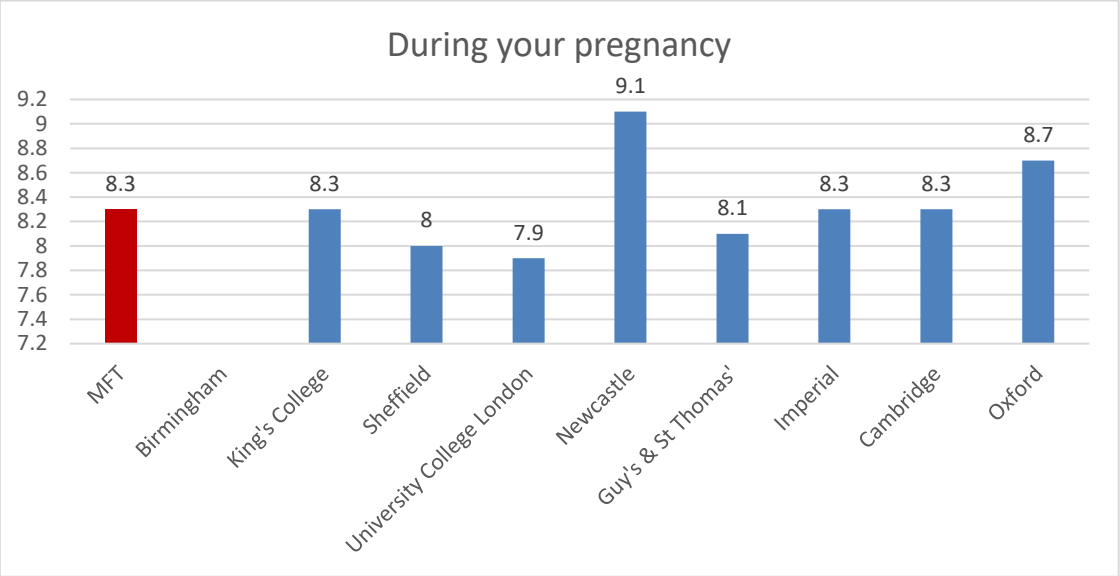
National Maternity Survey (2022) results: comparison of MFT scores by category to Shelford Group Trusts



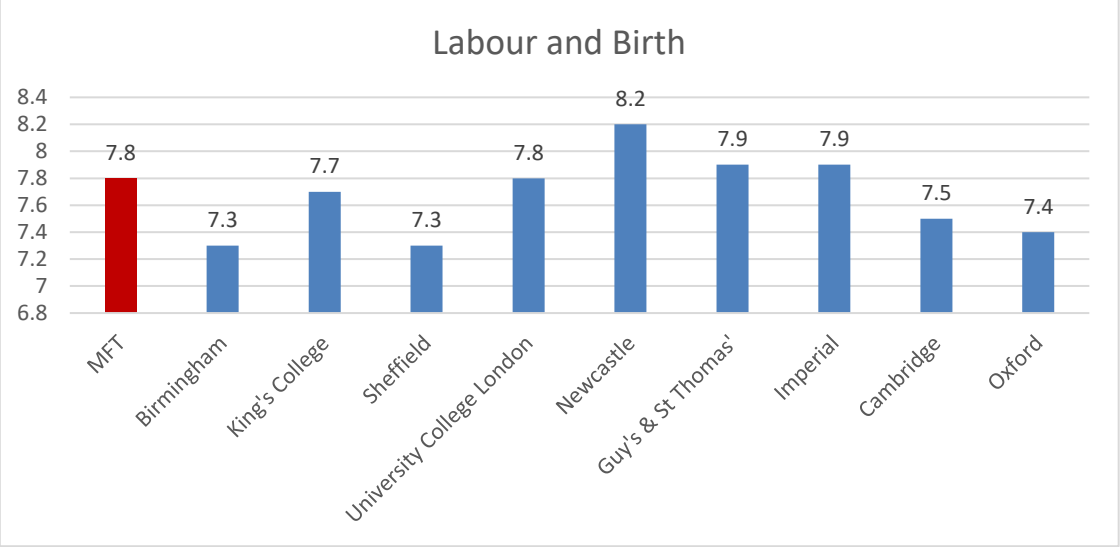
Graph 33: Comparison of scores for category 'The start of your care in pregnancy'



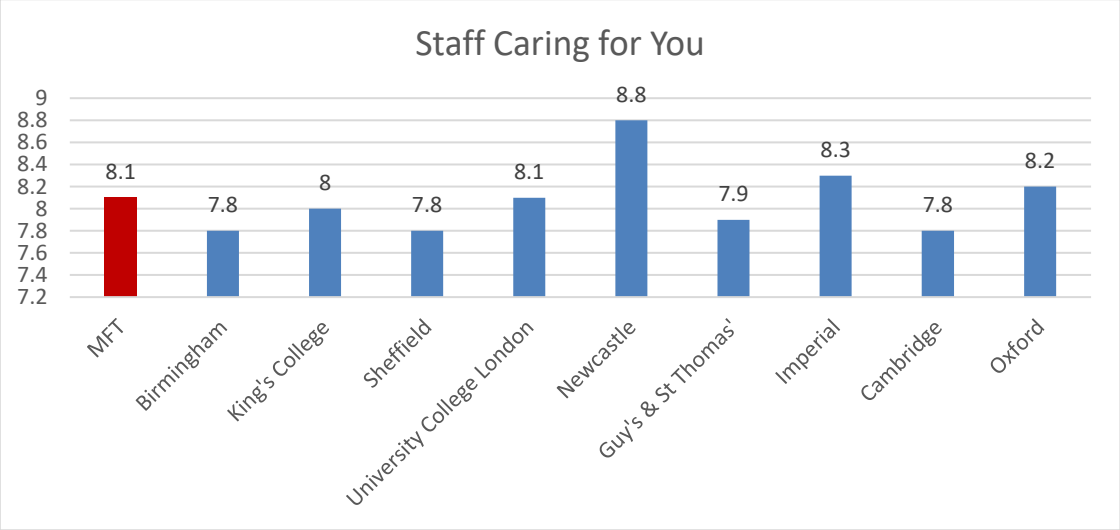
Graph 34: Comparison of scores for category 'Antenatal check ups'



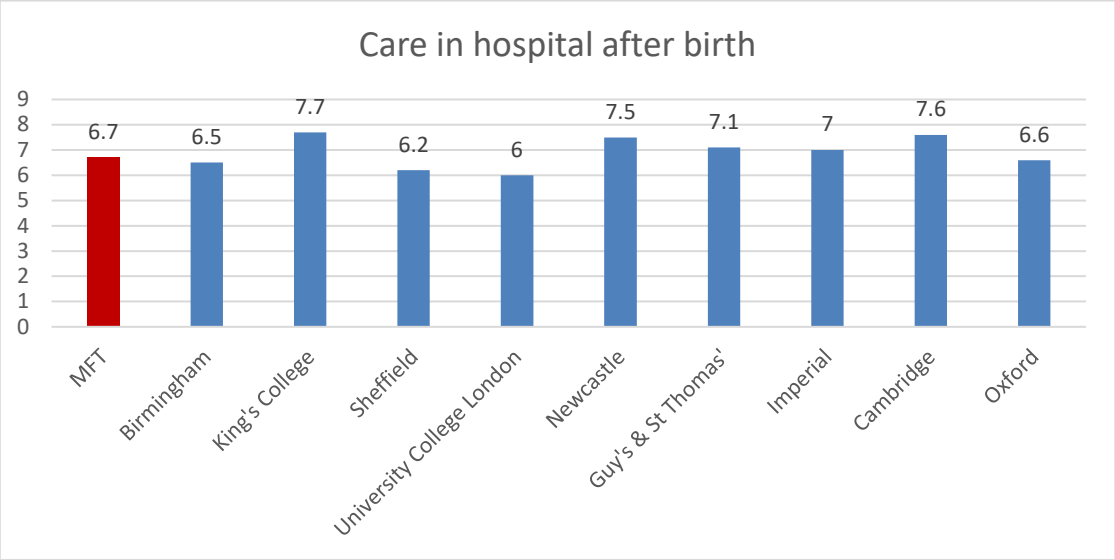
Graph 35: Comparison of scores for category 'During your pregnancy'



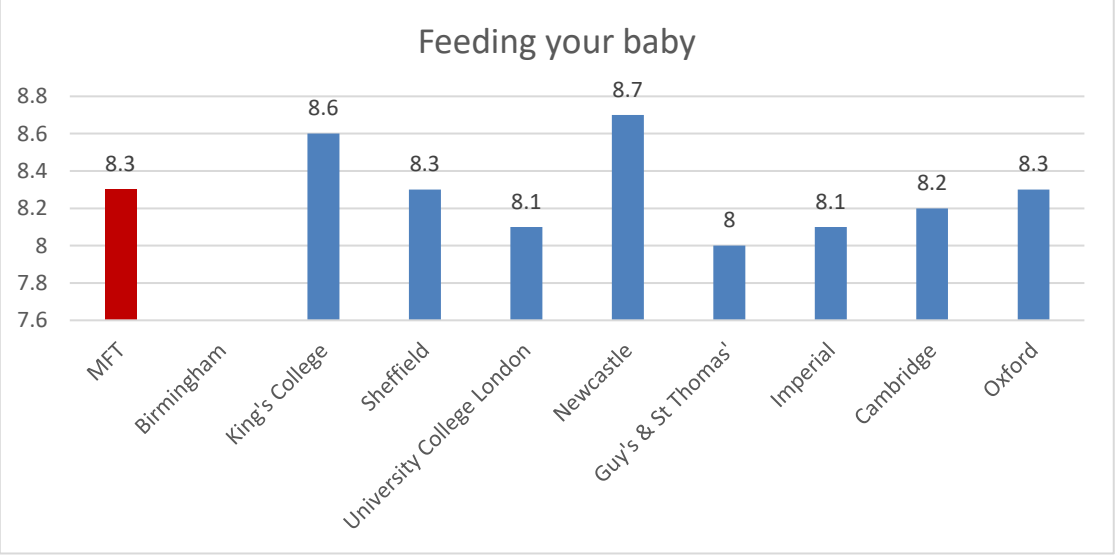
Graph 36: Comparison of scores for category 'Labour and Birth'



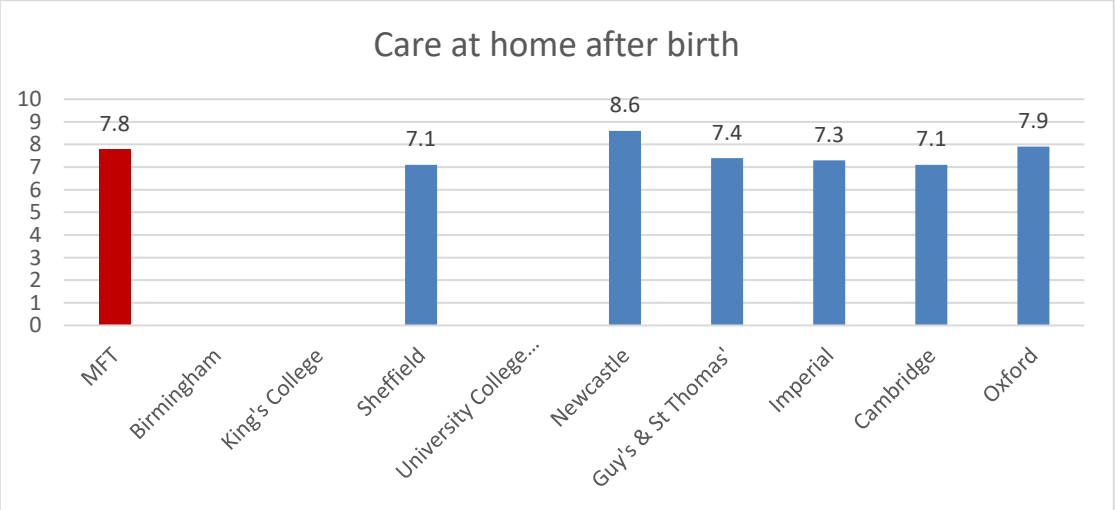
Graph 37: Comparison of scores for category 'Staff caring for you'



Graph 38: Comparison of scores for category 'Care in hospital after birth'



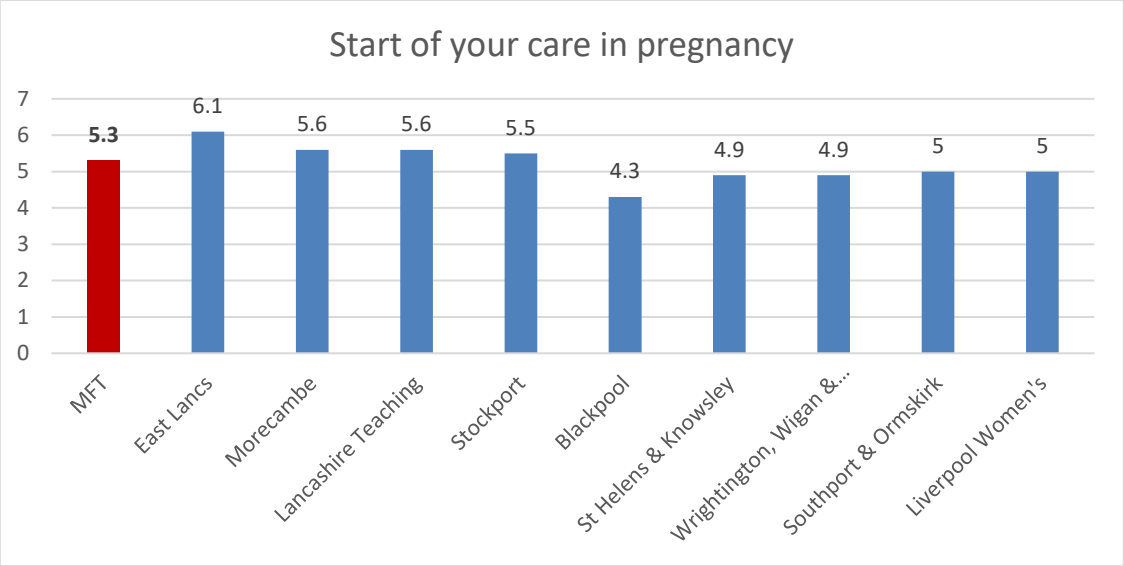
Graph 39: Comparison of scores for category 'Feeding your baby'



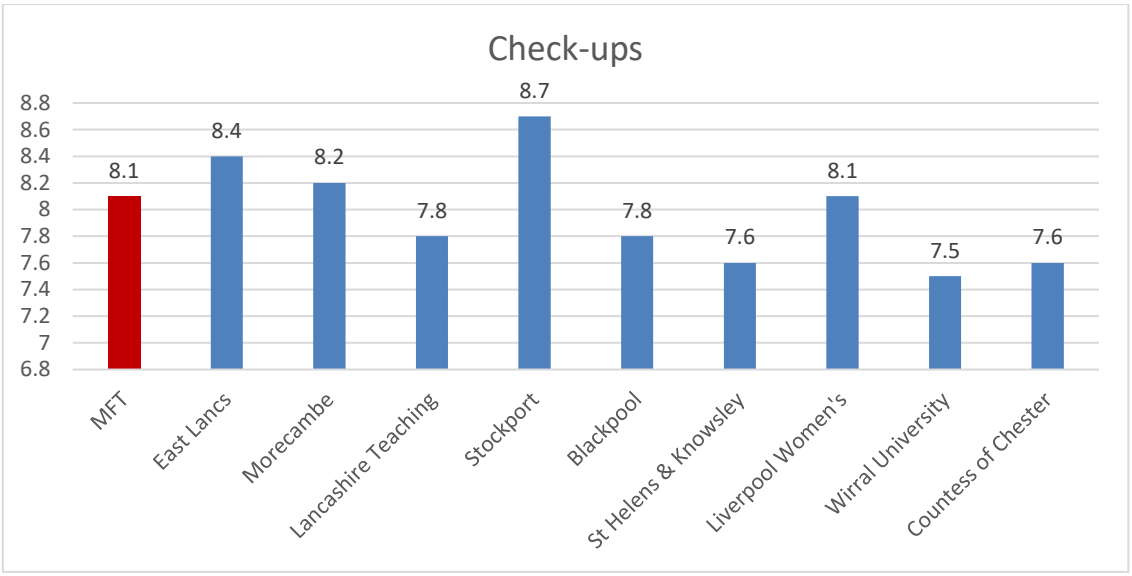
Graph 40: Comparison of score for category 'Care at home after birth'

Appendix 13

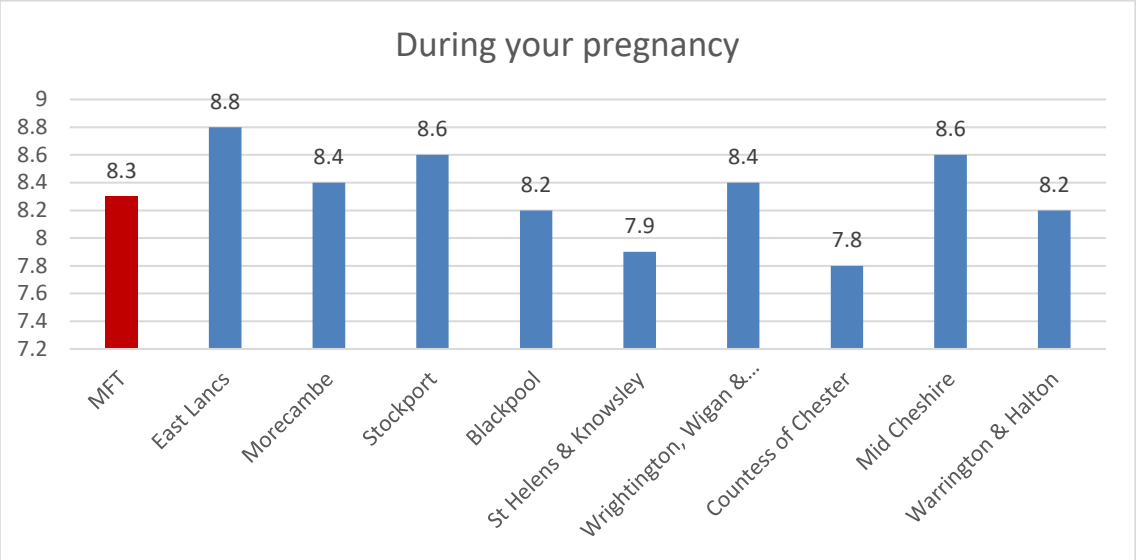
National Maternity Survey (2022) results: comparison of MFT scores by category to other trusts within the region



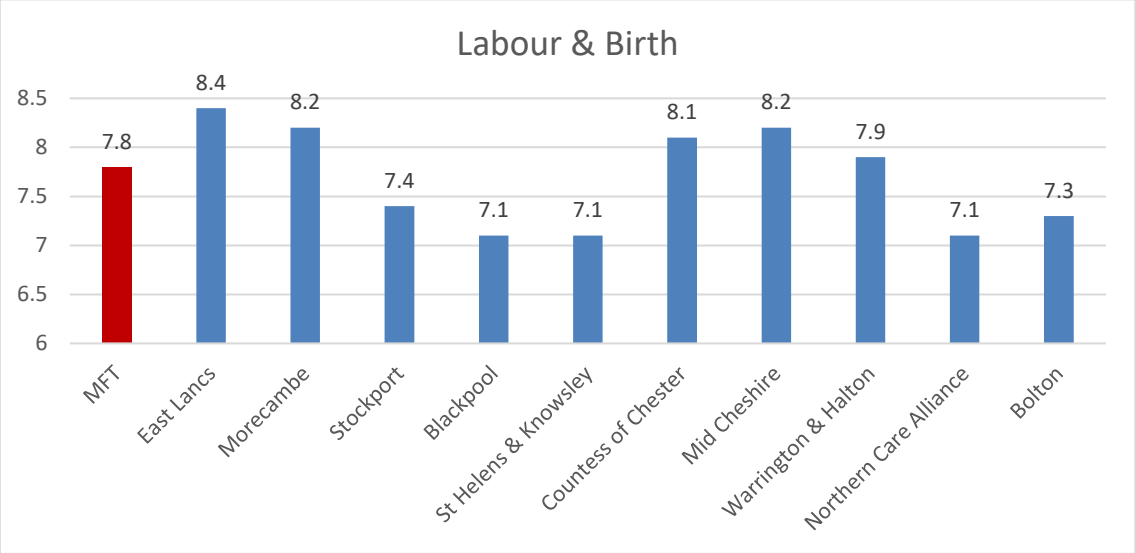
Graph 41: Comparison of scores for category 'The start of your care in pregnancy'



Graph 42: Comparison of scores for category 'Check-ups'

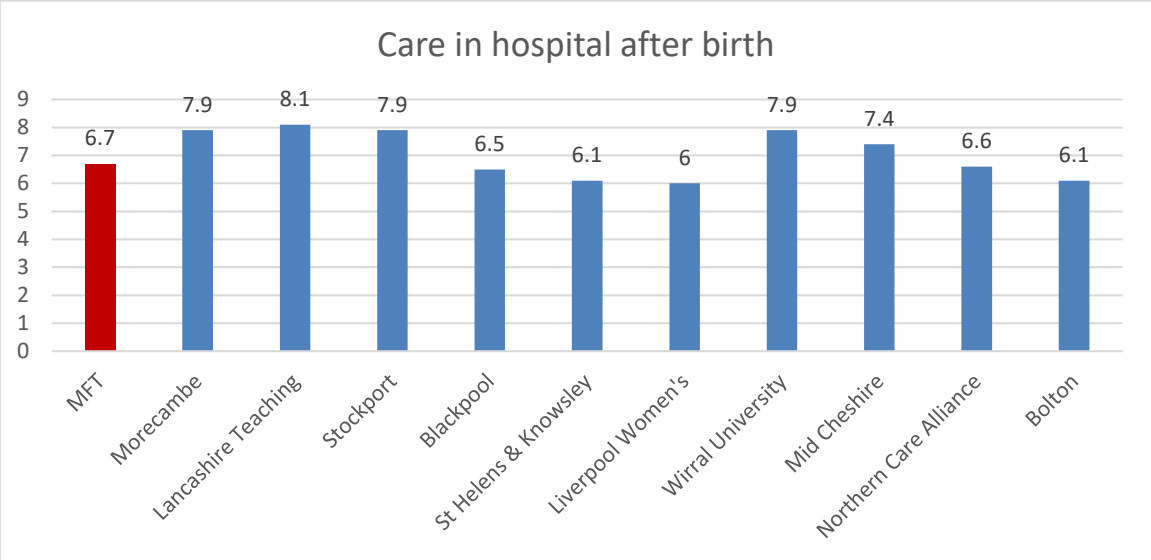


Graph 43: Comparison of scores for category 'During your pregnancy'

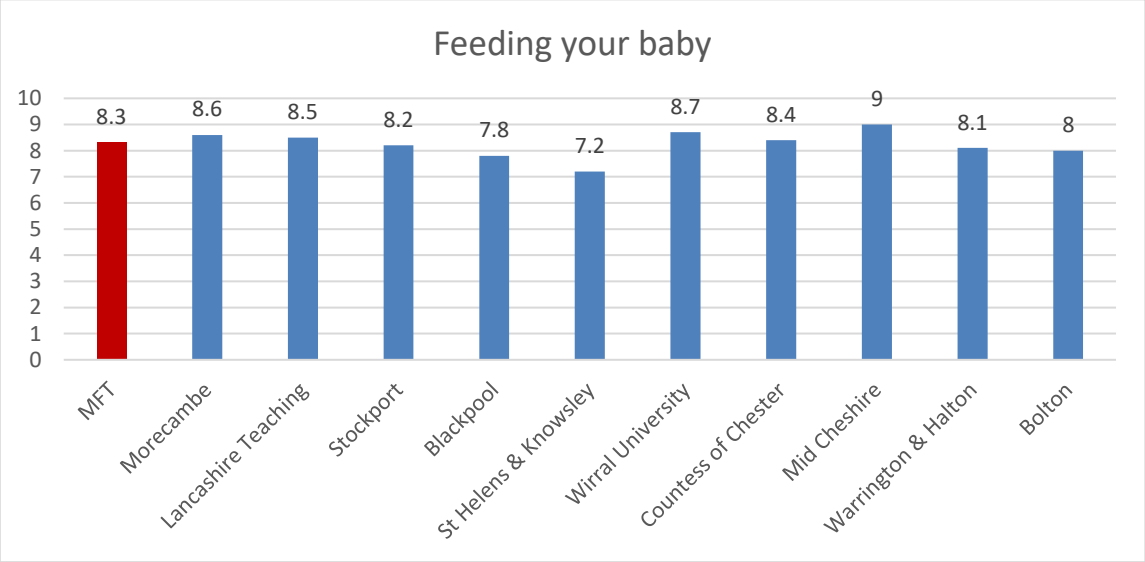


Graph 44: Comparison of scores for category 'Labour & Birth'

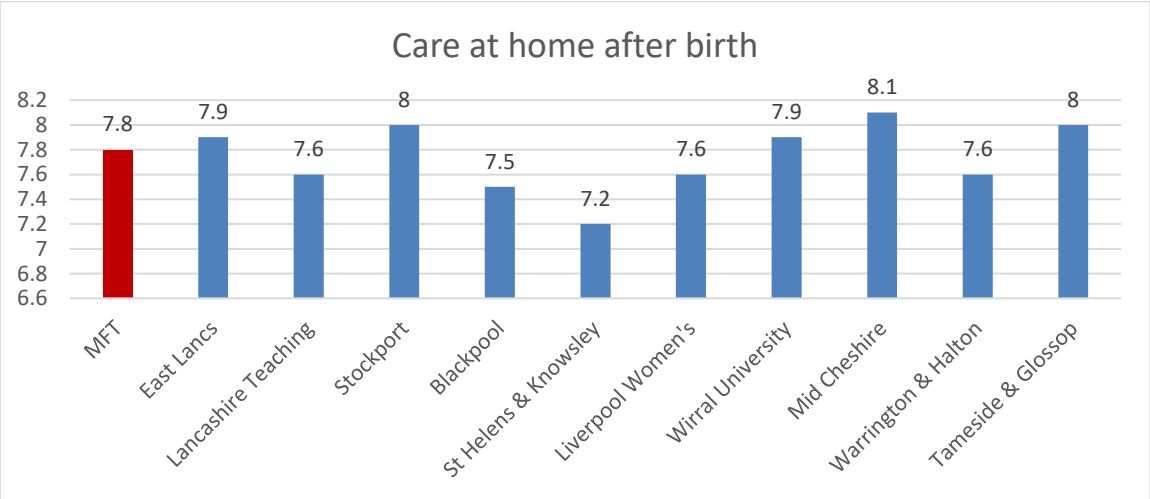
Graph 45: Comparison of scores for category 'Staff caring for you'



Graph 46: Comparison of scores for category 'Care in hospital after birth'



Graph 48: Comparison of scores for category 'Feeding your baby'



Graph 49: Comparison of scores for category 'Care at home after birth'

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Agenda Item 11.3

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Gail Meers, Corporate Director of Nursing, Quality and Patient Experience
Date of paper:	September 2023
Subject:	Annual Complaints Report 2022/2023
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:	MFT must prepare an annual report which must: • Specify the number of complaints received. • Specify the number of complaints upheld. • Specify the number of complaints referred to the PHSO. • Summarise the themes of complaints. • Summarise how the complaints were handled. • Summarise lessons learned as a result of complaints.
Recommendations:	The Board of Directors is asked to note this Complaints Report for 2022/23 and, in line with statutory requirements, provide approval for the report to be published on the Trust website.
Contact:	Name: Gail Meers, Corporate Director of Nursing, Quality and Patient Experience Tel: 0161 276 8862

1. Introduction

1.1 The Trust adheres to the Statutory Instruments No. 309, which requires NHS bodies to provide an annual report on the Trust's complaints handling, which must be made available to the public under The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. This annual report reflects all complaints and concerns made by (or on behalf of) patients of MFT, between 1st April 2022 and 31st March 2023.

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 Organisation (LCO) across the MFT Group.

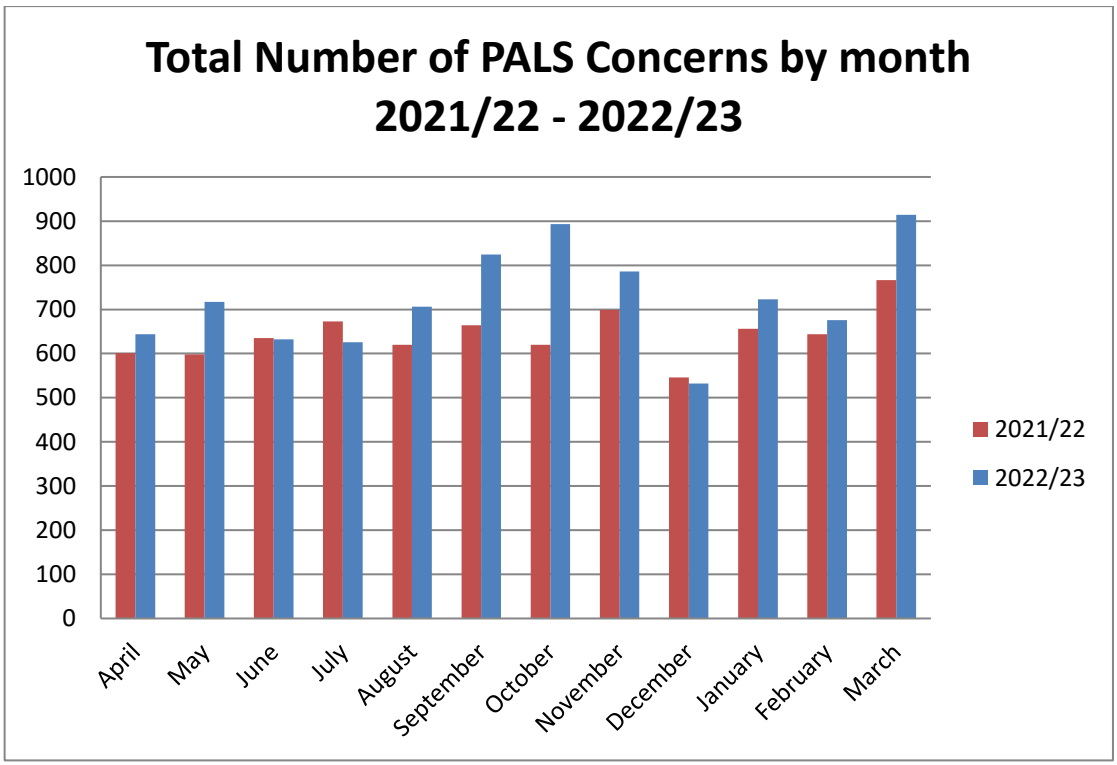
2. Summary of PALS and Complaints activity 2022/23

- In 2022/23 the Trust received 8,673 PALS concerns; a 12.3% increase from the 7,722 received in 2021/22. This was mainly due to increases in PALS concerns relating to 'Appointment Delays and Cancellations' at Wythenshawe, Trafford, Withington and Altrincham Hospitals (WTWA), The University Dental Hospital of Manchester (UDHM) and the Manchester Royal Eye Hospital (MREH).
- The Trust received 2,021 complaints during 2022/23; an increase of 21.4% from the 1,665 received in 2021/22, with the largest increase relating to 'Treatment and Procedure' at the Royal Manchester Children's Hospital (RMCH).
- 11% (217) of complaints were 'fully upheld', 73% (1,421) were 'partially upheld' and 16% (312) were 'not upheld'.
- 'Communication' and 'Appointment Delays and Cancellations' were the main themes of PALS concerns; 'Treatment and Procedure' was the main complaints theme.
- 99.8% of complaints were acknowledged within 3 working days and 88.7% of complaints were responded to within the agreed timescale; 87.4% of PALS concerns were closed within 10 working days.
- During 2022/23 the Parliamentary and Health Service Ombudsman (PHSO) informed the Trust of 11 completed investigations into MFT complaints. In summary, 1 (9%) case was 'fully upheld', 6 (55%) cases were 'partially upheld' and 4 (36%) cases were 'not upheld'.

- The Trust, and each Hospital/MCS/LCO, held regular forums where themes and trends relating to complaints are discussed with focused actions agreed for improvement.

3.0 An overview and thematic analysis of PALS contacts

3.1 The Trust saw an increase of 12.3% in PALS concerns from the previous year, with 8,673 PALS concerns being received compared to the 7,722 received in 2021/22. **Graph 1** below shows the number of PALS concerns received by month for 2022/23 compared to the previous year.



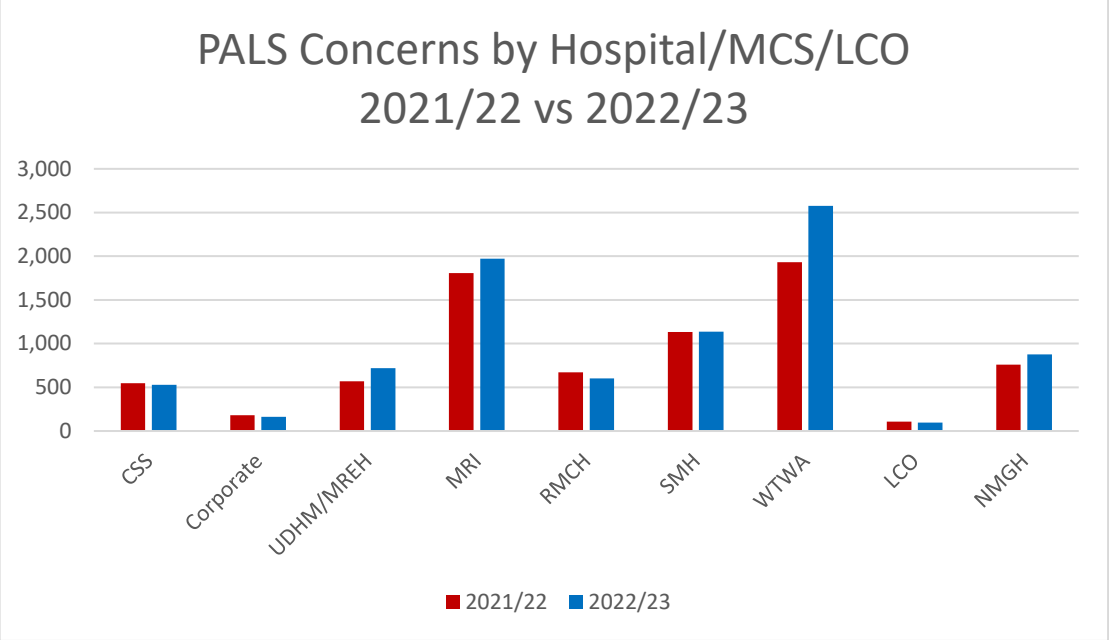
Graph 1: Total number of PALS concerns received by month 2021/22 - 2022/23.

3.2 **Graph 2** below shows the number of concerns received by each Hospital/MCS/LCO during 2021/22 and 2022/23. Wythenshawe, Trafford, Withington and Altrincham Hospitals (WTWA) and Manchester Royal Infirmary (MRI) received the greatest number of PALS concerns, receiving 2,578 and 1,973 respectively.

3.3 Overall, the greatest increase in PALS concerns was in WTWA with a 33.5% increase being noted compared to 2021/22. WTWA received almost twice as many concerns relating to 'Appointment Delays and Cancellations' in 2022/23 compared to 2021/22.

3.4 The University Dental Hospital of Manchester (UDHM) and the Manchester Royal Eye Hospital (MREH) also saw a large increase in PALS concerns with a 26.6% increase being noted compared to 2021/22. Of the 719 concerns received 84.8% related to 'Appointment Delays and Cancellations' and 'Communication'.

3.5 A 10% reduction in concerns received was noted in the Royal Manchester Children's Hospital (RMCH) and Manchester and Trafford Local Care Organisation (LCO). Both decreases were driven by reductions in concerns related to 'Treatment and Procedure'.



Graph 2: PALS concerns received by Hospital/MCS/LCO 2021/22 vs 2022/23.

3.6 **Chart 1** and **Graph 3** below show the distribution of the main PALS themes and indicates that the greatest proportion of PALS concerns relate to 'Communication', 'Appointment Delays/Cancellations' and 'Treatment and Procedure'. The greatest increase in PALS concerns was in relation to 'Appointment Delays/Cancellations' with 39.8% increase being noted compared to 2021/22.

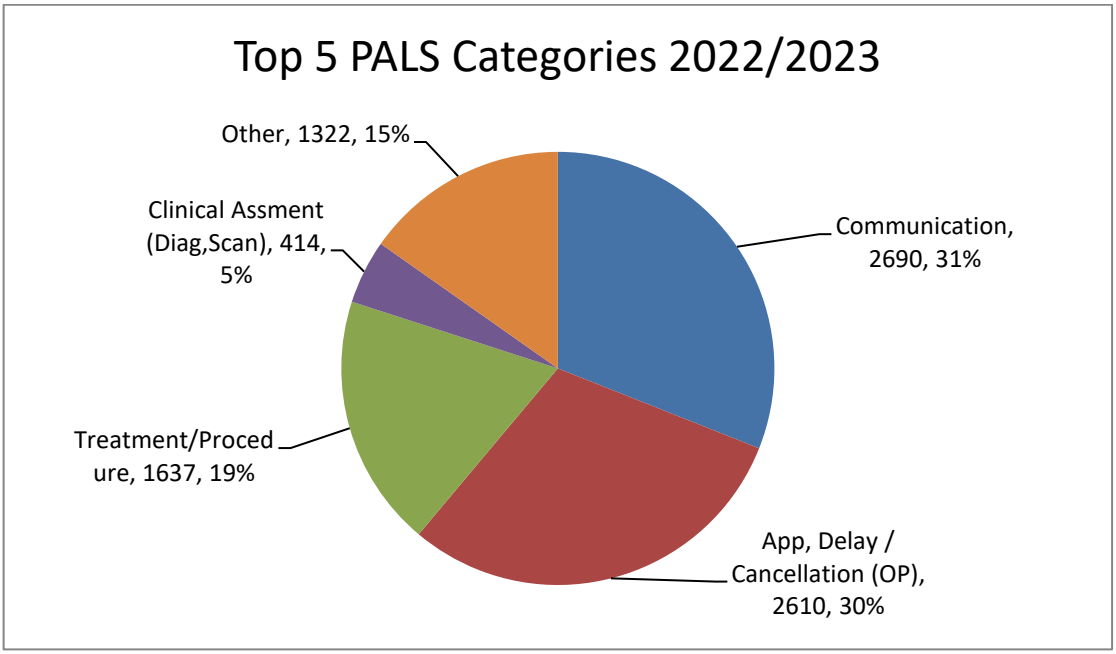
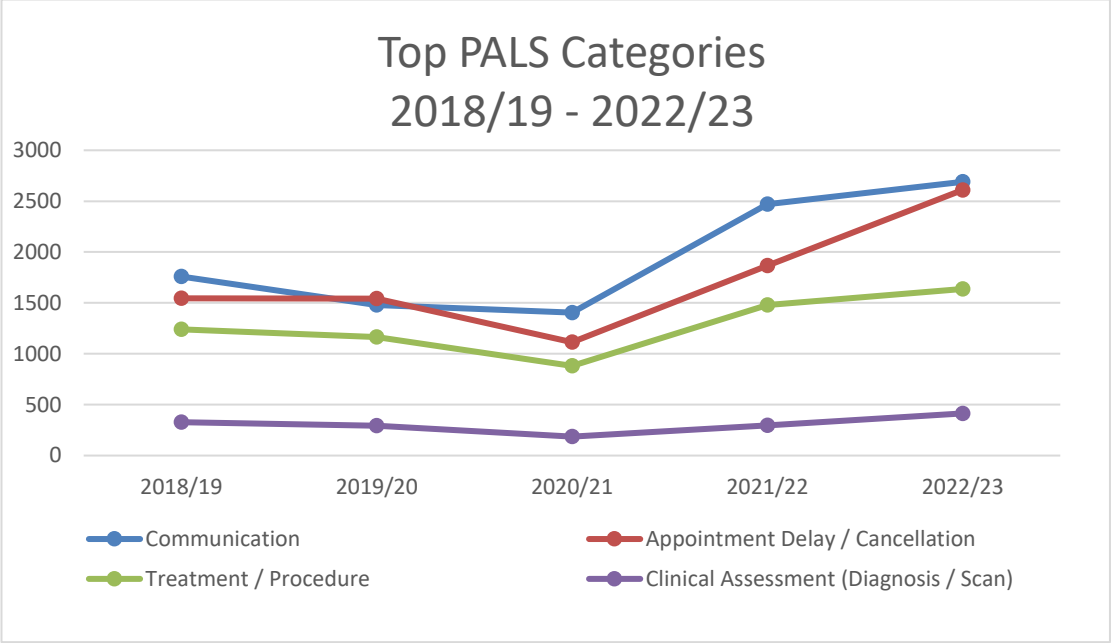


Chart 1: Top PALS categories 2022/23.



Graph 3: Top PALS categories 2018/19 to 2022/23.

3.7 **Chart 2** below highlights the top 3 professions referenced in complaints and PALS concerns for any reason. As in 2020/21 and 2021/22 medical staff are the highest group referenced with a total of 3,227 PALS concerns. These numbers are comparable to those from 2021/22, when adjusted for increased organisational activity**.**

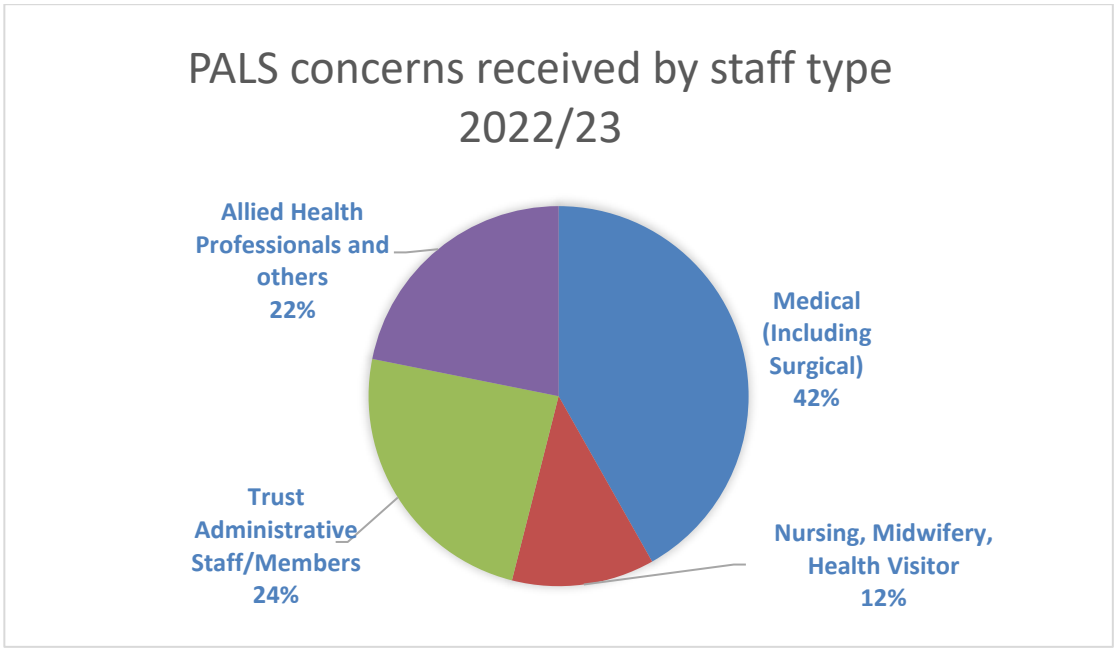


Chart 2: PALS concerns received by staff type 2022/23.

3.8 **Table 1** below provides a breakdown of the sources of PALS concerns received. Email and telephone are the most popular methods for patients and their representative to raise concerns, with the greatest increase has been seen in the number of email concerns raised (1,156 more concerns via email than in 2021/22); however, the greatest percentage increase during 2022/23 has been with the number of concerns being raised in person (face-to-face), with a 46.8% rise from the previous year.

Category	2021/22	2022/23	% change
Comment Box	0	0	0
Email	3723	4879	1,156 (31.1%)
Face to Face	316	464	148 (46.8%)
Fax	0	1	*No comparison*
From Complaints	0	4	*No comparison*
From Family Support	0	0	0
From PALS	1	2	1 (100.0%)
Letter	29	20	-9 (-31.0%)
Telephone	3644	3165	-479 (-13.1%)
Tell Us Today	0	0	0
Website	0	0	0
Totals	**7722**	**8673**	**817 (12.3%)**

Table 1: Sources of new PALS concerns 2022/23.

3.9 This has been supported by the PALS Team Leaders working to improve awareness of the service and becoming more accessible. PALS was advertised in 'MFT Time' (a weekly email sent to all MFT staff) in February 2023, to raise staff awareness of PALS and how PALS can support both patients/relatives, and staff alike. Staff were informed of the different ways patients, their representatives or staff can contact PALS, with an emphasis on in-person and via telephone or email/post, with PALS offices across different sites open for members of the public to raise concerns on a walk-in basis, without the need for an appointment in advance.

3.10 During Q4, the PALS Team Leaders attended Heads of Nursing Forums across the Hospitals/MCS/LCO and Team Leader/Senior Clinician Training Programmes, to raise staff awareness of PALS and their freedom to actively seek feedback to improve services and seek local resolution. PALS Team Leaders will continue to attend these forums and training programmes, throughout 2023/24, and are available to meet with patients and their representatives in person at Receptions and in departments/wards.

3.11 Understanding complaint themes alongside other quality, safety and patient experience metrics supports organisations identify issues, areas for improvement and poor practice. The Trust's What Matters to Me (WMTM) Patient Experience Framework supports the triangulation of data and information from a wide range of sources across the organisation. Examples of these include themes from the annual national survey results; the Trusts local Quality Care Round (QCR) data; the Friends and Family Test and WMTM Patient Experience survey feedback, along with incidents, complaints, PALS and compliments.

3.12 Triangulation of this data provides the opportunity for Hospitals/MCS's/LCO's to analyse, identify issues and areas for improvement, compare findings and correlate themes. Where themes correlate, it can provide early indication and intelligence to act on the data, reduce risks and prevent harm. Similarly, negative patient feedback has a close correlation with patient complaints and understanding the nature of complaints provides the opportunity for learning lessons from lived experience of our services and is an effective way of improving patient care.

3.13 In addition to the FFT, the WMTM Survey is one of the main ways that MFT measures patient experience. The Survey asks patients a series of questions about their recent experience in relation to the nine domains below:

- Communication
- Equality and Diversity
- Hygiene and Personal Care
- Patient and the Carer
- Infection Prevention (IP) Control
- Nutrition and Hydration
- Pain
- Patient Safety
- Privacy and Dignity

The Trust has a lower and an upper benchmark target for the WMTM Surveys. The lower target is 85% and the upper target is 95% achievement in all domains.

3.14 Another method the NHS gauges patient satisfaction is through the Friends and Family Test (FFT). The FFT is a single question survey which asks patients, carers or family members to rank their experience of care.

The FFT questions are:

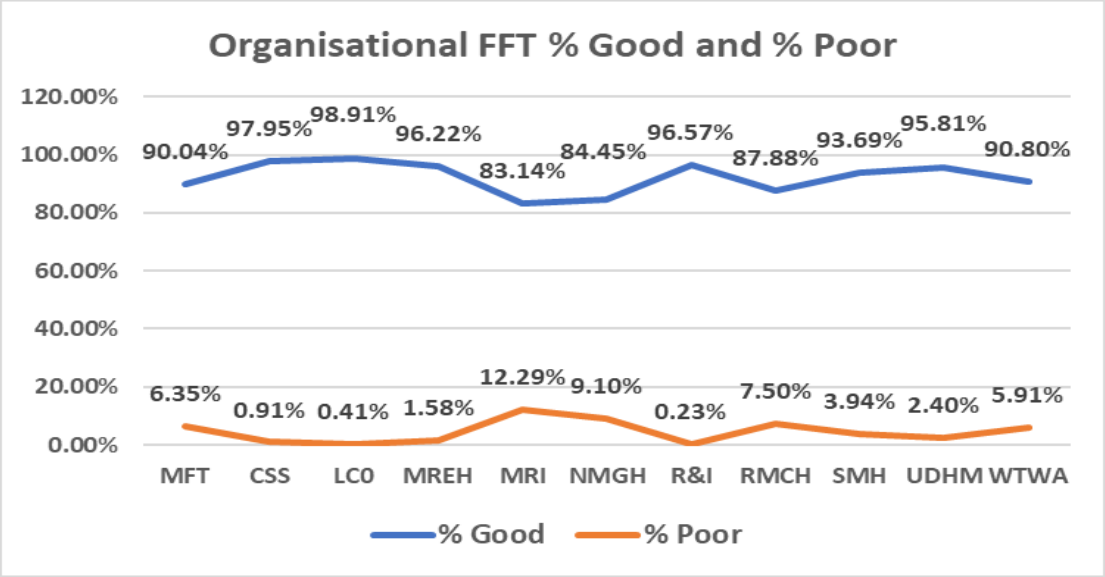
'Thinking about your recent visit overall, how was your experience of our service?'

'Please can you tell us what was good about your care and what we could do better?'

The answers are ranked by choosing one of the following; very good, good, neither good nor poor; poor; very poor, don't know. The score is a simple comparison of the percentage of those completing the test who would recommend their experience as good and very good, against the percentage of those who would not recommend the care experience and rate the scores as very poor or poor.

3.15 **Graph 3** below shows the overall FFT results for the Hospitals/MCSs/LCO and Trust as a whole, where patients have rated their experience between good and poor as a percentage. The line graph shows that five areas achieved above the Trust upper benchmark of 95%. These were, Clinical Scientific Services (CSS), LCO, Research and Innovation (R&I), MREH and UDHM.

MRI and North Manchester General Hospital (NMGH), Royal Manchester Children's Hospital (RMCH), Saint Mary's Hospital (SMH), Wythenshawe, Trafford, Withington and Altrincham Hospitals (WTWA) scored below the Trust target of 95% for FFT. It is useful to compare the lower FFT satisfaction scores with Complaints activity, to see if there is any correlation. MRI received the lowest % satisfaction rate scoring 83.14%, and scored the highest poor satisfaction rate of 12.29%, an increase from 11.57% the previous year. This correlates with the increase seen in PALS and Complaints for MRI in 2022/23.



Graph 3: Trust overall FFT results showing patient ratings as % Good and % Poor Scores captured during 2022/23 by Hospital/MCS/LCO.

3.16 WMTM and FFT feedback comments can be themed via sentiment analysis which is a process of computationally identifying and categorising opinions expressed in a piece of text to determine sentiment. The sentiment analysis reveals the top negative comments for both surveys.

3.17 **Table 2** below shows the top 3 primary negative feedback relating to What Matters to Me (WMTM) themes. The top negative WMTM theme was 'Waiting', which correlates with the top PALS category, namely 'Appointment Delays/Cancellations' which was seen in the majority of PALS concerns received.

Top Three Negative WMTM Themes 2022/23			
WMTM	**Theme 1**	**Theme 2**	**Theme 3**
MFT Total	Waiting	Food & Beverages	Hygiene
CSS	Food & Beverages	Waiting	Pain
LCO	Food & Beverages	Pain	Comfort
MREH	Waiting	Food & Beverages	Politeness
MRI	Waiting	Food & Beverages	Hygiene
NMGH	Waiting	Pain	Food & Beverages
R & I	Waiting	Emotional & Physical Support	Communicating to Patients
RMCH	Hygiene	Waiting	Food & Beverages
SMH	Waiting	Pain	Food & Beverages
UDHM	Waiting	Hygiene	Privacy, Dignity & Respect
WTWA	Waiting	Food & Beverages	Hygiene

Table 2: Top 3 Negative Themes based on WMTM Feedback captured during 2022/23 by Hospital/MCS/LCO

3.18 **Table 3** below shows the top 3 primary negative Friends and Family Test (FFT) themes, which were reported at Trust level. As noted in PALS concerns and WMTM above the main negative FFT theme reported by all Hospitals/MCSs/LCO was also 'waiting'.

Top Three Negative FFT Themes 2022/23			
WMTM	**Theme 1**	**Theme 2**	**Theme 3**
MFT Total	Waiting	Pain	Emotional & Physical Support
CSS	Waiting	Food & Beverages	Pain
LCO	Waiting	Emotional & Physical Support	Facilities
MREH	Waiting	Facilities	Emotional & Physical Support
MRI	Waiting	Pain	Emotional & Physical Support

NMGH	Waiting	Pain	Comfort
R&I	Waiting	Emotional & Physical Support	Professional & Competent
RMCH	Waiting	Emotional & Physical Support	Pain
SMH	Waiting	Emotional & Physical Support	Comfort
UDHM	Waiting	Pain	Facilities
WTWA	Waiting	Pain	Food & Beverages

Table 3: Top 3 Negative Themes based on FFT feedback captured during 2022/23 by Hospital/MCS/LCO.

3.19 It has not been possible to carry out a comparison of the WMTM themed data between 2021/22 and 2022/23, due to a technical issue relating to the provider of the Patient Experience Platform system.

The technical issue has now been rectified by the company provider and sentiment analysis can now function effectively for both FFT and WMTM survey comments and results for 2022/23 will be made available for comparison in future.

4.0 PALS responsiveness and KPI

4.1 During 2022/23, the average response rate to PALS concerns was 5.3 days, which is a slight increase from the 4.9 days average during 2021/22. In total, during 2022/23, 87.4% of PALS cases were closed within 10 working days and as can be seen from **Table 2**, the responsiveness was noted to be improving at the end of 2022/23.

4.2 Improvements in responsiveness have been supported by the implementation of the PALS Escalation Standard Operating Procedure, with timely escalation of cases to senior management undertaken prior to the approaching deadline. In addition to this, weekly Hospital/MCS/LCO/Corporate Services PALS Key Performance Indicator (KPI) meetings have also recently been introduced, with the progress of every open PALS case discussed with the respective staff managing the cases.

	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23
Resolved in 0-10 days	1846	1810	1923	2042
Resolved in 11+ days	203	256	402	234
% Resolved in 10 working days	90%	88%	83%	90%

Table 2: Closure of PALS concerns within timeframe 2022/23

4.3 **Table 3**, below, shows the number of PALS concerns resolved within the Trust's 10-day response timescale, by each Hospital/MCS/LCO, as well as those which exceeded this target. Again, this shows a great improvement in reducing the number of cases exceeding 10 days, within the final quarter of the year.

	<10 days Q1	>10 days Q1	<10 days Q2	>10 days Q2	<10 days Q3	>10 days Q3	<10 days Q4	>10 days Q4
WTWA	584	56	568	81	573	96	596	49
MRI	419	53	439	60	390	99	456	64
RMCH	115	13	113	21	144	35	142	19
UDHM/MREH	150	8	155	10	209	27	147	9
SMH	247	30	250	47	253	35	267	28
CSS	61	16	81	11	120	25	192	15
Corporate	16	14	12	6	29	13	54	14
LCO	30	1	23	2	14	5	20	4
NMGH	224	11	169	18	191	67	168	31
Grand Total	1846	202	1810	256	1923	402	2042	233

Table 3: Number of PALS concerns taking longer than 10 days to close by Hospital/MCS/LCO 2022/23.

4.4 **Table 4**, below, shows the number of PALS concerns that were escalated to formal complaints. Responding to PALS concerns in a timely manner can prevent concerns being escalated to formal complaints. This has been achieved via the PALS escalation SOP and weekly PALS KPI meetings, but also via improved training and awareness of the positive effect closing PALS cases in a timely manner can have. The Customer Services Manager and PALS Team Leaders will deliver more training on local resolutions, across the Trust, throughout 2023/24.

	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23
No of PALS cases escalated	13	15	20	10

Table 4: Number of PALS concerns escalated to formal complaints 2022/23

5.0 An overview and thematic analysis of Complaints contacts

5.1 The number of responses for WMTM fell from 30,806 in 2021/22 to 25,682 in 2022/23 (-16.6%). Similarly, the number of FFT responses received during 2022/23 decreased from 147,519 responses in 2021/22 to 120,433 responses in 2022/23 (-18.4%).

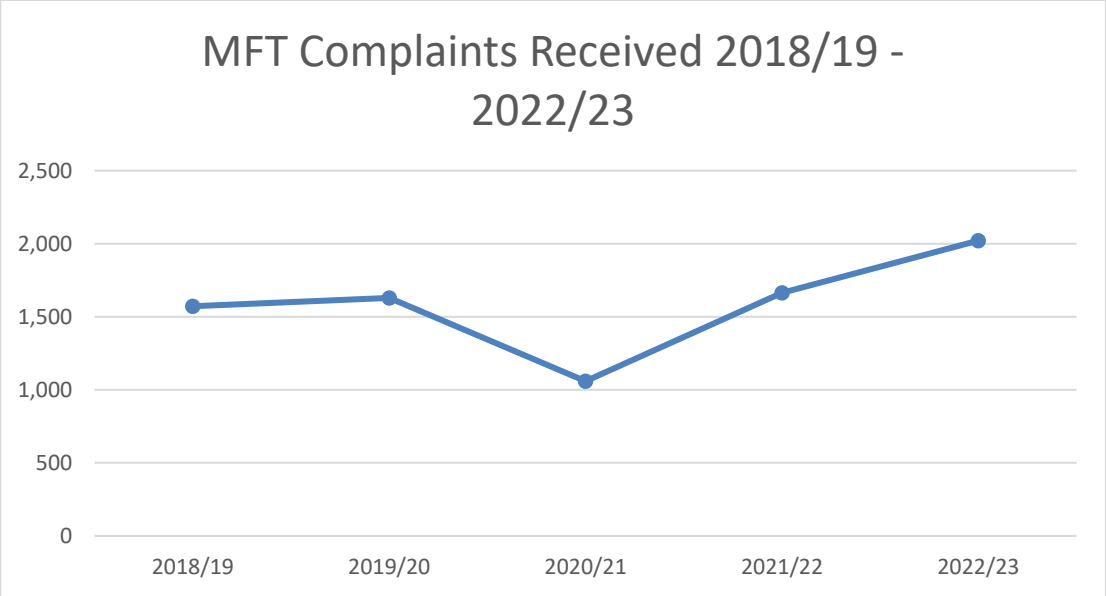
5.2 The decrease in WMTM and FFT response rates can be attributed to a range of factors including, device issues, Wi-Fi connectivity and an ineffective process in place to promote and offer patients the opportunity to complete the surveys.

5.3 Work continues, in collaboration with wards and departments, to explore ways to maximise the number of surveys completed by patients, families and carers to ensure that local feedback is gained, and issues and themes are identified to drive quality improvements. Oversight is provided through various forums, such as the Quality and Patient Experience Forum and through the accreditation process where themes are identified and discussed. An FFT Patient Experience co-ordinator dedicated supporting the clinical areas and engaging with staff to increase their survey response numbers.

5.4 Of the 120,433 FFT responses received, 6.4% related to a 'poor' experience (this shows an increase of 2.9%). Of note 90% of service users at the Trust reported their experience of our services as 'good'. This suggests that the patients and representatives responding to the FFT survey were less satisfied with their experience during 2022/23 than the previous year, which correlates with the increase in complaints received during 2022/23.

5.5 There were 2,021 complaints received during 2022/23, in comparison to the 1,665 received in 2021/22 an increase of 21.4%.

5.6 **Graph 6** below shows the increasing number of complaints the Trust has received since the COVID-19 pandemic and North Manchester General Hospital (NMGH) coming under MFT management, due to the increase in organisation activity through an increase in the number of patient attendances in Emergency Departments and inpatient consultant episodes (see **Table 5**).



Graph 6: MFT complaints received 2018/19 - 2022/23.

5.7 As a measure of performance, the number of complaints should be considered in the context of organisational activity. **Table 5** below shows the number of complaints in the context of Inpatients, Outpatients and Emergency Department attendances for 2022/23 compared to previous years. It is acknowledged that the Trust has seen not only an increase in the number of complaints but also in the rate of complaints per patient appointments, attendances in the Emergency Department and inpatient consultant episodes.

		2019/20	2020/21	2021/22	2022/23
Inpatient	Formal Complaints Received (FC)	523	419	531	624
	Finished Consultant Episodes (FCE)	431,667	337,049	455,841	450,081
	Rate of FCs per 1000 FCEs	1.21	1.24	1.16	1.39
	% of FCs per FCE	0.12%	0.12%	0.12%	0.14%
Outpatient	Formal Complaints Received (FC)	711	380	665	919
	Number of Appointments	2,541,377	1,293,384	1,470,442	1,854,418
	Rate of FCs per 1000 Appointments	0.28	0.29	0.45	0.50
	% of FCs per Appointments	0.03%	0.03%	0.05%	0.05%
AE	Formal Complaints Received (FC)	191	105	270	314
	Number of Attendances	413,741	267,867	482,908	483,880
	Rate of FCs per 1000 attendances	0.46	0.39	0.55	0.65
	% of FCs per 1000 attendances	0.46%	0.39%	0.56%	0.65%

Table 5: Number of complaints received by patient activity 2019/20 – 2022/23.

5.8 Whilst WTWA and MRI received the most complaints, with 496 and 450 respectively, Table 8 shows that the largest increase in complaints was in RMCH with a 41.9% increase being noted compared to the previous year, partially driven by an increase in complaints related to ‘Treatment and Procedure’.

5.9 Of the 237 complaints received, 38.8% related to 'Treatment and Procedure'; part of which can be explained by the decrease in PALS concerns relating to this category, with concerns relating to 'Treatment and Procedure' requiring a more detailed formal complaint investigation and response. Despite the highest increase in the number of complaints since 2021/22, RMCH's poor satisfaction rate for FFT has remained unchanged since 2021/22; however, the WMTM scores for RMCH for 2022/23 is 84.37 % which is below Trust standard (95%). There were also low WMTM scores seen for RMCH, relating to Hygiene and Personal Care (67.89%) and Nutrition and Hydration (78.87%) in 2022/23.

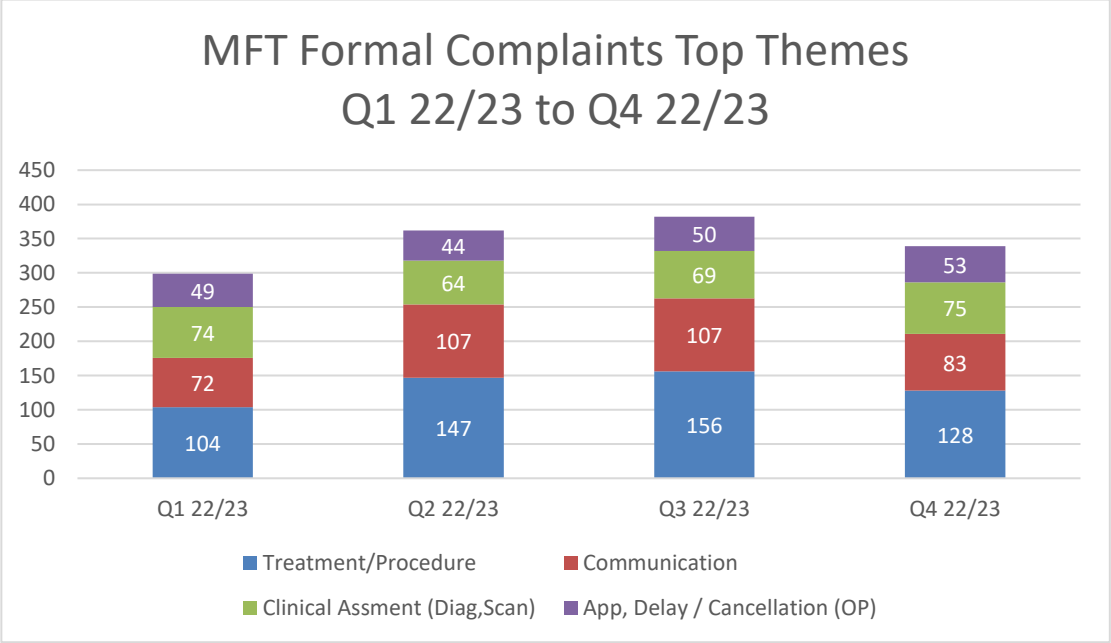
Hospital / MCS / Division	2018/19	2019/20	2020/21	2021/22	2022/23	% change from 2021/22 to 2022/23
CSS	82	103	67	96	120	**25.0%** ↑
Corporate Services	91	68	44	54	66	**22.2%** ↑
UDHM/MREH	115	96	39	103	95	**-7.8%** ↓
MRI	452	419	283	356	450	**26.4%** ↑
RMCH	167	189	111	167	237	**41.9%** ↑
SMH	190	194	160	243	286	**17.7%** ↑
WTWA	442	515	317	406	496	**22.2%** ↑
LCO	27	44	38	56	50	**-10.7%** ↓
NMGH	-	-	-	184	221	**20.1%** ↑
MFT Total	**1,573**	**1,628**	**1,059**	**1,665**	**2,021**	**21.4%** ↑

Table 8: Complaints received by Hospital/MCS/LCO 2018/19 to 2022/23.

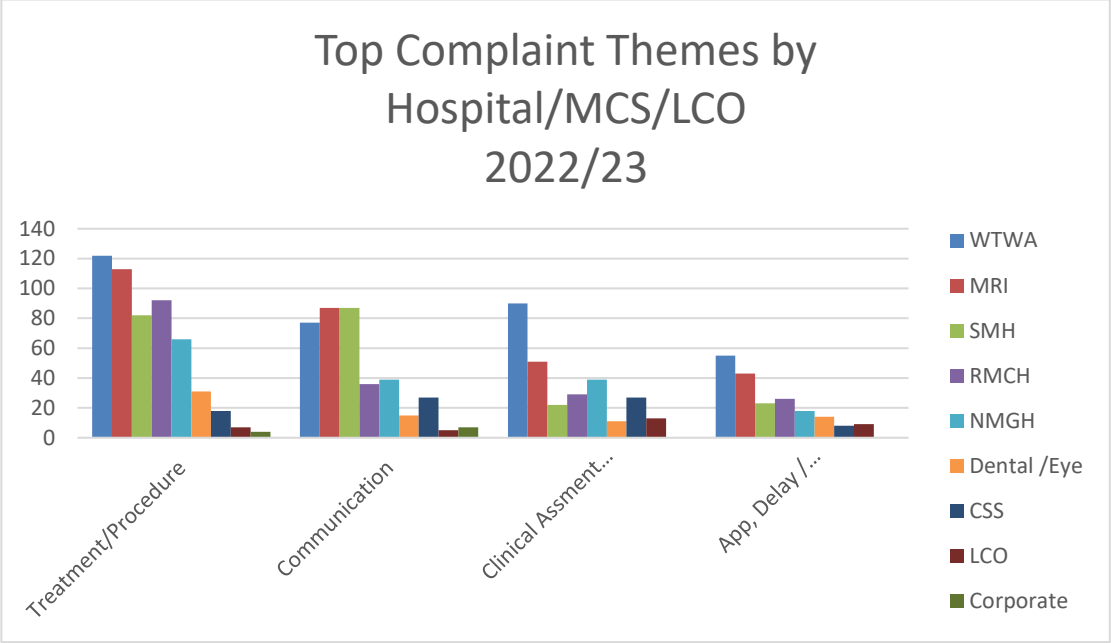
5.10 FFT data for MRI correlates with the increase in complaints, as there was an increase in the poor satisfaction rate for FFT for MRI from 11.57% to 12.29%. Similarly, WTWA experienced an increase in the poor satisfaction rate for FFT, from 2.24% in 2021/22 to 3.91% in 2022/23.

5.11 The greatest decrease in complaints was in the LCO and UDHM/MREH both experiencing a reduction in the number of complaints received in year-on-year, -10.7% and -7.8% respectively. The LCO saw much improved 'Communication' and 'Attitude of Staff', whilst UDHM/MREH saw a reduction in complaints relating to 'Treatment and Procedure'. The decrease in complaints correlates to the high level of good satisfaction rate for FFT reported by the LCO (98.6%) and the overall positive WMTM score (98.15%).

5.12 The opportunity to learn from complaints is an effective way of improving patient care and experience. Complaints are categorised by themes, and staff work to improve the quality of care in areas where recurring complaint themes emerge, or where practice is identified as requiring improvement. **Graph 7** below demonstrates the most prevalent categories of complaints raised in 2022/23. 'Treatment and Procedure' was the main theme of complaints received, followed by 'Communication' and 'Clinical Assessment'. These top 3 themes were the same as 2021/22; however, this year saw the emergence of an increase in complaints relating to 'Appointment Delay/Cancellation', with the largest number of complaints relating to this being received in WTWA and MRI. Due to the COVID-19 pandemic and introduction of MFT's new patient electronic record system, HIVE, in September 2022, there continues to be an outpatient backlog in a number of specialities across WTWA. WTWA has established a director-led Outpatient Improvement Group with focus on improving productivity and efficiency to support delivery of the WTWA annual plan and 65-week wait RTT performance.



Graph 7: Top Complaint Themes Q1 – Q4 2022/23



Graph 8: Top complaint themes by Hospital/MCS/LCO 2022/23.

5.13 **Graph 8** below shows the breakdown of complaint themes by Hospital/MCS/LCO. WTWA received the most complaints relating to 'Treatment / Procedure' (122), Clinical Assessment (90), and Appointment Delay/Cancellation (55), whilst MRI and SMH received the most complaints relating to 'Communication' (87).

5.14 As described above the top negative theme reported for FFT and WMTM was 'Waiting', which aligns with the increase in complaints relating to 'Appointment Delay/Cancellation' (themes highlighted in **Tables 2 and 3**). WTWA and MRI both reported 'Waiting' as their top negative theme.

5.15 **Chart 3** below highlights the top 3 professions referenced in complaints, for any reason. As in 2020/21 and 2021/22 Medical Staff are the highest group referenced with a total of 1,452 complaints, followed by nursing, midwifery, health visiting staff who are referenced in 577 concerns/complaints. These numbers are comparable to those from 2021/22, when adjusted for increased organisational activity. Whilst recording limitations prevent further analysis of this data to determine whether these references relate to specific grades of medical staff or certain nursing, midwifery or health visiting staff, it is recognised that medical staff are the main lead practitioner for episodes of care, and nursing, midwifery and health visiting staff are often the first point of contact for patients. It is not, therefore unusual, or unexpected for these staff groups to be cited by patients who wish to raise a concern or make a complaint.

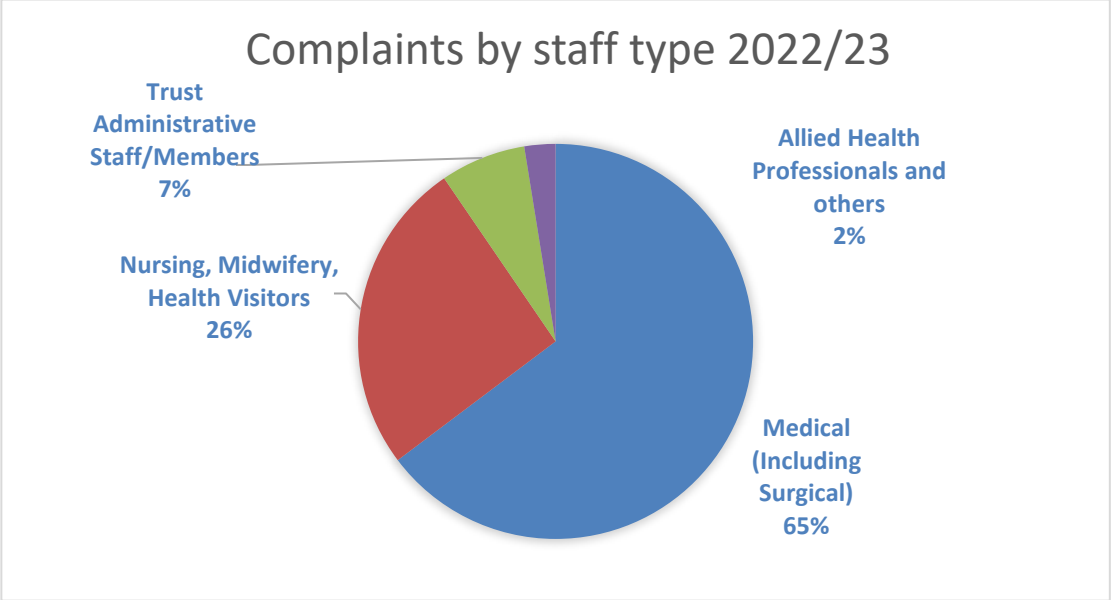
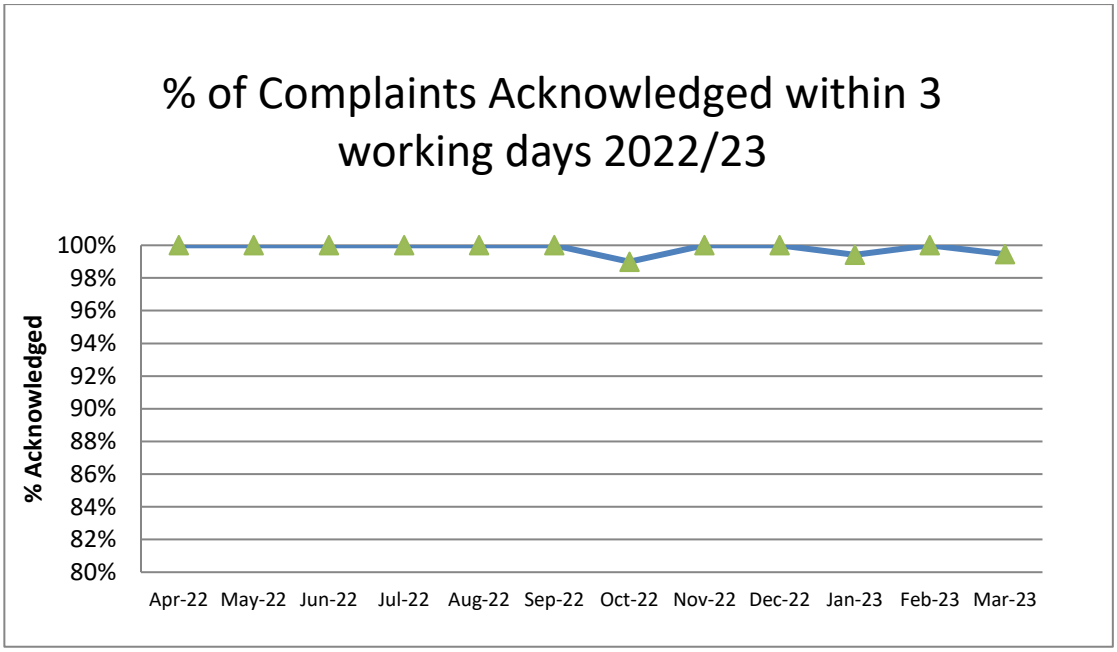


Chart 3: Complaints received by staff type 2022/23.

6.0 Complaints responsiveness and KPI

6.1 The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 place a statutory duty upon the Trust to acknowledge complaints within 3 working days. **Graph 9** below shows the Trust's adherence with this requirement, on a monthly basis. Throughout the year, the Trust acknowledged 99.8% of all new complaints within 3 working days.



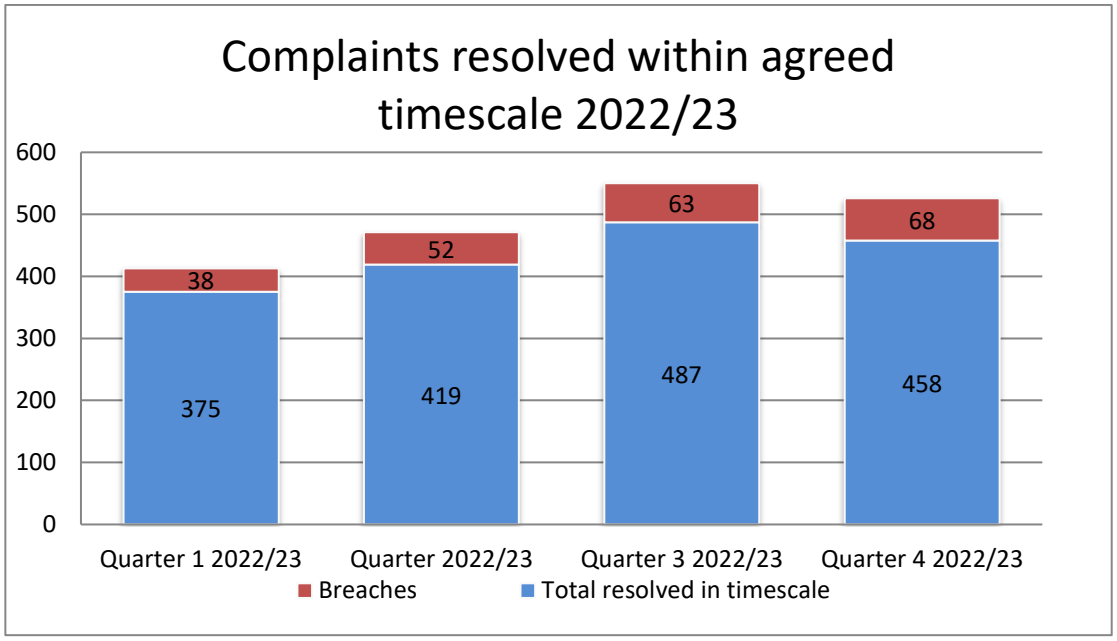
Graph 9: % of complaints acknowledged ≤ 3 working days during 2022/23.

6.2 There were 4 occasions where the Trust failed to acknowledge complaints within the 3 working day mandatory timescale. On each occasion, an investigation took place and action was taken to prevent a recurrence of the root cause. In all cases, the complainants were contacted, and apologies were provided and accepted.

6.3 Against the Trust's target of 90% of complaints being responded to within the agreed timescale, the Trust achieved a success rate of 88.7% of complaints within the agreed timescale, which is lower than the 90.4% rate achieved during 2021/22. **Graph 10** depicts the number of complaints responded to within time, and breaches, throughout each quarter, with **Table 9** detailing the breakdown by Hospital/MCS/LCO. The drop in the overall number of complaints being responded to within the Trust timescale, was driven by a decrease in SMH's responsiveness throughout the year (decreasing from 82% in Q1 to 62% in Q4, with an overall response rate of 71%). WTWA was the best performing Hospital/MCS/LCO, responding to 99% of their complaints within the agreed timescale. **Graph 11** shows the number of days taken to resolve each complaint. The spikes around 25, 40 and 60 working days are aligned to the Trust's complaint responses deadlines.

6.4 To improve the compliance with complaint response deadlines, the structure of the weekly Hospital/MCS/LCO/Corporate Services Complaints KPI meetings has been standardised across the Trust. Hospitals/MCSs/LCO/Corporate Services are monitoring their Complaints KPIs extremely closely to enable timely updates to be provided to the Corporate Complaints Team, with any delays and breaches of deadlines being escalated to the Corporate Senior Leadership Team (SLT).

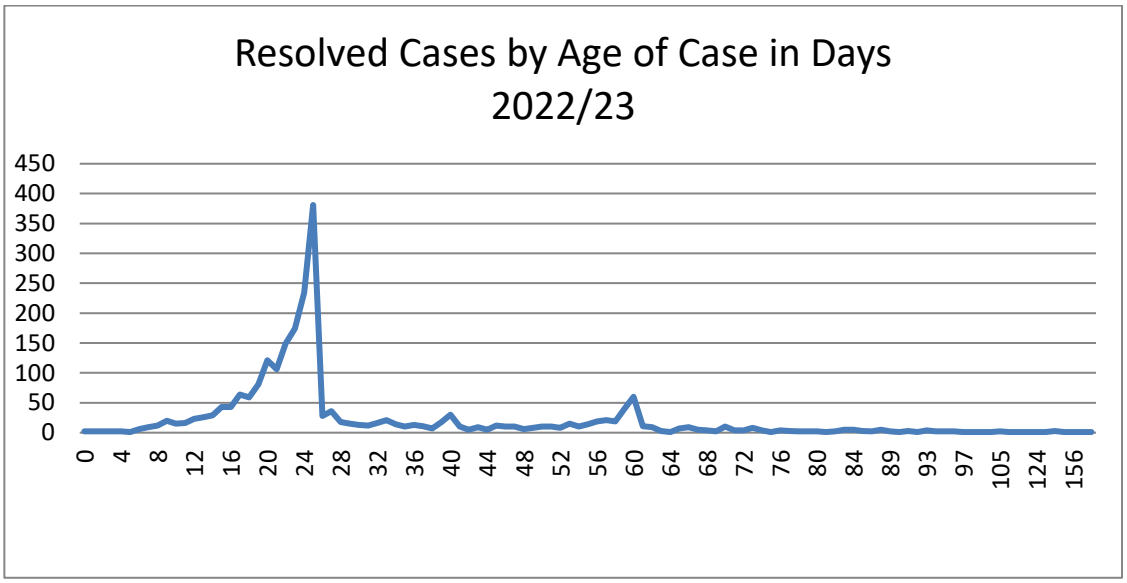
6.5 All meetings are now held via MS Teams, which has improved engagement between the Complaints Team and the Hospitals/MCSs/LCO and had a positive impact on timely updates being shared with the complainants on the progress of their case.



Graph 10: Complaints responded to within agreed timescale 2022/23.

Hospital/MCS/LCO	Q1	Q2	Q3	Q4	Overall
CSS	79%	87%	84%	95%	87%
UDHM/MREH	83%	100%	88%	92%	90%
LCO	100%	75%	63%	85%	82%
MRI	91%	93%	94%	91%	92%
RMCH	100%	97%	95%	97%	97%
SMH	82%	73%	70%	62%	71%
WTWA	100%	97%	100%	98%	99%
NMGH	94%	98%	94%	95%	95%
Total	91%	89%	89%	87%	89%

Table 9: Complaints responded to within agreed timescales by Hospital/MCS/LCO 2022/23.



Graph 11: Number of days taken to resolve complaints during 2022/23.

7.0 Complaints outcomes

7.1 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 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.

7.2 Often complaints relate to more than one issue. In conjunction with the Hospital/MCS/LCO/Corporate Services 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, based on which a fact is proven is identified to support the complaint, 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’.

7.3 During 2022/23, 217 (11%) of the complaints investigated and responded to were 'fully upheld', 1,421 (73%) were 'partially upheld' and 312 (16%) were 'not upheld'. **Table 10** demonstrates the outcome status of all complaints, which shows that there was an increase in the number of complaints being fully upheld each quarter.

7.4 The main themes of 'fully upheld' complaints were 'Treatment/Procedure' and 'Communication'. MRI (35) and SMH (34) received the highest number of 'fully upheld' complaints, with SMH receiving the most about 'Treatment/Procedure' (13) and 'Communication' (8).

7.5 The MFT overall WMTM score for communication was 88.52%. This is below the Trust standard of 95%. In order to address complaints relating to communication, the PALS and Complaints Team are increasing the number and types of training sessions they offer, to help staff in the Hospitals/MCS/LCO address communication issues and locally resolve these, thus reducing the number being escalated to formal complaints. In addition to this, PALS and Complaints E-Learning Customer Service – Module 2 package was launched during 2022/23, on the Trust's e-learning platform.

7.6 In addition to the above, the Quality Improvement Team host Bee Brilliant which is a quality initiative programme that focusses on themes that arise throughout the year. The theme planned for Quarter 1 2023/2024 was Communication, the theme which accounted for 18.21% of the total amount of complaints received.

Number of Closed Complaints		Upheld	Partially Upheld	Not Upheld	Information Request
Q1 22/23	413	46	285	77	5
Q2 22/23	471	53	351	63	4
Q3 22/23	550	57	421	72	0
Q4 22/23	526	61	364	100	1
2022/23	**1960**	**217**	**1421**	**312**	**10**

Table 10: Outcome of MFT complaints 2022/23.

8.0 Re-opened complaints

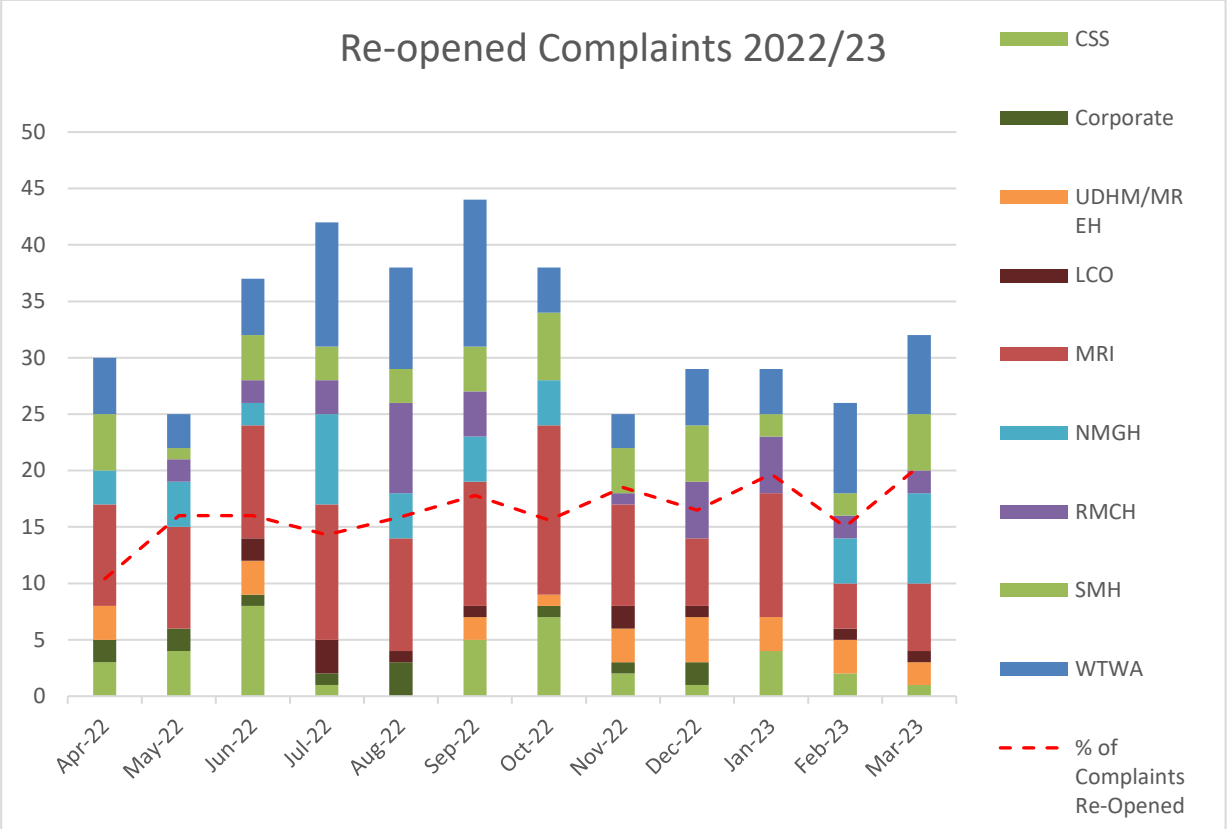
8.1 A complaint is considered 're-opened' if any of the following categories can be applied:

- 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.

8.2 The number of re-opened complaints is used as a proxy indicator to measure the quality of the initial response. A total of 399 (19.7%) cases were re-opened during

2022/23, against the Trust tolerance threshold of 20%. This compares to 339 (16.9%) re-opened in 2021/22.

8.3 **Graph 12** demonstrates the percentage of complaints re-opened by month during 2022/23.

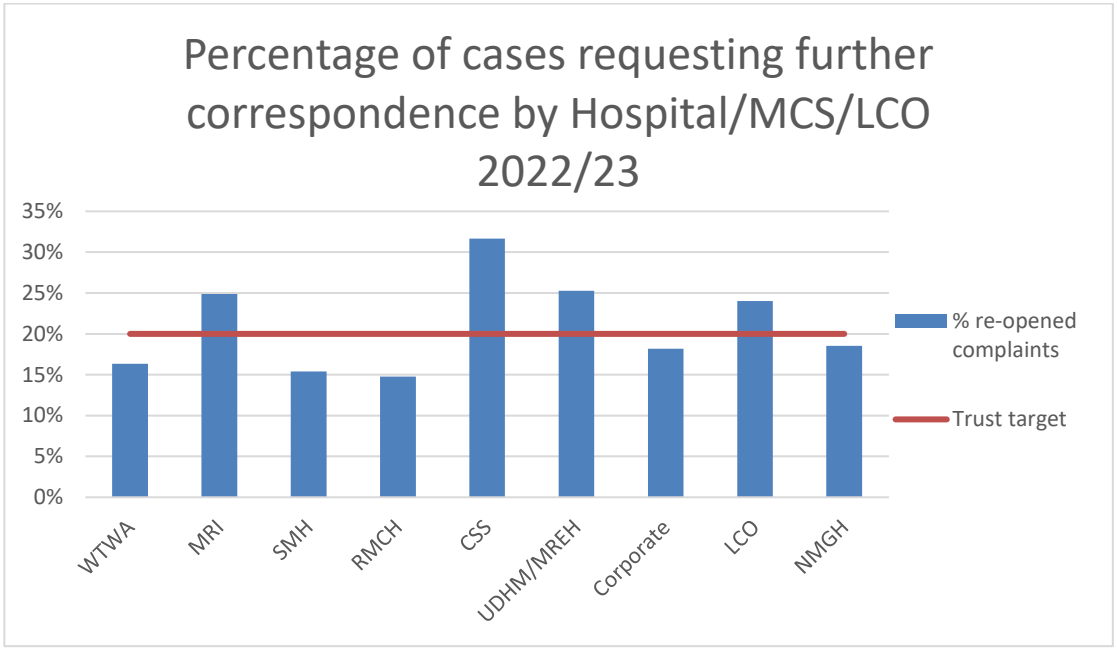


Graph 12: Number and % of re-opened complaints by Hospital/MCS/LCO 2022/23.

8.4 **Graph 13** demonstrates the percentage of complaints re-opened by month. MRI have seen the greatest increase in re-opened complaints, throughout 2022/23, and received the most with 112. CSS have seen the highest percentage of re-opened complaints, following 3 years of decreasing re-opened complaints, with UDHM/MREH and LCO also failing to meet the Trust target.

8.5 In 100 of the 399 complaints requiring re-opening, the primary reason was due to the 'complainant disputing the information contained within the response', with WTWA and MRI (which received the largest number of overall complaints) receiving the greatest number for this reason, 28 and 23 respectively.

8.6 To address the large number of re-opened complaints, the Complaints Team have updated their Complaints Investigation and Response Letter Writing Training Programme and are delivering specific sessions solely for each Hospital/MCS/LCO staff to ensure attendance, as well as sessions available for all staff to book via the Trust's Learning Hub. This is with the aim to improve the quality of complaint responses and reduce the number of re-opened complaints.



Graph 13: % of re-opened complaints by Hospital/MCS/LCO 2022/23.

9.0 Parliamentary Health Service Ombudsman (PHSO)

9.1 The PHSO is commissioned by Parliament to provide an independent complaint handling service for complaints that have not been resolved by the NHS England (NHSE) and UK government departments. The PHSO is not part of the Government, NHSE, or a regulator. The PHSO is accountable to Parliament and their work is scrutinised by the Public Administration and Constitutional Affairs Committee.

9.2 The PHSO make final decisions on complaints that have not been resolved by NHSE and UK government departments and other public organisations. The PHSO do this fairly and without taking sides. Their service is free. The PHSO considers and reviews complaints where someone believes there has been injustice or hardship because an organisation has not acted properly or fairly or has given a poor service and have not put things right.

9.3 During 2022/23 the PHSO opened 15 new cases for investigation into MFT complaints.

9.4 The PHSO informed the Trust of 11 completed investigations into MFT complaints. **Table 11** below shows the outcomes of the PHSO investigation resolved in 2021/22 and 2022/23.

	2021/22	**2022/2023**
Fully upheld	2 (40%)	1 (9%)
Partially upheld	3 (60%)	6 (55%)
Not upheld or withdrawn	0	4 (36%)

Table 11: Outcome of PHSO investigations into MFT complaints 2021/22 and 2022/23.

9.5 The 'upheld' complaint was regarding a WTWA complaint, and the PHSO recommended the Trust write to the patient to apologise for the impact of not identifying loose bone fragments post-surgery, as well as make a payment of £650 for the negative impact this caused. WTWA completed these recommendations and developed an action plan to improve care and prevent a recurrence.

9.6 The 'partially upheld' cases related to CSS, RMCH, MRI and WTWA complaints. In each case, the Trust complied with the PHSO's recommendations to write to the patients/complainants to apologise for failings and produce an action plan setting out the actions the Trust identified as being necessary to learn from the complaints and precent recurrences and improve patient care and experience.

10.0 Lessons learned

10.1 This section of the report provides examples of improvements made in response to feedback from complaints.

10.2 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.

10.3 Each Hospital/MCS/LCO holds regular forums where themes and trends relating to complaints are discussed with focused actions agreed for improvement. In addition to this, the Complaints Review Scrutiny Group (CRSG), chaired by the Corporate Director of Nursing for Quality and Patient Experience, and supported by a nominated Non-Executive Director, met on six occasions reviewing 12 complaints in total.

10.4 The CRSG process scrutinises complaints investigated and responded to by MFT and contributes to the learning from these complaints, to improve patient experience and positive change through open dialogue and reflection. The management teams from the Hospitals/MCSs/LCO each presented a case based upon a complaint they had received. Learning and associated actions identified from the cases were discussed, and assurance was provided that complaints are investigated with appropriate action taken when needed.

10.5 Each Hospital/MCS/LCO also feed into the Quality and Patient Experience Forum, which is constituted as a sub-group of the Group Quality and Safety Committee and NMAHP Professional Board. The overall purpose of the group is to provide the corporate strategic direction in relation to quality and patient experience, ensuring patients and families are at the core of all we do. This forum supports the collaboration of services, shares best practice, and provides a clear link to triangulate themes across the Trust.

10.6 Detailed below, in **Table 12**, 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
LCO	Concerns received regarding a family being unhappy with the level of care their father received and the provision of catheter equipment.	As part of the daily Safety Huddle all staff are to review in advance of visiting patients at home that all necessary catheter equipment is available. Staff to ensure: • that were appropriate patients are registered with the Continence service and provided with the necessary support for the ordering of equipment. Action to form part of the department's newly developed staff induction. • Staff to ensure a supply of catheter equipment available within their vehicles. • Staff to ensure clear communication channels at all times with patients and family members to ensure they are fully appraised of all actions taken by the team.
MREH	Concerns relating to incorrect details regarding a telephone appointment, contained within a patient appointment letter and incorrect contact numbers provided for appointment teams.	All booking letters have been checked and corrected as part of the transition to HIVE. Booking Clerks and team have been reminded of the importance of accuracy and to ensure the check that the appointment details in letters are correct prior to posting. MREH Administrative Teams have been reminded of the correct telephone numbers to provide to patients who need to contact the Appointment Booking Team.
UDHM	Concerns regarding patient voicemail messages left by a patient not being responded to by the Administration Team.	The process for reviewing telephone voicemails has been reviewed by the Directorate Manager. The Directorate Manager is devising a Standard Operating Procedure (SOP) for the Administration Team, to describe the expected standards for responding to

		messages left by patients and the recording of this communication into the Electronic Patient Record (EPR) system (HIVE).
CSS	Concern regarding a delay in the patient's GP receiving the results of the skin biopsy.	Samples will be sent to an external company to perform part of the sample processing. This is already underway and has led to a significant improvement in processing times. The daily workload within the Histopathology laboratory reviewed, to determine the staff available to complete this work. Where it is seen that work cannot be completed within an appropriate timeframe, these cases will be sent to an external company for processing. The Department's recruitment strategy reviewed within the Histopathology laboratory, to identify different ways of finding potential candidates to fill vacant posts.
WTWA	Concerns regarding poor palliative care and end of life care, during a patient's inpatient stay on the ACCU.	Refresher end of life training for all the nursing staff on the Acute Coronary Care Unit (ACCU), provided by the Palliative Care Team. This included medication management for symptom control and communication with patients and their families. The Ward Manager for the Acute Coronary Care Unit has reiterated the importance of effective communication with the nursing staff on the Unit and she has requested for all nursing staff to complete the Trust's Sage and Thyme communication training in the coming months. The importance of assisting relatives in distressing situations has been reiterated to the nursing staff on the Acute Coronary Care Unit, and the nursing staff who were on duty have been asked to reflect on this situation.

NMGH	Concern regarding a patient being left in the corridor for 25 hours and lack of updates.	ED introducing new pathways to help improve patient flow into the hospital, so patients can be seen in a cubicle rather than being nursed on the corridor. Patient Liaison Officer introduced to improve communication between staff, patients and their families.
RMCH	Concerns raised regarding a patient's care, specifically lack of hydration, pain relief and aftercare within Paediatric Dental Care Services. Concern regarding staff's lack of awareness and appropriate management of patient's disabilities.	Matron has spoken to ward teams regarding complainants' experiences and about learning improvements. Play Therapist to work with the patient to support them with ongoing treatment at RMCH. Clinical Lead for Dental Services has: • Liaised with colleagues in Paediatric Maxillo-Facial team to ensure improved communication during handover. • Liaised with colleagues in the Pain Management Team regarding improving the level of service being offered. • Discussed the poor experiences the complainant and patient had at the next audit and teaching 'ACE' day with the wider Dental team.
MRI	Concern regarding a sickle cell patient not receiving timely pain relief.	The Emergency Department (ED) team are working closely with colleagues from Haematology and are developing a pathway to ensure they provide a higher standard of timely care to patients with sickle cell disease including analgesia as per individual patients care plans. Patient Controlled Analgesia (PCA) machines are available in ED. Following the implementation of HIVE, it is now easier to review patients individual care plans.
SMH	Concerns raised in respect of telephones not being answered and timely calls not being made to patients.	Morning handover on Gynaecology Ward now includes an additional section to discuss any calls taken from patients overnight, to ensure they have the appropriate follow-up required.

		Secretaries in Outpatients now exploring all communication methods when cancelling patients to ensure they are notified and do not attend. Patient App implemented to improve patient contact with the Department of Reproductive Medicine.

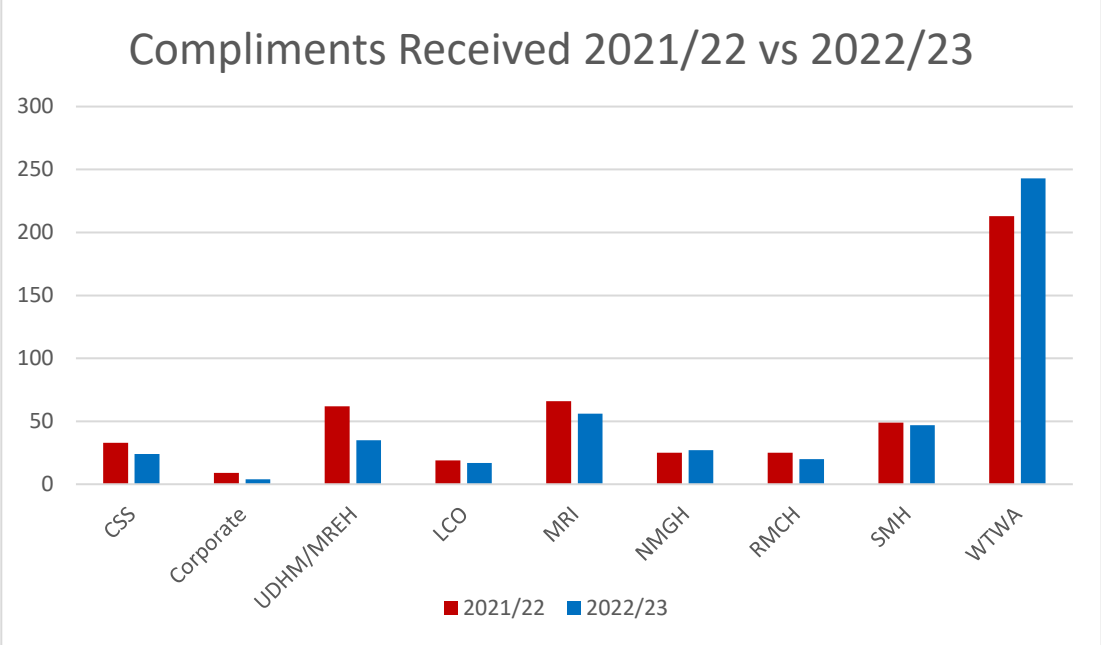
Table 12: Examples of actions resulting from complaints during 2022/23.

11.0 An overview of Compliments

11.1 Compliments received from people who use our services provide valuable feedback and an opportunity to learn from positive experiences. Positive patient experience feedback correlates to complements and is linked to the top positive themes seen in WMTM and FFT.

11.2 It is important to acknowledge only a fraction of the overall compliments received within the trust are captured and recorded on the Trusts Customer Service Database. The majority of compliments received 'verbally' and as 'thank you' cards directly by staff and are not logged or tracked by the Hospitals/MCSs/LCO.

11.3 **Graph 15** below shows the number of compliments, received from members of the public about MFT Hospitals/MCSs/LCO, recorded on the Trust's Customer Services Database.



Graph 15: MFT compliments received 2021/22 vs 2022/23.

11.4 Examples of compliments received include

- *"I managed to fracture and dislocate my ankle on Christmas morning. When we arrived the sister from the ED took me straight into Resus where my injury was very swiftly treated by the consultant on duty. My fracture was reduced and I was transferred quickly for surgery. I could not have been seen or treated more efficiently so a big thank you to the ED team. Today I have been to fracture clinic and had my temporary cast removed and a new one applied. Again all very efficient including the x ray. The plaster technician was fabulous, very knowledgeable and caring. A big shout out to all the staff in the ED and OPC who do an amazing job day in day out!"*

- *"I just wanted to provide feedback on the fantastic service that was provided by all the staff members from when we arrived early on Thursday morning, to leaving on Friday afternoon. All the staff members that looked after us were exceptionally professional and knowledgeable, whilst also being personable and empathetic towards both myself and my wife. Each one showed a genuine interest and made my wife feel like she was the only patient in their care. These qualities went a long way to making our experience such a positive one. I am aware of the current strain on the NHS at present and the often negative stories around staffing and the service provided. However, if this is the case at St Mary's, you would never have known. Again, this is credit to the staff looking after us. I am struggling to remember names, however, if possible, please pass on my feedback to each staff member who oversaw the birth of our beautiful daughter, they won't be forgotten and we feel they are now part of her life story. In years to come when we are discussing our daughter's birth, it would be difficult to do so without talking fondly of the service provided by, and the staff at, St Mary's."*

- *"I just wanted to send massive thank you to the PALS team! I called up seeking advice and support a couple of weeks ago regarding concerns about my partners health care. After being advised to attend A&E by the GP following abdominal pain and a high temperature (41 degrees), blood tests revealed significant infection markers. Due to his temperature decreasing he was sent home from A&E to be treated as an outpatient and given an 'urgent' CT scan which we shortly found out the date was for in 3 weeks' time! He was in significant pain affecting sleep, well-being and also impacted on his ability to attend work posing financial issues for us. A few days after speaking to your team he had a call offering a scan date within a couple of days to be seen more urgently. We are awaiting results and hopefully things will be taken from there. I just wanted to say thank you so much for moving things along for us and getting him the care he needed, we really appreciated your help and support at such a vulnerable time."*

11.5 The benefit of viewing compliments feedback alongside positive patient experience is that it is useful to understand the similarities and also formally acknowledge where care experience has been good. **Table 13** shows the top 3 positive feedback FFT themes that were reported at Trust level.

Top Three Positive FFT Themes 2022/23			
WMTM	**Theme 1**	**Theme 2**	**Theme 3**
MFT Total	Friendliness	Emotional & Physical Support	Professional & Competent
CSS	Emotional & Physical Support	Friendliness	Compassion
LCO	Friendliness	Emotional & Physical Support	Professional & Competent

MREH	Professional & Competent	Emotional & Physical Support	Emotional & Physical Support
MRI	Friendliness	Emotional & Physical Support	Helpfulness
NMGH	Friendliness	Emotional & Physical Support	Professional & Competent
R&I	Friendliness	Professional & Competent	Helpfulness
RMCH	Friendliness	Emotional & Physical Support	Compassion
SMH	Emotional & Physical Support	Compassion	Helpfulness
UDHM	Friendliness	Professional & Competent	Emotional & Physical Support
WTWA	Friendliness	Professional & Competent	Emotional & Physical Support

Table 13: Top 3 Positive Themes based on FFT feedback captured during 2022/23 by Hospital/MCS/LCO.

11.6 Ten out of eleven Hospitals/MCS/LCO reported that Friendliness and Emotional and Physical Support were in their top three positive FFT themes. Seven areas reported Professional and Competent, three areas reported Compassion and three areas reported Helpfulness in their top themes.

11.7 Similarly, **Table 14** below, shows the top 3 positive feedback WMTM themes that were reported at Trust level. The top positive feedback WMTM themes reported were Emotional and Physical Support, Friendliness, Compassion, Professional and Competent, Helpfulness and Hygiene.

Top Three Positive WMTM Themes 2022/23			
WMTM	**Theme 1**	**Theme 2**	**Theme 3**
MFT Total	Emotional & Physical Support	Friendliness	Compassion
CSS	Professional & Competent	Emotional & Physical Support	Compassion
LCO	Hygiene	Emotional & Physical Support	Compassion
MREH	Professional & Competent	Friendliness	Emotional & Physical Support
MRI	Friendliness	Emotional & Physical Support	Compassion
NMGH	Emotional & Physical Support	Professional & Competent	Helpfulness
R & I	Professional & Competent	Friendliness	Compassion
RMCH	Friendliness	Emotional & Physical Support	Compassion

SMH	Emotional & Physical Support	Compassion	Friendliness
UDHM	Friendliness	Professional & Competent	Emotional & Physical Support
WTWA	Emotional & Physical Support	Friendliness	Helpfulness

Table 14: Top 3 Positive Themes based on WMTM feedback captured during 2022/23 by Hospital/MCS/LCO.

12.0 Complaints improvements in 2022/23

12.1 A monthly audit of the complaints process has been developed and implemented during 2022/23, with the results formulating a complaints performance dashboard. The Customer Services Manager then uses this information to identify any occasions when the correct complaints handling process has not been followed, such as gaps in documentation or delayed notifications or calls not being returned in a timely manner. Reviews of the audit data and dashboard highlight areas where additional support/training is required, which the PALS and Complaints Manager and Customer Services Manage then implement accordingly.

12.2 To address the low number of returns of complaints Equality Diversity and Inclusion (ED&I) monitoring forms and thus the poor collection of data, the complaints ED&I has been updated, in line with the data fields on the Trust's electronic patient administration system (HIVE) to capture the protected characteristics under the Equality Act. This update now means that ED&I data can also be collected direct from HIVE when the patient is the complainant, as well as completed forms when patients are not the complainants, to improve the data collection percentage. ED&I data for complaints received during 2022/23 is included in **Appendix 1.** Further work is planned during 2023/24, with the Customer Services Manager working collaboratively with colleagues within Patient Services Department, to explore further opportunities to improve ED&I data collection and accessibility to the complaints service.

12.3 A new advanced telephone system was implemented in the PALS and Complaints Department in March 2023. This new system was identified as being necessary, as a result of feedback from complainants, and has been implemented to improve telephone access to the PALS and Complaints Department and responsiveness to calls. The new telephone system provides the PALS and Complaints Manager and the Customer Service Manager with a 'live' electronic dashboard to monitor the number of calls into the service, and the responsiveness. This allows performance to be monitored, and any proactive support and improvements made as deemed necessary.

12.4 Following an increase in the number of complaint Local Resolution Meetings (LRM) being held, throughout 2022/23, updates were made to the LRM process to improve the organisation of LRMs for both staff and the public.

12.5 A secure method of sending confidential information to complainants, via email, was implemented to reduce delays in the complaints process caused by external Royal Mail issues and the receipt of signed consent. This was implemented to make it more accessible to make a complaint (removing the requirement for post for complainants who do not wish to use it), whilst also reducing the potential for information governance data breaches.

12.6 The renovation and re-location of the PALS office at NMGH was completed in 2022/23. The new office space is much larger accommodation than the old PALS office providing easier to use and access of services for all people. The new office now provides a private meeting room for members of the public wishing to meet and talk confidentially with a member of the PALS team.

12.7 To improve the process by which complaints and incidents concurrently run in parallel, the Customer Services Manager attends the Trust's Daily Safety Huddle and Weekly Group Safety Panel and is also working with the Risk Management Team to improve communication and timeliness of response for patients and their representatives.

13.0 Complaints improvements to be made in 2023/24

13.1 Continued areas for improvement and development during 2023/24 include:

- Update of PALS and Complaints sections of MFT website.
- Creation of a new online PALS contact form and of PALS and Complaints leaflets, posters, and banners.
- '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.
- Implementation of changes to the Complaints Process in accordance with the new PHSO Complaints Standards, to be enforced in April 2024.
- Exploration of the introduction of a PHSO/Complaints 'upheld' Learning Sub-Group.
- Exploration of the introduction of a Patient and Public Involvement Complaints Focus Group.
- Establish collaborative working relationships with charitable, voluntary and community organisations, to increase PALS awareness in Manchester.
- Re-open PALS office at Trafford General Hospital.
- Audit of PALS process to identify areas for improvement.
- Ongoing work continues to embed the CIVICA Patient Experience Platform across the organisation promoting the opportunity for areas to increase the number of patients that complete the WMTM and FFT surveys which in turn provides us with the opportunity to triangulate data with Complaints themes.
- The implementation of the MFT Carers Strategy including the promise of MFT Carer's Strategy Commitments. This may improve the experience of our carers community and may have a correlation with future fall in complaints from this group.
- The Patient Experience Team are developing a Patient Stories data base which will detail the themes within each film can then be clearly catalogued. This will provide the opportunity to triangulate patient experience feedback with complaint themes. Patient stories could also be offered to complainants that have not yet found a resolution to their complaint to support the sharing of their story.
- The MFT Experience and Involvement Strategy: Our Commitment to Patients Families and Carers 2020-2023, is due to be reviewed and will be an opportunity to work in partnership with key stakeholders to set the direction for the inclusion of patients and service users to co-design MFT services. This work will be done collaboratively with the wider Patient Services Team, including the Complaints and PALS teams. There may be a possibility to identify previous complainants as part of this process when identifying service users as key stakeholders.

14.0 Conclusion and recommendations

14.1 The Trust is grateful to those patients, families and carers who have taken the time to raise their concerns and complaints and acknowledges their contribution to improving services, patient experience and patient safety.

14.2 The Board of Directors is asked to note the content of this report, the work undertaken by the Corporate and Hospital/MCS/LCO teams to improve the patient's experience of raising complaints and concerns and, in line with statutory requirements, provide approval for the report to be published on the Trust's website.

APPENDIX 1

	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23
Disability					
Yes	32	28	32	27	15
No	13	17	17	11	12
Not Disclosed	382	390	472	511	489
Total	**427**	**435**	**521**	**549**	**516**
Disability Type					
Learning Difficulty/Disability	2	1	0	0	1

Long-Standing Illness or Health Condition	29	13	20	19	7
Mental Health Condition	9	5	7	5	3
No Disability	0	0	0	1	0
Other Disability	3	3	9	5	2
Physical Disability	10	6	7	8	10
Sensory Impairment	2	1	5	5	8
Not Disclosed	372	406	473	506	485
Total	**427**	**435**	**521**	**549**	**516**
Gender					
Man (Inc Trans Man)	172	184	201	226	210
Woman (Inc Trans Woman)	249	247	315	316	299
Non-binary	0	0	0	0	0
Other Gender	0	0	1	4	1
Not Specified	6	4	2	3	5
Not Disclosed			2		1
Total	**427**	**435**	**521**	**549**	**516**
Sexual Orientation					
Heterosexual	100	58	129	92	80
Lesbian / Gay/Bi-sexual	3	9	3	5	6
Other	3	7	16	14	9
Do not wish to answer	15	9	11	18	11
Not disclosed	306	352	362	420	410
Total	**427**	**435**	**521**	**549**	**516**
Religion/Belief					
Christianity	65	48	75	54	54
Buddhist	0	0	1	0	1
Do not wish to answer	12	6	16	4	8
Muslim	9	5	11	11	9
No religion	51	43	53	59	40
Other	3	3	3	6	3
Sikh	0	0	1	1	0
Jewish	0	0	4	3	3
Hindu	0	3	1	3	3
Not disclosed	286	327	356	406	395
Humanism	1	0	0	1	0
Paganism	0	0	0	1	0
Total	**427**	**435**	**521**	**549**	**516**
Ethnic Group					
Asian Or Asian British - Bangladeshi	1	1	3	1	0
Asian Or Asian British - Indian	1	5	6	2	5

Asian Or Asian British - Other Asian	3	4	5	5	6
Asian Or Asian British - Pakistani	5	6	10	11	11
Black or Black British – Black African	4	8	6	6	5
Black or Black British – Black Caribbean	4	11	5	7	8
Black or Black British – other Black	4	4	1	2	3
Chinese Or Other Ethnic Group - Chinese	1			1	2
Mixed - Other Mixed	4	1	1	4	1
Mixed - White & Asian	1		3	2	1
Mixed - White and Black African		1	1		
Mixed - White and Black Caribbean	2	1	2	4	1
Not Stated	100	85	112	109	105
Other Ethnic Category - Other Ethnic	7	5	4	8	10
White - British	153	145	180	200	183
White - Irish	9	6	3	4	5
White - Other White	8	11	10	7	9
Not disclosed	120	141	169	176	161
Total	**427**	**435**	**521**	**549**	**516**

Table 15: Equality and Diversity Monitoring Information for complaints during 2022/23.

Agenda Item 11.4

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Gail Meers, Corporate Director of Nursing, Quality and Patient Experience
Date of paper:	August 2023
Subject:	Quality and Patient Experience Report: Quarter 1, 2023/2024
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:	Delivering an excellent experience for patients, their families and their significant others.
Recommendations:	The Board of Directors are asked to note the contents of the report.
Contact:	Name: Gail Meers, Corporate Director of Nursing, Quality and Patient Experience Tel: 0161 276 4738

1. Introduction

1.1 This report relates to Manchester University Hospital Foundation Trust (MFT) Patient Experience activity including complaints across Manchester University NHS Foundation Trust during Quarter 1, 1st April to 30th June 2023 (Q1).

1.2 We are committed to delivering safe, effective and person-centred care. Capture and use of feedback is central to ensuring delivery of our aims. Several approaches are in place that support people to choose a feedback mechanism that best suits their needs. These include:

- National Surveys, Friends and Family Test
- What Matters to Me Survey (WMTM)
- Via the NHS website and Care Opinion
- In writing by letter/email via PALS/Complaints
- Via the Accreditation process
- Face to face and daily contact with our service users

1.3 Feedback provides the Trust with a rich source of patient experience whilst also offering insight into what matters to patients and service users. Using all methods of information available enables the Trust to better understand the patient's experience of the services offered and delivered and is beneficial to help prioritise where to focus efforts on action planning.

1.4 A wide range of examples are presented in the report from the different sources, including PALS concerns, complaints, feedback (Friends and Family Test (FFT), Patients Surveys, What Matters to Me (WMTM) and the Accreditation process.

1.5 The Trust's What Matters to Me (WMTM) Patient Experience Framework supports the triangulation of data and information from a wide range of sources across the organisation. Examples of these include themes from the Annual National Survey results; the Trust's local Quality Care Round (QCR) data; FFT and WMTM Patient Experience survey feedback, along with incidents, complaints, PALS and compliments.

1.6 Triangulation of data, along with feedback from Interpretation Services (ITS) and other sources provides the opportunity for the Hospitals/MCSs/LCO to analyse, identify areas for improvement, compare findings and correlate themes.

1.7 All feedback is shared with the relevant Hospitals/MCSs/LCO to enable the relevant teams to share feedback and consider suggestions for improvements made by patients and service users.

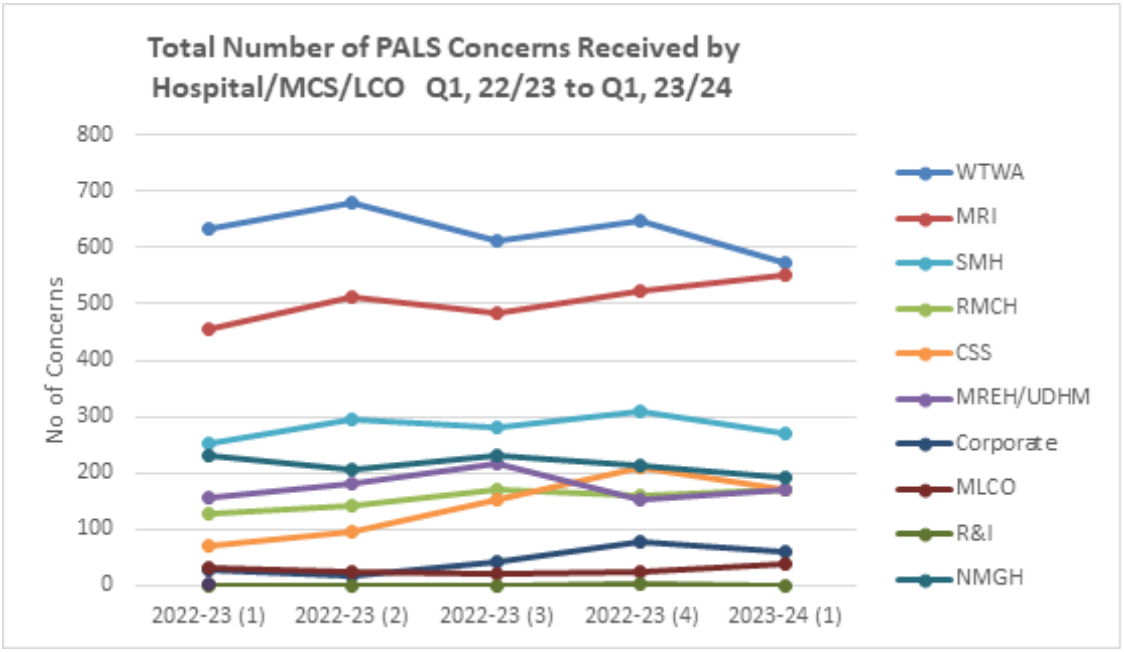
1.8 This report provides the following:

- **An overview and summary of activity and brief thematic review**
- **A summary of improvements achieved**, and those planned to ensure learning from Corporate Patient Services activity is embedded in everyday practice.
- **Equality and Diversity information** and **planned improvement activity**.
- Supporting information referred to throughout the report is included at **Appendix 1**.

2. PALS and Patient Experience Feedback

2.1 The Trust saw a decrease of 4.97% in PALS concerns with 2,199 PALS concerns being received in Q1 compared to the 2,314 received in Q4, 2022/23.

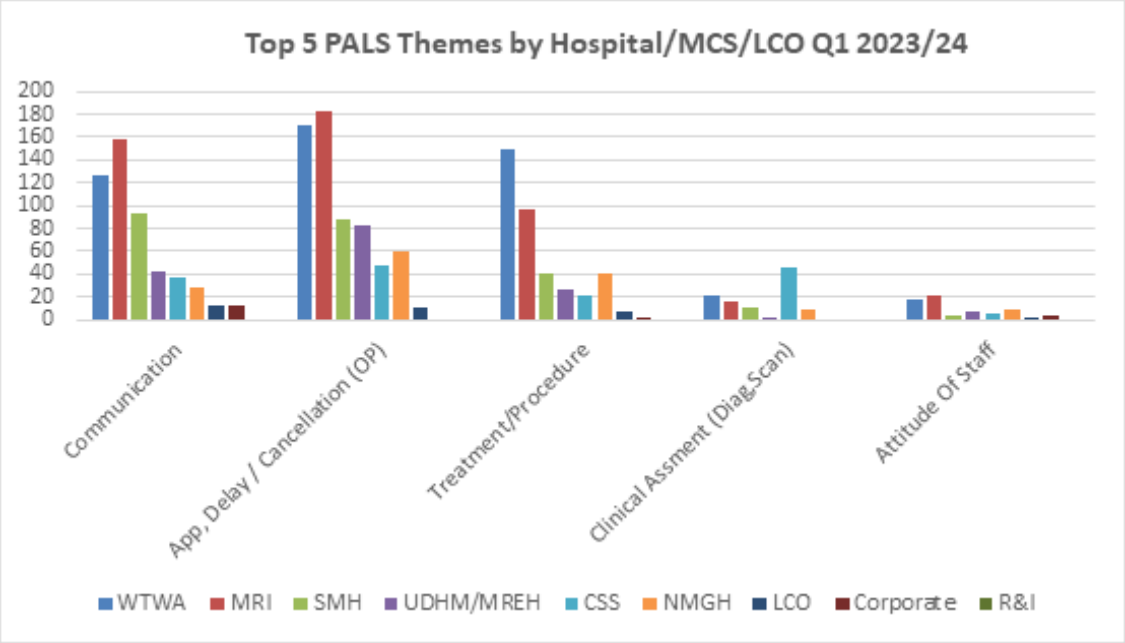
2.2 **Graph 1** below shows the number of concerns received by each Hospital/MCS/LCO each quarter. Wythenshawe, Trafford, Withington, Altrincham (WTWA) and Manchester Royal Infirmary (MRI) received the greatest number of PALS concerns, receiving 574 and 553 respectively. Clinical Scientific Services (CSS) saw the largest percentage decrease in PALS concerns, receiving 18.58% fewer than the previous quarter. Saint Mary's Hospital Managed Clinical Service (SMH) (-12.95%) and WTWA (-11.56%), also achieved a reduction in PALS concerns.



Graph 1: PALS Concerns Received by Hospital/MCS/LCO Q1, 2023/24

2.3 **Graph 2** shows the distribution of the main PALS themes and indicates that the greatest proportion of PALS concerns in Q1 relate to 'Appointment Delays/Cancellations', which also saw the greatest increase in PALS concerns from the previous quarter. MRI and WTWA receiving the most PALS concerns regarding this. 'Communication' and

'Treatment and Procedure' also accounted for a large proportion of PALS concerns in Q1.



Graph 2: Themes of PALS concerns received by Hospital/MCS/LCO Q1, 2023/24

2.4 The Trust is committed to improving patient access, safety, clinical quality and outcomes. It is recognised that there are a number of patients who are waiting longer than we would wish for routine care.

As part of our 2023/24 commitments, MFT has a Group Improvement Programme in place, led by a hospital Chief Executive and the Joint Group Medical Director, specifically aimed at delivering improved patient experience relating to our key national targets across pathways, taking into account existing capacity, productivity opportunities and correcting data quality/systems issues. It is anticipated that this work programme will have an overall positive impact on waiting times and experiences of our patients.

2.5 Understanding complaint themes alongside other quality, safety and patient experience metrics supports organisations identify issues, areas for improvement and poor practice. Patient satisfaction is also captured through the Friends and Family Test (FFT). The FFT is a single question survey which asks patients, carers or family members to rank their experience of care.

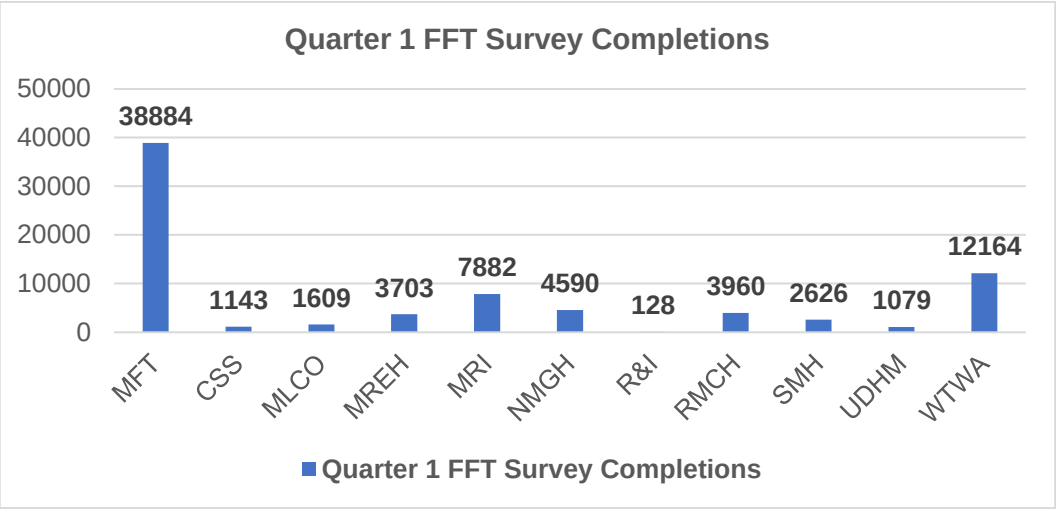
The FFT questions are:

- "Thinking about your recent visit overall, how was your experience of our service?", followed by
- "Please can you tell us what was good about your care and what we could do better?

2.6 The answers are ranked by choosing one of the following: 'very good', 'good', 'neither good nor poor'; 'poor'; 'very poor', 'don't know'. The score is a simple comparison of the percentage of those completing the test who would recommend their experience as

'good' and 'very good', against the percentage of those who would not recommend the care experience and rate the scores as 'poor' or 'very poor'.

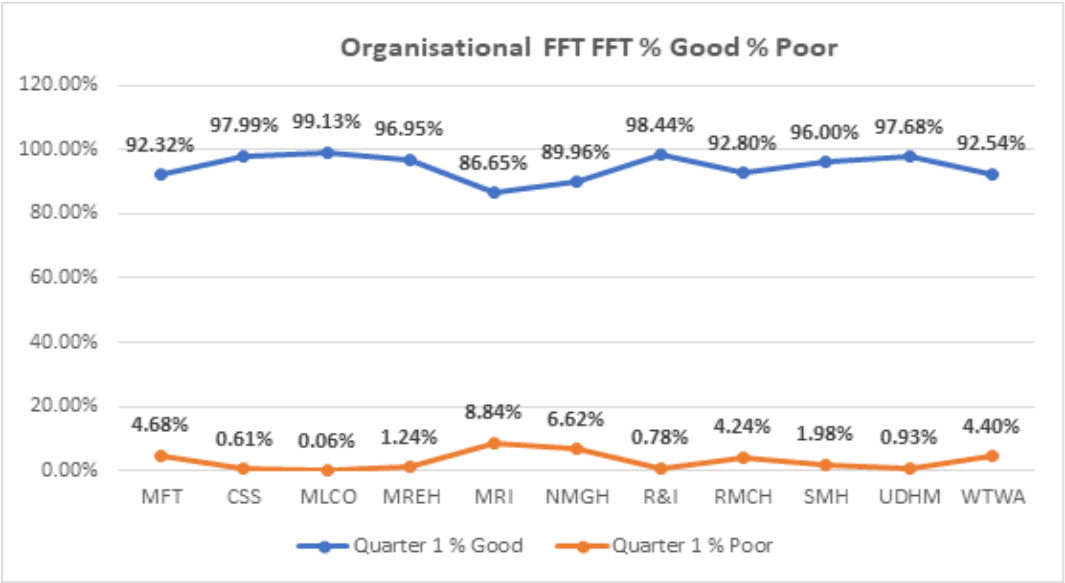
2.7 In Quarter 1, 38,884 FFT responses were collected. **Graph 3** shows the number of responses collected by each Hospital/MCS/LCO.



Graph 3: Total Number of FFT Responses Quarter 1, 2023/24

2.8 **Graph 4** shows the overall FFT results for the Hospitals/MCSs/LCO and Trust as a whole, where patients have rated their experience between 'good' and 'poor' as a percentage.

2.9 It is useful to compare the lower FFT satisfaction scores with Complaints activity, to see if there is any correlation. MRI received the lowest % satisfaction rate scoring, 86.65% and scored the highest poor satisfaction rate of 8.84%, which correlates with the increase seen in PALS and Complaints for MRI in Q1.



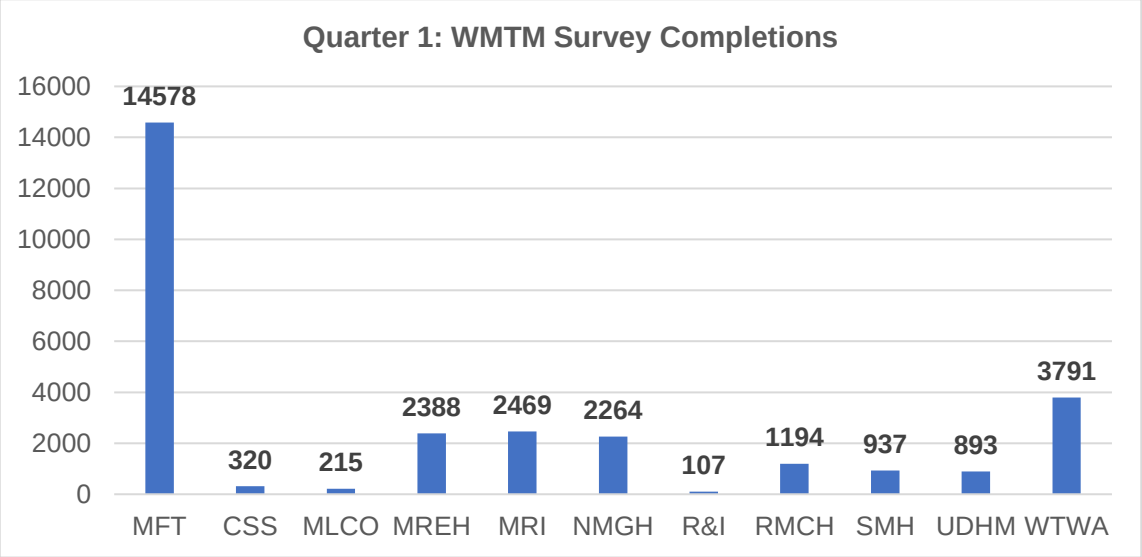
Graph 4: Trust overall FFT results showing patient ratings as % Good and % Poor Scores captured during Q1, 2023/24 by Hospital/MCS/LCO

2.10 In addition to the FFT, the WMTM survey captures patients experience. WMTM scores are also assessed through the Clinical Accreditation process. A lower and an upper benchmark target for the WMTM surveys exists: the lower target is 85% and the upper target is 95% achievement in all domains. The survey asks patients a series of questions about their recent experience in relation to the nine domains below:

- Communication
- Equality and Diversity
- Hygiene and Personal Care
- Patient and the Carer
- Infection Prevention (IP) Control
- Nutrition and Hydration
- Pain
- Patient Safety
- Privacy and Dignity

2.11 The Trust baseline target for the WMTM and Quality Care Rounds (QCR) results is 85% and the upper target is 95% in all domains. These responses alongside quality, safety, and patient experience data provide teams with a triangulated view of an area; identifying elements that require improvements, but also areas of strength and outstanding practice.

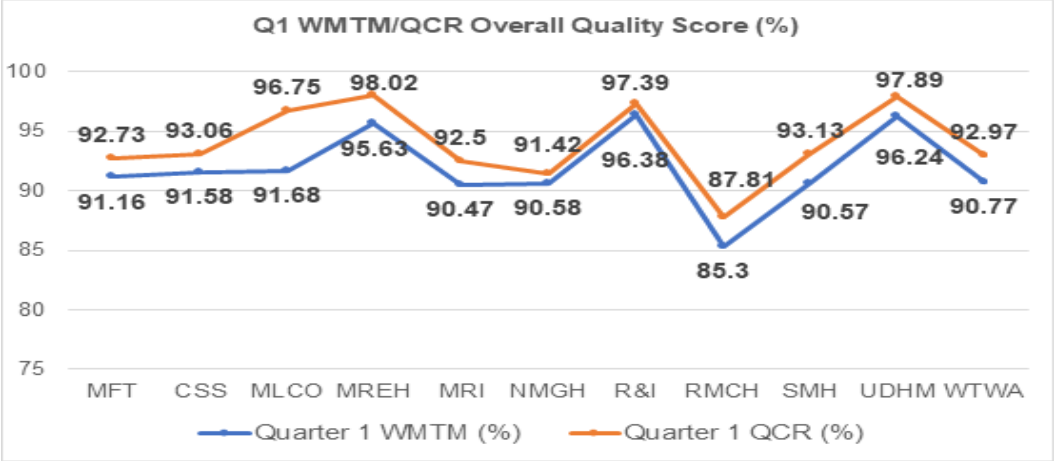
2.12 **Graph 5** shows in Quarter 1 2023/24, 14,578 WMTM surveys were completed with WTWA completing the greatest number of WMTM Surveys (3,791).



Graph 5: Total Number of WMTM Responses, Quarter 1, 2023/24

2.13 **Graph 6** shows the overall quality score for WMTM and QCR by Trust and Hospitals/MCSs/LCO. Against the Trust lower and higher benchmark targets of 85% and 95% respectively, All Hospitals/MCSs/LCO, except for the Royal Manchester Children's Hospital (RMCH), achieved above the 85% baseline for WMTM and QCR. The LCO achieved above 95% for overall quality in QCR, similarly Manchester Royal Eye Hospital and University Dental Hospital of Manchester (MREH/UDHM) and Research and

Innovation (R&I) scored above 95% in overall quality in both WMTM and QCR during Quarter 1, 2022/23.



Graph 6: Overall Quality Score for WMTM/QCR during Quarter 1, 2023/24

2.14 WMTM and FFT feedback comments are themed via sentiment analysis, which is the process of computationally identifying and categorising opinions expressed in a piece of text to determine sentiment. The sentiment analysis reveals the top comments for both surveys. **Table 1** shows the top 3 primary negative feedback relating to WMTM themes. The top negative WMTM theme in Q1 2023/24 was 'Waiting', which correlates with the top PALS category 'Appointment Delays/Cancellations'.

Top 3 Negative WMTM Themes Quarter 1, 2022/23			
	1	**2**	**3**
MFT	Waiting	Food & Beverages	Pain
CSS	Food & Beverages	Waiting	Pain
LCO	Food & Beverages	Pain	Comfort
MREH	Waiting	Food & Beverages	Hygiene
MRI	Waiting	Food & Beverages	Hygiene
NMGH	Waiting	Food & Beverages	Pain
R&I	Waiting	Parking	Emotional and Physical Support
RMCH	Hygiene	Waiting	Comfort
SMH	Waiting	Hygiene	Pain
UDHM	Waiting	Hygiene	Privacy Dignity and Respect

WTWA	Waiting	Food & Beverages	Pain

Table 1: Top 3 Negative Themes based on WMTM Feedback captured during Q1 2023/24 by Hospital/MCS/LCO

2.16 **Table 2** shows the top 3 positive feedback WMTM themes that were reported at Trust level during Q1. 'Professional and Competent' was the main theme for four Hospitals/MCSs, followed by 'Emotional and Physical Support' leading in three Hospitals/MCSs/LCO.

Top 3 Positive WMTM Themes Quarter 1, 2023/24			
	1	**2**	**3**
MFT	Emotional and Physical Support	Friendliness	Compassion
CSS	Professional and Competent	Emotional and Physical Support	Compassion
LCO	Hygiene	Compassion	Emotional and Physical Support
MREH	Professional and Competent	Emotional and Physical Support	Friendliness
MRI	Friendliness	Emotional and Physical Support	Compassion
NMGH	Professional and Competent	Emotional and Physical Support	Compassion
R&I	Friendliness	Compassion	Professional and Competent
RMCH	Friendliness	Emotional and Physical Support	Compassion
SMH	Emotional and Physical Support	Compassion	Friendliness
UDHM	Professional and Competent	Friendliness	Emotional and Physical Support
WTWA	Emotional and Physical Support	Compassion	Professional and Competent

Table 2: Top 3 positive WMTM Themes Quarter 1

3. PALS responsiveness and Key Performance Indicators (KPI)

3.1 During Q1, 91.9% of PALS cases were closed within 10 working days, which is an improvement of 2.2% on the previous last quarter. As seen in **Table 2**, PALS responsiveness has improved, for two consecutive quarters.

3.2 Improvements in responsiveness have been supported by the implementation of the updated PALS Escalation Standard Operating Procedure, with timely escalation of cases to senior management undertaken prior to the approaching deadline. Weekly Hospital/MCS/LCO/Corporate Services PALS KPI meetings have also been introduced, with the progress of every open PALS case discussed with the respective staff managing the cases.

	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Q1 23/24
Resolved in 0-10 days	1846	1810	1923	2042	2112
Resolved in 11+ days	203	256	402	234	185
% Resolved in 10 working days	90.2%	87.9%	82.7%	89.7%	91.9%

Table 3: Closure of PALS concerns within timeframe Q1, 2022/23 - Q1, 2023/24

3.3 **Table 4** shows the number of PALS concerns that were escalated to formal complaints and vice-versa. There was a large increase in the number of formal complaints being de-escalated to PALS cases and the Customer Services Manager and PALS Team Leaders will be delivering more training on local resolutions, across the Trust, throughout 2023/24.

	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Q1 23/24
Number of PALS cases escalated to formal Complaints	13	15	20	10	14
Number of formal Complaints de-escalated to PALS	3	14	7	11	27

Table 4: Number of PALS concerns escalated to formal complaints and complaints de- escalated to PALS concerns Q1, 22/23 – Q1, 23/24

3.4 The number of WMTM survey responses increased by 42.1% from 10,258 in Q4, 2022/23 to 14,578 in Q1, 20232/24. There was a small decrease of 3.5% in the number of FFT responses received, falling from 40,318 to 38,884. Of the 38,884 FFT responses received, 4.68% related to a 'poor' experience (this shows a decrease of 0.98%). Of note, 92.32% of service users at the Trust reported their experience of our services as 'good', which has increased by 1.54% compared to the previous quarter.

3.5 Work continues, in collaboration with wards and departments, to explore ways to maintain and improve the number of FFT and WMTM surveys completed by patients, families and carers. This ensures that local feedback is captured, and that issues and themes can be identified to drive quality improvements. Themes are identified and discussed at a number of dedicated to patient experience including Quality and Patient Experience Forum and through the Accreditation process. An FFT Patient Experience Co-ordinator dedicated to supporting the clinical areas and engaging with staff and patients to increase their survey response numbers.

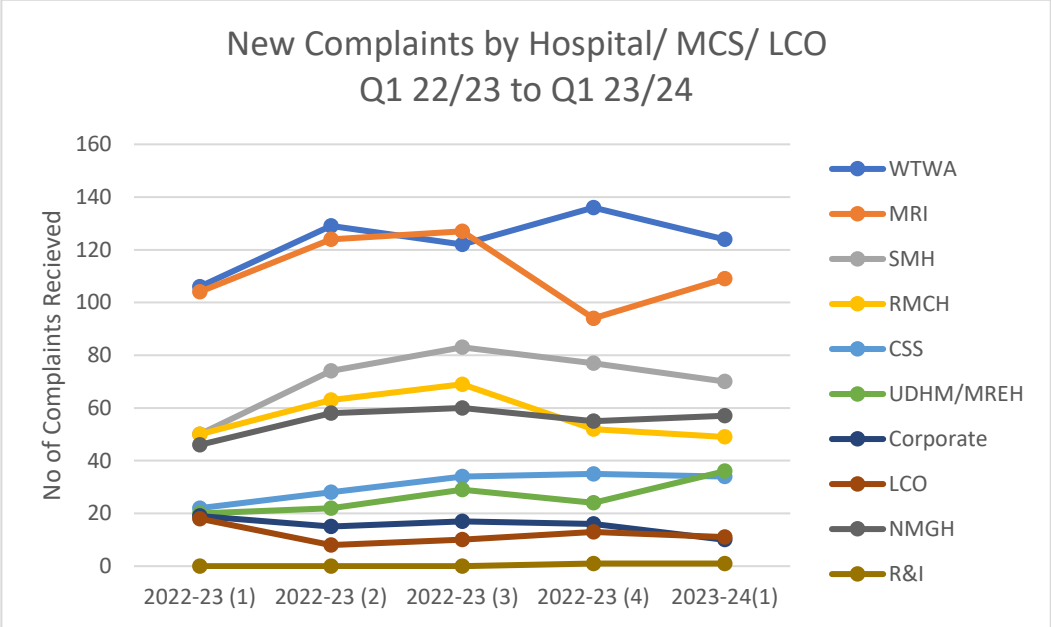
4. Complaints

4.1 There was a slight decrease (0.4%) in complaints in Q1, with 501 new complaints being received compared to the 503 received the previous quarter. **Graph 4** shows the number

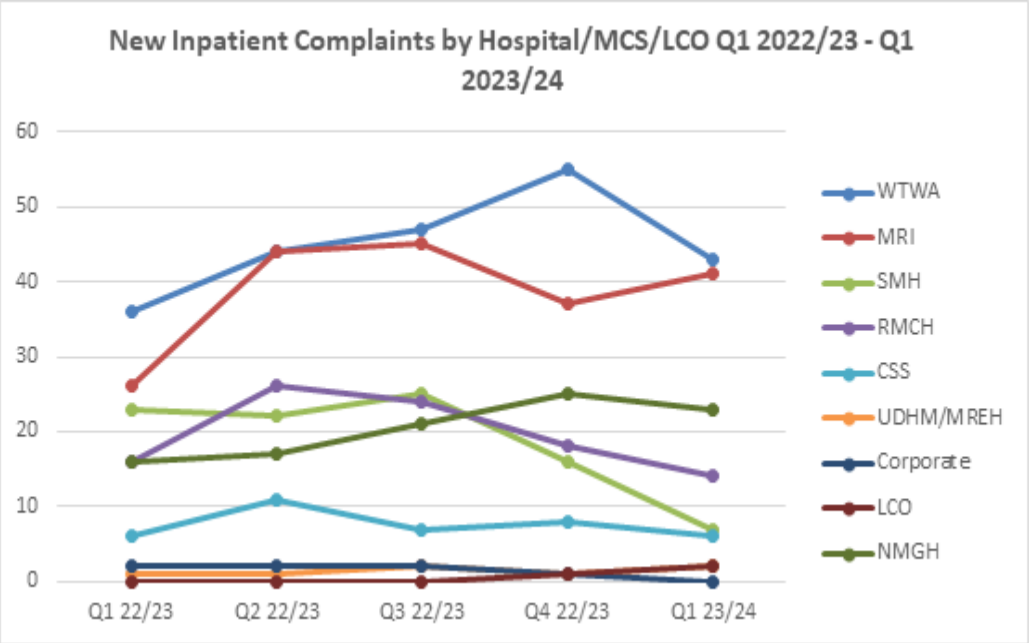
of complaints received by each Hospital/MCS/LCO/Corporate Services each quarter, with **Graphs 5 and 6** showing the split between Inpatient and Outpatient services.

4.2 WTWA and MRI received the greatest number of complaints, receiving 124 and 109 respectively. WTWA has seen a 9% decrease in complaints received in Q1, driven by a 41% reduction in complaints related to 'Communication' and a 38% decrease in 'Appointment Delays/Cancellation' complaints. MRI's complaints increased by 16%, with the largest increases being in relation to complaints about 'Communication' (57% increase) and 'Treatment/Procedure' (38% increase).

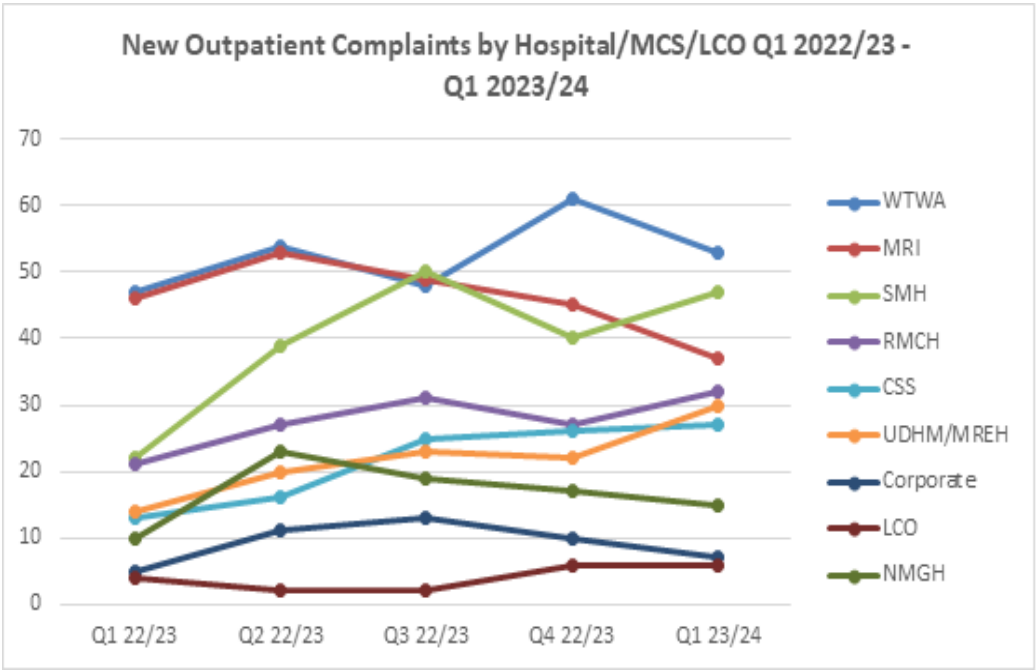
4.3 Corporate Services' complaints decreased by the greatest percentage (-38%). The LCO also experienced a 15% decrease in the number of complaints received and SMH received 9% fewer complaints, due to large reduction in complaints regarding 'Communication'.



Graph 4: New Complaints Received by Hospital/MCS/LCO/Corporate Services Q1, 2022/23 – Q1 2023/24



Graph 5: New Inpatient Complaints Received by Hospital/MCS/LCO/Corporate Services Q1, 2022/23 – Q1, 2023/24

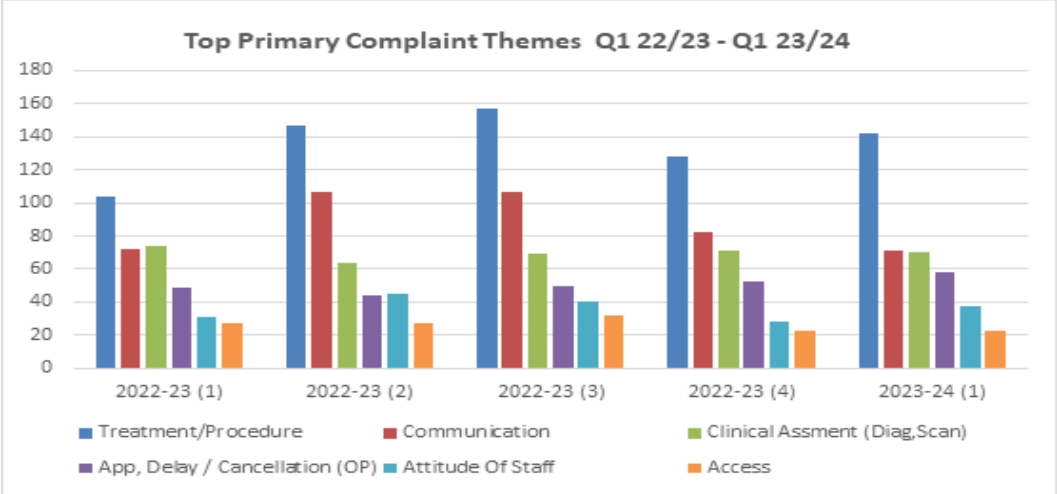


Graph 6: New Outpatient Complaints Received by Hospital/MCS/LCO/Corporate Services Q1, 2022/23 – Q,1 2023/24

4.4 Listening and learning from complaints helps us directly improve patient care and experience. By categorisation and theming the complaints received, teams work to improve the quality of care where themes emerge, or where practice is identified as requiring improvement.

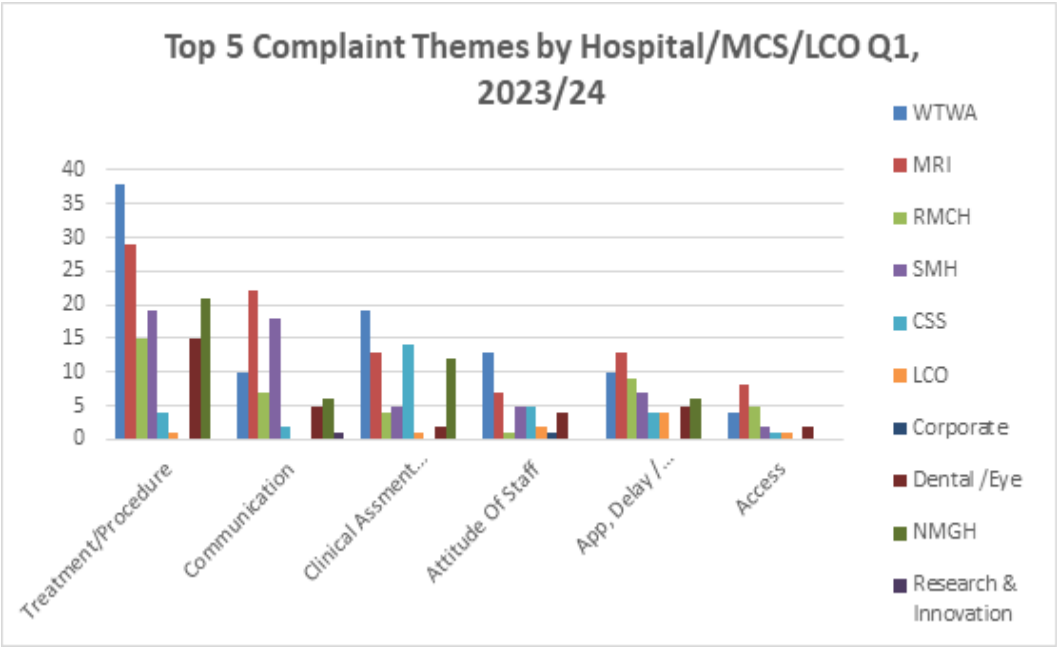
The top 5 primary categories remained unchanged with 'Treatment/Procedure' and 'Communication' remaining the top 2 categories (**Graph 7**). Complaints regarding 'Attitude of staff' increased from Q4 by 35.7%, however this was still a reduction in

comparison to Q2 and Q3 from 2022/23. There has also been a large increase (11.5%) in complaints relating to 'Appointment Delay/Cancellation'.



Graph 7: Top Primary Complaint Themes Q1, 2022/23 - Q1, 2023/24

4.5 WTWA received the most complaints relating to 'Treatment/Procedure' (38), whilst MRI received the most complaints relating to 'Communication' (22); both of which are increases from the previous quarter. **Graph 8** shows the distribution of the top 5 themes by Hospital/MCS/LCO/Corporate Services.



Graph 8: Top 5 themes by Hospital/MCS/LCO/Corporate Services Q1, 2023/24

5. Complaints Responsiveness and KPI

5.1 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. During Q1, 2023/24, 466 (99.8%) eligible complaints were formally acknowledged within 3 working days of receipt, with 1 case was not acknowledged within the 3 working day timeframe see Table 5 below.

	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Q1 23/24
Number of 3 day acknowledgements completed	462	533	567	505	466
Number of breaches	0	0	2	2	1

Table 5: Complaints Acknowledgement Performance Q1, 2023/24

5.2 The delay occurred due to an administrative error during the complaints triage stage, with the incorrect case handler being selected. The PALS and Complaints Manager and Complaints Team Leaders have undertaken a review of the process for triaging complaints, and an updated new Standard Operating Procedure is being developed to be finalised during Quarter 2.

5.3 The Trust achieved closure of 88.3% (target 90%) of complaints within the agreed timescale, representing an increase in comparison to the previous quarter, as seen in Table 6. To improve the compliance with complaint response deadlines, the structure of the weekly Hospital/MCS/LCO/Corporate Services Complaints KPI meetings has been standardised across the Trust. Hospital/MCS/LCO/Corporate Services monitor Complaints KPIs to enable timely updates to be provided to the Corporate Complaints Team, with any delays and potential breaches of deadlines escalated to senior management.

	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Q1 23/24
Resolved in 0-25 days	291	329	370	352	358
Resolved in 26-40 days	46	52	66	61	68
Resolved in 41+ days	76	90	114	113	94
Total resolved	**413**	**471**	**550**	**526**	**520**
Total resolved in timescale	**375**	**419**	**487**	**458**	**459**
% Resolved in agreed timescale	**90.8%**	**89.0%**	**88.5%**	**87.1%**	**88.3%**

Table 6: Comparison of complaints resolved by timeframe Q1, 2022/23 – Q1, 2023/24

6. Outcomes from Complaints Investigations

6.1 Often complaints relate to more than one issue. In conjunction with the Hospitals/MCSs/LCO/Corporate Services 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 (for instance, 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'.

6.2 During Q1, 60 (12%) of the complaints investigated and responded to were fully upheld, 365 (72%) were partially upheld and 80 (16%) were not upheld. **Table 7** demonstrates the outcome status of all complaints between Q1, 2022/23 and Q1, 2023/24.

Number of Closed Complaints		Upheld	Partially Upheld	Not Upheld	Information Request
Q1 22/23	413	46	285	77	5
Q2 22/23	471	53	351	63	4
Q3 22/23	550	57	421	72	0
Q4 22/23	526	61	364	100	1
Q1 23/24	507	60	365	80	2

Table 7: Outcome of MFT complaints Q1 2022/23 – Q1 2023/24

6.3 The main themes of 'fully upheld' complaints were 'Treatment/Procedure', 'Communication' and 'Appointment Delay/Cancellation'. 'Communication with patients', was the main sub-category. The PALS Team Leaders are currently reviewing and updating the PALS training, to include customer service and local resolution, to help staff in the Hospitals/MCSs/LCO address and locally resolve communication issues, thus reducing the number being escalated to formal complaints.

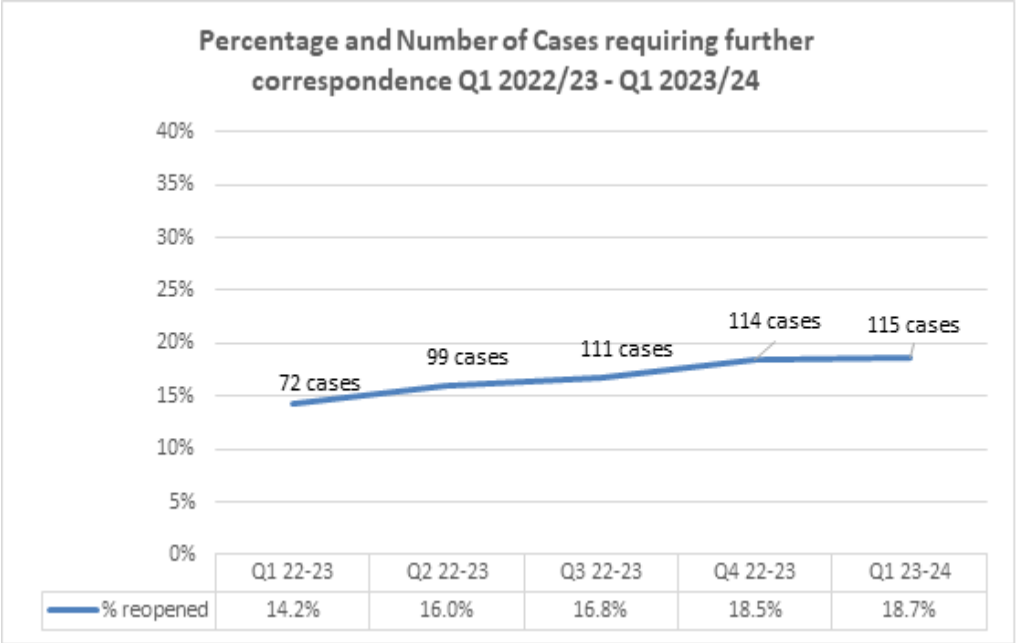
7. Re-opened Complaints

7.1 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 fully address all issues satisfactorily.
- The complainant expresses dissatisfaction with the response.

7.2 The number of re-opened complaints is used as a proxy indicator to measure the quality of the initial response. During Q1, 18.7% of complaints were reopened (115 cases in total) against the Trust tolerance threshold of 20%. This is comparative to the previous quarter, where 18.5% of complaints were reopened (117 cases in total).

7.3 **Graph 9** demonstrates the percentage of complaints re-opened from Q1, 2022/23 – Q1, 2023/24. Table 8 provides an overview of the primary reasons for the complaint being re-opened by Hospital/MCS/LCO/Corporate Services during Q1.



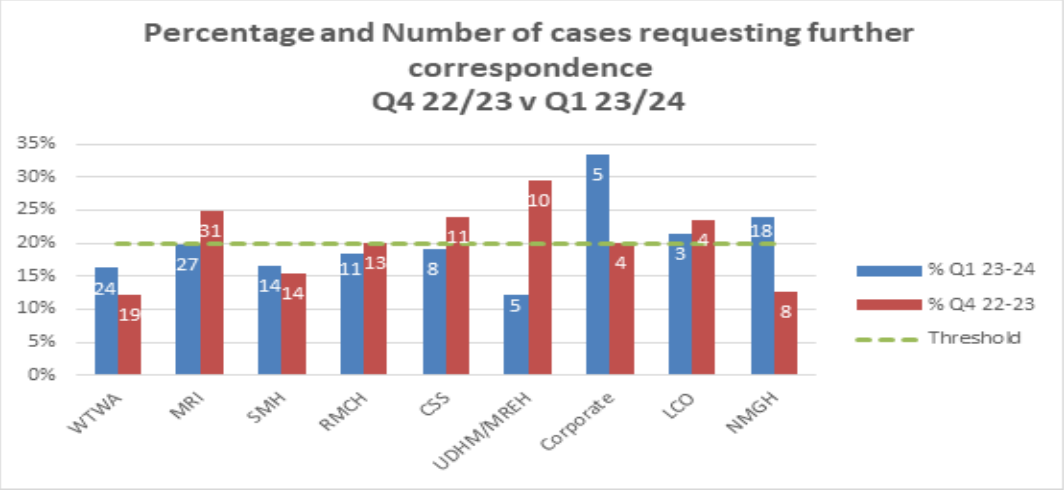
Graph 9: Total re-opened complaints Quarter 1, 2022/22 - Quarter 1, 2023/24

	Disputes Information	New Questions	Not All Issues Fully Addressed	Request Local Resolution Meeting	Other	Total	% Re-opened
WTWA	8	4	9	3	0	24	16.2%
MRI	5	10	7	2	3	27	19.9%
CSS	1	2	3	2	0	8	19.0%
RMCH	5	3	3	0	0	11	18.3%
Corporate	1	2	2	0	0	5	33.3%
LCO	2	0	1	0	0	3	21.4%
NMGH	5	2	8	3	0	18	24.0%
SMH	3	4	4	1	2	14	16.7%
UDHM/MREH	2	2	1	0	0	5	12.2%
Total	**32**	**29**	**38**	**11**	**5**	**115**	**18.7%**

Table 8: Total re-opened complaints by Hospital/MCS/LCO Quarter 1, 2023/24

7.4 In 38 of the 115 complaints requiring re-opening, the primary reason was due to the 'complaint response not fully addressing all issues'. This is a 24% reduction from Q4 2022/23, following the Complaints Team increasing the number of Complaints Investigation and Response Letter Writing Training Programme sessions they have delivered across the Trust. This has contributed to higher quality complaint responses and reduce the number of re-opened complaints. WTWA, North Manchester General Hospital (NMGH) and MRI received the most re-opened complaints. The Complaints Team have offered further bespoke training sessions for these Hospital/MCS/LCO. The 20% threshold was exceeded by Corporate Services (33.3%), NMGH (24%), LCO (21.4%), as depicted in **Graph 10.**

7.5 Fluctuations in the total number of complaints received in a Hospital/MCS/LCO/Corporate Services can result in large percentage changes for those areas where the overall number of complaints are low, which is the case for Corporate Services and the LCO.



Graph 10: Percentage of re-opened complaints by Hospital/MCS/LCO/Corporate Services, Q4 2022/23 - Q1, 2023/24

8. Parliamentary and Health Service Ombudsman (PHSO)

8.1 The PHSO is commissioned by Parliament to provide an independent complaint handling service for complaints that have not been resolved by the NHS England (NHSE) and UK government departments. The PHSO is not part of the Government, NHSE, or a regulator. The PHSO is accountable to Parliament and their work is scrutinised by the Public Administration and Constitutional Affairs Committee.

8.2 The PHSO make final decisions on complaints that have not been resolved by NHSE and UK government departments and other public organisations. The PHSO do this fairly and without taking sides and their service is free. The PHSO considers and reviews complaints, where someone believes there has been injustice or hardship because an organisation has not acted properly or fairly or has given a poor service and have not put things right.

8.3 During Q1 2023/24 the PHSO opened four new cases for investigation into MFT complaints. Two of these were for WTWA, with one each for RMCH and SMH and are currently being processed through the systems in place.

9. Lessons learned from complaints

9.1 This section of the report provides examples of improvements made in response to feedback from complaints. 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.

9.2 Each Hospital/MCS/LCO holds regular forums where themes and trends relating to complaints are discussed with focused actions agreed for improvement. **Table 29**, Appendix 1 includes examples of how learning from complaints has led to changes that have been applied in practice. In addition to this, the Complaints Review Scrutiny Group (CRSG), chaired by the Corporate Director of Nursing for Quality and Patient Experience, and supported by a Non-Executive Director, met on four occasions during Q1 reviewing 6 complaints in total.

9.3 The CRSG process scrutinises complaints investigated and responded to by MFT and contributes to the learning from these complaints, to improve patient experience and positive change through open dialogue and reflection. The management teams from the Hospitals/MCSs/LCO presented a case based upon a complaint they had received. Learning and associated actions identified from the cases were discussed, and assurance was provided that complaints are investigated with appropriate action taken when needed.

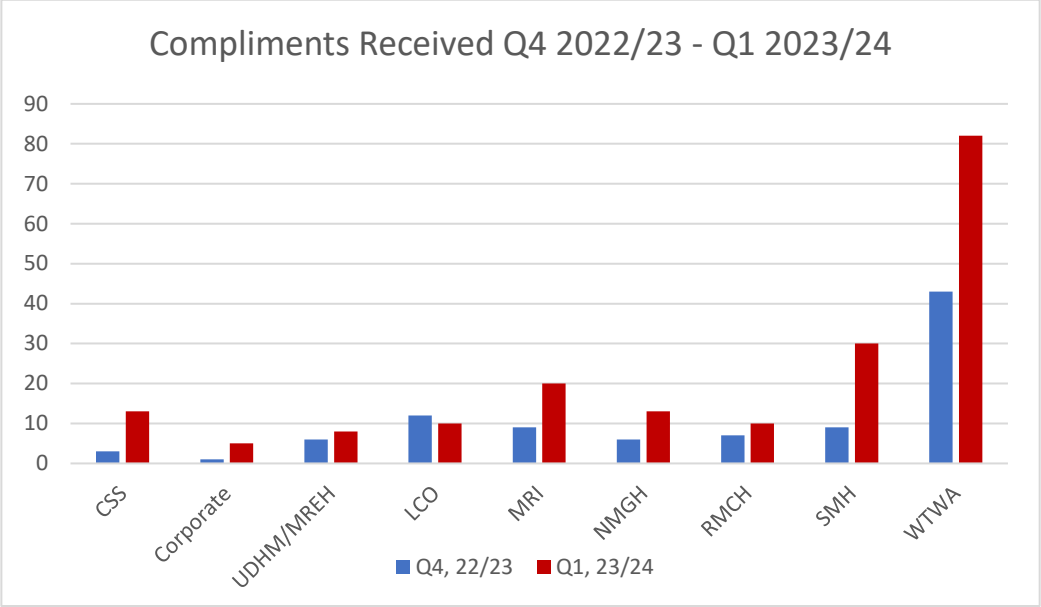
9.4 Each Hospital/MCS/LCO also feed into the Quality and Patient Experience Forum, which is constituted as a sub-group of the Group Quality and Safety Committee and NMAHP Professional Board. The overall purpose of the group is to provide corporate strategic direction in relation to quality and patient experience, ensuring patients and families are at the core of all we do. This forum supports the collaboration of services, shares best practice, and provides a clear link to triangulate themes across the Trust.

10. An overview of Compliments and positive feedback

10.1 Compliments received from the public provide valuable feedback and provide opportunity to learn from positive experiences. Positive patient experience feedback explicably correlates to compliments and can be linked to the top positive themes seen in WMTM and FFT.

10.2 It is important to acknowledge only a fraction of the overall compliments received within the trust are captured and recorded on the Trusts Customer Service Database (Ulysses). The majority of compliments are received verbally (either in person or via the telephone) and as ‘thank you cards’ directly to staff, which are not logged or tracked by the Hospitals/MCSs/LCO.

10.3 **Graph 11** shows the number of compliments, received from members of the public about MFT Hospitals/MCSs/LCO, recorded on the Trust’s Customer Services Database. SMH’s compliments increased by 233%, with WTWA receiving the most compliments overall (82), which is an increase of 91% from the previous quarter.



Graph 11: MFT compliments received Q4 2022/23 vs Q1 2023/24

10.4 Examples of compliments received during Q1 2023/24 are included below:

"I would like to thank you for the most superb care I have had from Manchester Royal Eye Hospital. I underwent day case surgery in May 2023, when I had a vitreo-retinal procedure with IOL insertion. I have been seen in the Eye Clinic on several occasions, and invariably the staff have been kind, professional and efficient - including the reception team, nurses, those performing the retinal scans, and the ophthalmologists of all grades. The care on the Day Unit and in theatre was really excellent - everyone I encountered was friendly, professional, thorough and caring. I was kept updated and informed throughout, people were considerate at all times and I felt that my welfare was their genuine priority. Throughout, the Eye Hospital was impressively clean and that just adds to the confidence that you feel as a patient in that environment. I was really impressed at what a superb surgeon I had - but it's not just about technical expertise, it's about clinical judgement and decision-making, how you counsel patients and communicate with them, how you work with the whole team to care for your patients - and he brilliant in all those areas. I am truly grateful that these professionals have cared for me and my sight with such kindness and world-class expertise."

"I had an operation at Manchester Royal Infirmary in April 2023 and stayed in two nights. I was on the post-surgical ward. I wanted an email to personally say how brilliant the care was that I received. In particular, there was a wonderful nurse on the night shirt. He was an amazing nurse, a lovely person and made me feel completely at ease and comfortable. He deserves great recognition for the job he does and I would like him to personally receive this great feedback from me."

"I am writing to express my gratitude towards for the amazing care the doctor gave to my son in the A&E department at Royal Manchester Children's Hospital. She went above and beyond for him and he is now in much better health and that is thanks to her. She provided regular updates throughout the day and went above and beyond to make sure my son was still going to receive the most appropriate care once he left the

hospital and even took up more of her time to phone me a week later to ask how he was getting on and if his follow up appointments were in place. I really appreciate everything she has done for us and she deserves recognition for being such a fantastic doctor. Thank you so much again."

"I just wanted to pass on my compliments and appreciation for the Maternity Triage Team. I discovered last week that I was pregnant, then while visiting family in Manchester I started bleeding. 111 referred me to Saint Marys, and I had amazing, empathetic care from the start. The colleague I spoke to by phone was reassuring and pragmatic and it's a tiny detail but when she said "I'll keep an eye out for you when you get here" it felt like a really caring, human recognition of my worry. The ward clerk was clear and efficient and put me at ease and gave me confidence I would be seen and the process would be ok. The midwives who did the initial assessment were so kind about the fact I hadn't realised I was pregnant, super-efficient in getting through a whole load of teats, gave me lots of reassurance ahead of starting the doppler so I wouldn't freak out if they couldn't find a heartbeat and then shared my joy when they did - but I had such confidence that they cared about me and would look after me in any outcome it was just amazing. And they thought about me as a whole human, told me I had time for lunch and where I could get some. Finally the doctor I saw was so empathetic for my concerns, so informal in checking the story so far, explaining what she was doing and helping me to understand the scans as she did them, then giving me really clear advice about what to do next. It was an absolutely amazing experience on a day that I felt on the edge of tears, helped me shift from feeling scared and out of control to reassured, cared for and clear about my plan. I know just how much pressure maternity services are under at the moment, which makes me all the more appreciative of people bringing their skill and care as well as technical expertise. Thank you so much."

10.5 The benefit of viewing compliments feedback alongside positive patient experience is that it is useful to understand the similarities and also formally acknowledge where care experience has been good. Table 9 shows the top 3 positive feedback FFT themes that were reported at Trust level during Q1 2023/24.

Top 3 Positive FFT Themes. Quarter 1, 2023/24			
	1	**2**	**3**
MFT	Friendliness	Emotional and Physical Support	Professional and Competent
CSS	Emotional and Physical Support	Friendliness	Professional and Competent
LCO	Emotional and Physical Support	Friendliness	Compassion
MREH	Professional and Competent	Friendliness	Emotional and Physical Support
MRI	Friendliness	Professional and Competent	Emotional and Physical Support
NMGH	Emotional and Physical Support	Helpfulness	Professional and Competent
R&I	Friendliness	Professional and Competent	Helpfulness

RMCH	Friendliness	Emotional and Physical Support	Compassion
SMH	Compassion	Emotional and Physical Support	Friendliness
UDHM	Professional and Competent	Friendliness	Emotional and Physical Support
WTWA	Friendliness	Professional and Competent	Emotional and Physical Support

Table 9: Top 3 Positive Themes based on FFT feedback captured during Q1 2023/24 by Hospital/MCS/LCO

Four Hospitals/MCSs reported 'Friendliness' as their main theme, with three Hospitals/MCSs/LCO reporting 'Emotional and Physical Support'.

10.6 **Table 10** shows the top 3 positive feedback WMTM themes that were reported at Trust level during Q1. 'Professional and Competent' was the main theme for four Hospitals/MCSs, followed by 'Emotional and Physical Support' leading in three Hospitals/MCSs/LCO. This table is also presented at section 2.

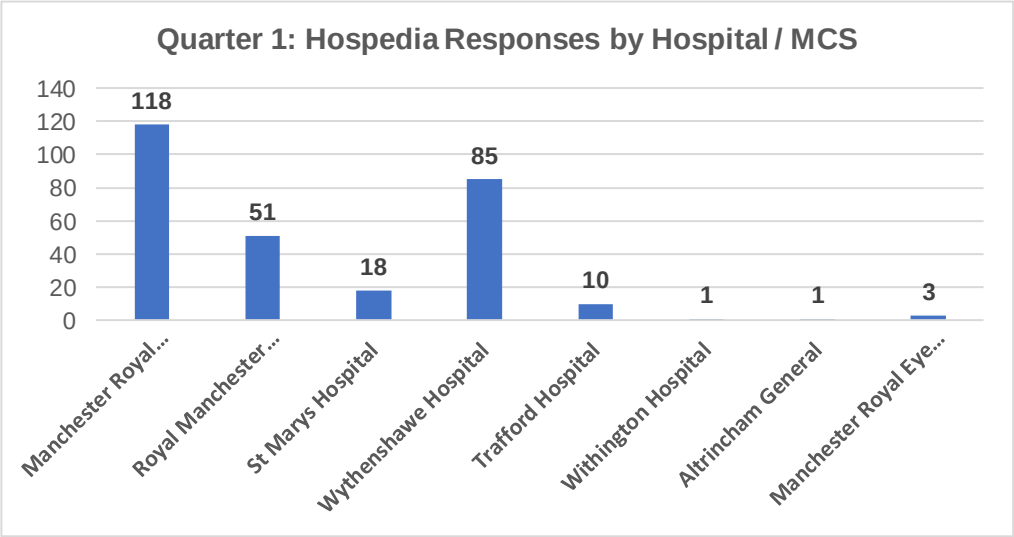
Top 3 Positive WMTM Themes Quarter 1, 2023/24			
	1	**2**	**3**
MFT	Emotional and Physical Support	Friendliness	Compassion
CSS	Professional and Competent	Emotional and Physical Support	Compassion
LCO	Hygiene	Compassion	Emotional and Physical Support
MREH	Professional and Competent	Emotional and Physical Support	Friendliness
MRI	Friendliness	Emotional and Physical Support	Compassion
NMGH	Professional and Competent	Emotional and Physical Support	Compassion
R&I	Friendliness	Compassion	Professional and Competent
RMCH	Friendliness	Emotional and Physical Support	Compassion
SMH	Emotional and Physical Support	Compassion	Friendliness
UDHM	Professional and Competent	Friendliness	Emotional and Physical Support
WTWA	Emotional and Physical Support	Compassion	Professional and Competent

Table 10: Top 3 Positive Themes based on WMTM feedback captured during Q1 2023/24 by Hospital/MCS/LCO

10.7 The WMTM Themes varied, with no obvious themes showing through. Although four Hospitals/MCSs areas reported 'Professional and Competent' as their main theme; three areas reported 'Friendliness'; Two areas reported 'Emotional and Psychological Support'; and the LCO reported 'Hygiene' as their main theme.

10.8 The Corporate Patient Experience Team has also continued to monitor 'WMTM' patient experience feedback collected through Hospedia bedside television entertainment units, and this is shared with clinical areas where appropriate to improve patient experience.

10.9 During Quarter 1, 287 Hospedia responses were received. Graph 12 highlights the three hospitals that achieved the most Hospedia responses during Quarter 1. These are MRI with 118 responses, Wythenshawe Hospital with 85 and RMCH with 51 responses.



Graph 12: Number of Hospedia WMTM Responses by Hospital/MCS/LCO during Quarter 1, 2023/24

8.10 The following are examples of the "What Matters to Me" feedback comments received on Hospedia during Quarter 1.

29/06/2023 – "Having open lines of communication"

30/05/23 – "Kindness and respect, all staff good here"

23/05/23 – "Cleanliness"

07/05/23 – "First class but could be better at times when demands on nurses are stretched"

14/06/23 – "Friendly caring staff, being kept up to date"

03/05/23 – "Making sure I get the right treatment so I can go home pain-free and live my life properly again"

22/04/23 – "what matters the most is about being listened to and not being rushed, which is often not the case"

11. NHS Website and Care Opinion

11.1 The NHS Website and Care Opinion are independent healthcare feedback websites whose objective is to promote honest and meaningful conversations about patient experience between patients and health services. During Quarter 1, 2023/24, there have been 67 new cases from NHS Website or Care Opinion activity processed through Ulysses.

11.2 **Table 11** below provides four examples of feedback received and the subsequent responses posted on the Care Opinion and NHS Website that were published in Quarter 1 2023/24.

Manchester Royal Infirmary
'Quality colorectal cancer team' Had bowel cancer removed this year. The whole process was well managed and made me feel at ease. Excellent communication with the consultant both prior and on the day of the operation. The aftercare team were brilliant. The food was really nice as well! Overall, the service I received was as good if not better than private care. The NHS is without doubt the best thing ever created in the UK. Thanks.
Response:
Thank you for taking the time to share your positive feedback regarding your experience of our cancer services at Manchester Royal Infirmary. It is always good to read such positive words in response to the conscientious work of all our staff and great to hear that you felt well looked-after throughout your stay. Your other comments are especially gratifying. We have forwarded your message for sharing with all the staff involved who will really appreciate your comments.
Wythenshawe Hospital
'First class care' My husband was taken ill at Manchester Airport and was taken by ambulance to your hospital. He was seen quickly in the Emergency Department and detailed information about his condition and the tests/treatment he needed was given to both him and family members who were with him. He was later transferred to the Acute Medical Receiving Unit and discharged the following day. All staff we met were highly professional and helpful and did their best to put our minds at ease at what was a very worrying time. We couldn't fault the way they cared for my husband. You have a fantastic hospital and staff and we are very grateful to you for making his stay as comfortable as possible and ensuring that we, his family, had as much information as we needed to reduce our anxiety. Thank you.
Response:
Thank you for your positive comments posted on the NHS / Care Opinion website regarding the care your husband received at the Emergency Department and AMRU at Wythenshawe Hospital. It was very kind of you to take the time to write and compliment the staff as it is always good to receive positive feedback which reflects the hard work and dedication of our staff. It was reassuring to read that you thought the staff were so professional and helpful, and supportive to your family as well. I can assure you that we have passed on your thoughts to senior colleagues at Wythenshawe Hospital who will share your comments with the staff involved.
North Manchester General Hospital

Been under the car of the piu team on F4a for several months and every visit has been excellent. From my arrival to the care and treatment and the follow up every bit of the visit is taken care of in a professional, friendly manner making what can be a worrying moment a more bearable, relaxed visit. Even better is that I was able to be treated at my local hospital rather than having to go to Manchester Royal Infirmary each time. Thank you one and all.
Response:
Thank you for your positive comments posted on the NHS / Care Opinion website regarding the care you received on ward F4 at North Manchester General Hospital. It was very kind of you to take the time to write and compliment the staff as it is always good to receive positive feedback which reflects the hard work and dedication of our staff. It was especially pleasing to read that you found our staff so supportive and reassuring. I can assure you that we have passed on your thoughts to the Head of Nursing at NMGH who will share your comments with the staff involved.

Table 11: Examples of feedback posted on the Care Opinion and NHS Website

12. National Survey Activity - The National Urgent and Emergency Care 2022

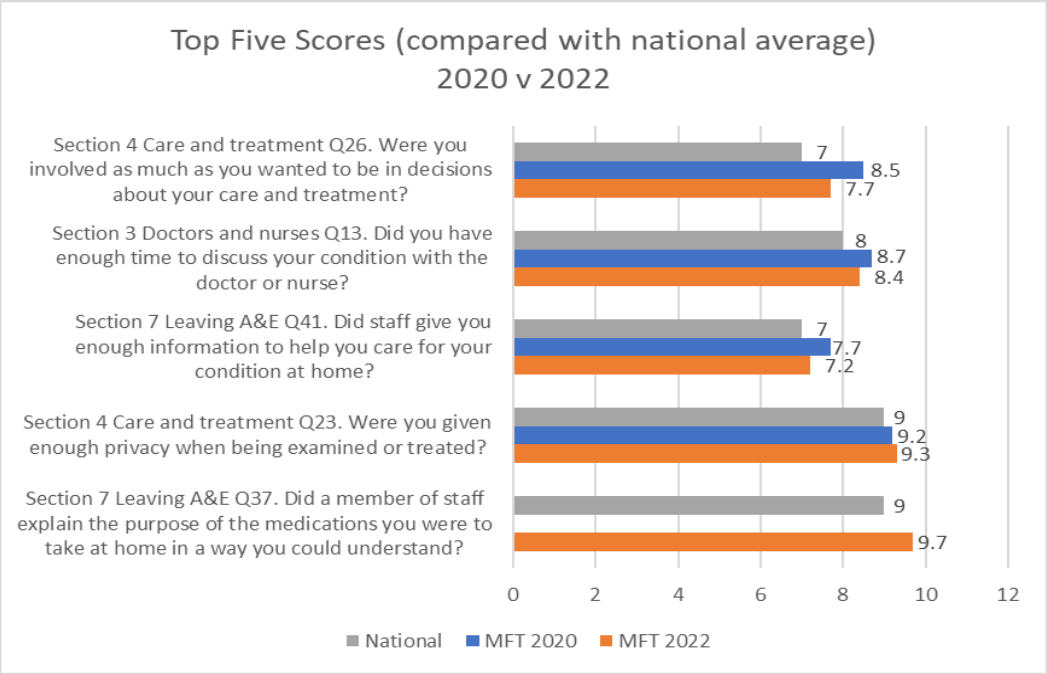
12.1 The National Urgent and Emergency Care (UEC) Patient Experience Survey occurs every second year and was published by the Care Quality Commission (CQC) during July 2023.

12.2 The UEC 2022 involved a postal questionnaire of people ages 16 years and over who attended Type 1 (A&E Department) or Type 3 (Urgent Treatment Centre, Urgent Care Centre or Minor Injuries Unit) services during September 2022.

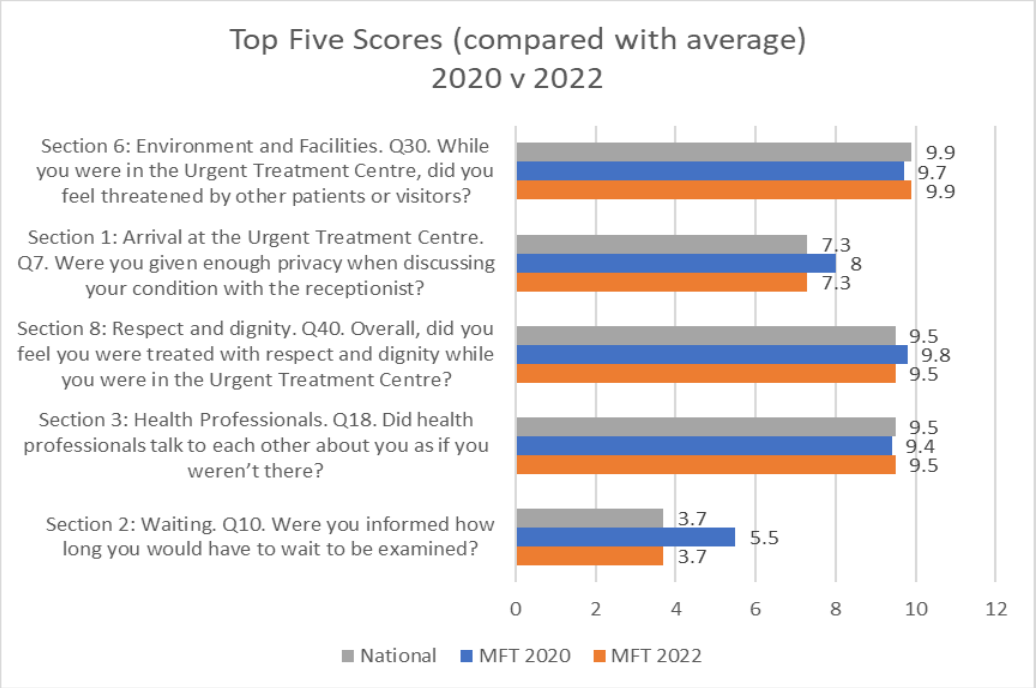
12.3 Completed responses were received from 29,357 people who attended a Type 1 department, a response rate of 22.6%. 7,418 people completed responses were received from people who attended a Type 3 department, a response rate of 22.1 Trusts responsible for Type 1 departments only created a random sample of 1,250 patients. Trusts that also directly run Type 3 departments sampled 950 patients from Type 1 departments and 580 patients from Type 3 departments totalling 1,530 patients.

12.4 The UEC 2022 results demonstrate the trust's results are predominantly 'about the same' as other NHS Trusts.

12.5 **Graphs 13 and 14** below demonstrates Types 1 and Type 3 top five results respectively for MFT that are the highest compared with the national average.

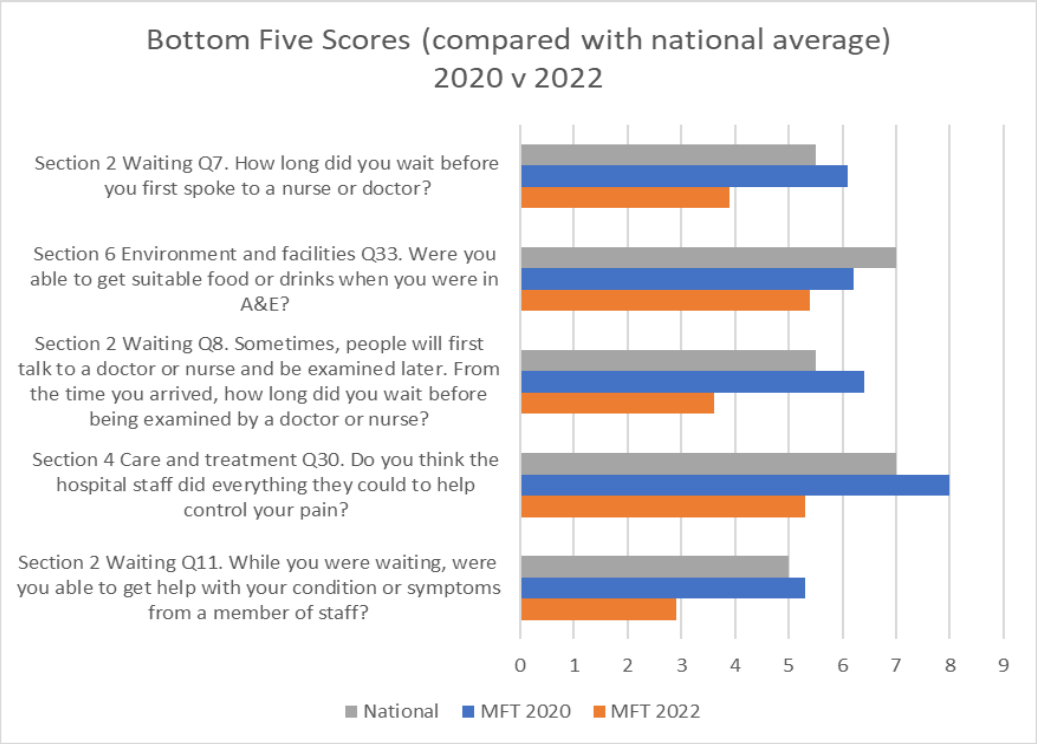


Graph 13

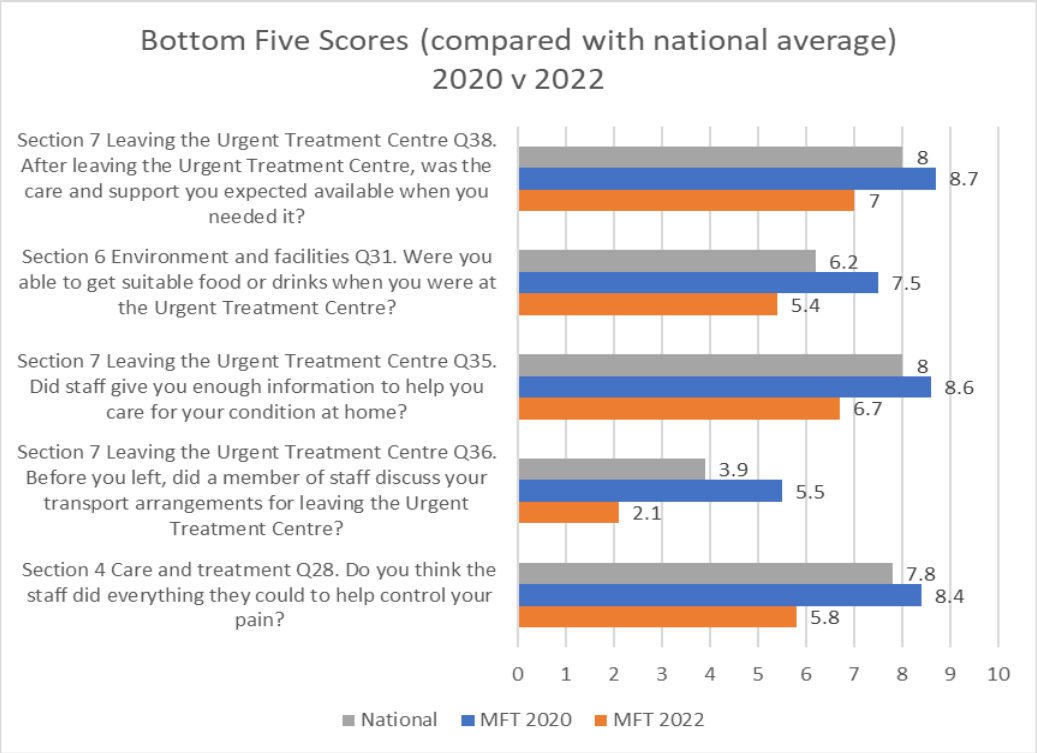


Graph 14

12.6 **Graph 15 and 16** below illustrates the Types 1 and 3 bottom five results for MFT that are lowest compared with the national average.



Graph 15



Graph 16

12.7 It is recognised that the COVID-19 pandemic has had a detrimental impact on the waiting times and waiting lists for patients across many NHS services. The Hospitals/MCSs/LCO continue to work towards reducing delays for patients through recovery programmes in both elective and non-elective pathways to improve waiting times.

12.8 Similarly, improvement plans are being developed locally within the Emergency Departments with specific focus on two areas namely, Waiting and Communication. This links in with the complaint's and WMTM themes reported around 'waiting'.

13. Bespoke Surveys

13.1 The Corporate Patient Experience Team manage a Survey Monkey account to support staff with the development of surveys and reporting processes to enable further opportunities to develop patient and staff feedback mechanisms. During Quarter 1, ten proformas requesting advice and support around enhancement of WMTM feedback was received from wards and departments across the trust.

13.2 During this quarter four new surveys have gone live on Survey Monkey. The Corporate Patient Experience team produced 60 individual survey reports for different teams across the trust throughout Quarter 1 from the Survey Monkey account.

13.3 The Corporate Patient Experience Team continued to develop a Standard Operating Procedure (SOP) for the bespoke survey offer. The purpose of this SOP is to ensure standardisation between Hospitals/MCSs/LCO teams approaching the Patient Experience Team for the bespoke surveys and enables the team to support improvements.

14. Carer's Strategy

14.1 The development of MFT's Carers Strategy has been a key workstream for the Corporate Patient Experience team throughout 2022/2023.

14.2 The Patient Experience Team facilitated an in-person Stakeholder Engagement Event during November 2022. Feedback using the What Matters to Me patient experience feedback tool was shared. This highlighted that the current feedback mechanisms did not support asking carers/family members for experience feedback when their loved ones received care or treatment at MFT. Feedback taken from the engagement activity has supported the development of the Commitments forming part of MFT's Carers Strategy.

14.3 5 key themes were identified from the engagement event:

- Identification and Recognition
- Communication
- Signposting and Partnership Working
- Education
- Reasonable Adjustments

14.4 To establish commitments for the strategy, each of these themes were reviewed and mapped against the following resources:

- MFT's Experience and Involvement Strategy: Our Commitments to Patients, Families and Carers 2020 - 2023

- Our plan for people with learning disabilities and/or autism, their families and carers 2022-2025
- MFT's Dementia Strategy 2023-2026
- MFT's Adult Supportive Palliative and End of Life Care Strategy 2021-2026

The culmination of all this preparatory work has led to the drafting of the MFT's Carer's Strategy, 2023-2026.

14.5 To gain further insight, in support of developing the Carer's Strategy, the Head of Patient Services and Patient Experience Programme Lead attended a Carers Event at Manchester Carer's Centre early 2023. The meeting enabled discussion around what should be included in the strategy. There was an opportunity to share the feedback gained from the recent Stakeholder Engagement Event which will help form the development of the MFT's Carer's Strategy commitments.

14.6 During Q1 a period of consultation was commenced, and a letter of invitation was sent to all stakeholders with a copy of the proposed strategy. Following the consultation period, all comments and feedback where collated. The MFT's Carer's Strategy, will be presented to the Professional Board of Directors for ratification, with a proposed formal launch planned during September 2023.

15. Patient Stories

15.1 During Quarter 1, four patient stories have been successfully completed. In May 2023, Natalie's story was shared at the Group Board of Directors (BoD) Meeting in May 2023. Natalie's story was about how the Cataract Clinic at MREH provide reasonable adjustments at their Best Interests Clinics to support patients with learning disabilities or patients living with dementia. The Group Chief Executive noted Natasha's story during his weekly message to all staff.

> *'I was incredibly impressed with the work Natalie has led, directly improving the timeliness of treatments for patients with learning disabilities or dementia. Both groups of patients often have complex needs which must be factored into their treatment plans to ensure they have the support they need for the procedures to be conducted safely and without distress. Natalie and team had noticed that when organising the support required for each patient, this could take some time to arrange and was leading to patients having to wait longer than necessary to have their sight improved. As Natale says, giving the gift of sight back to this group of patients with complex needs has an "absolutely profound" impact on them'.*

Extract from Mark's weekly Message, MFT Communications, 13 May 2023

15.2 The Corporate Patient Experience Team continue to work closely with the trust's Medical Illustrations team actively building a library of patient stories.

16. What Matters to Me /Quality Care Round – Community Services

16.1 MFT provided 50 iPads to support Manchester and Trafford Local Care Organisation in the collection of Patient Experience Feedback. 10 iPads per division were allocated with

the FFT and WMTM surveys loaded onto the devices. All iPads have been deployed to the 5 Manchester LCO divisions to support patient experience data collection. These areas include, Adult South, Adults and Specialist Services, Central, North Manchester Community Services and Trafford Local Care Organisation, for FFT and WMTM surveys. 10 iPads were also allocated and distributed to Children's City Wide during Quarter 1, and are currently in use.

16.2 MFT ratified two Community specific QCR surveys in June 2023, for domiciliary areas and treatment rooms. These have been downloaded to all Community iPads and departments to complete their monthly audit. In addition, there are four new WMTM surveys, that have been ratified, downloaded and in use (two Adult, two Children).

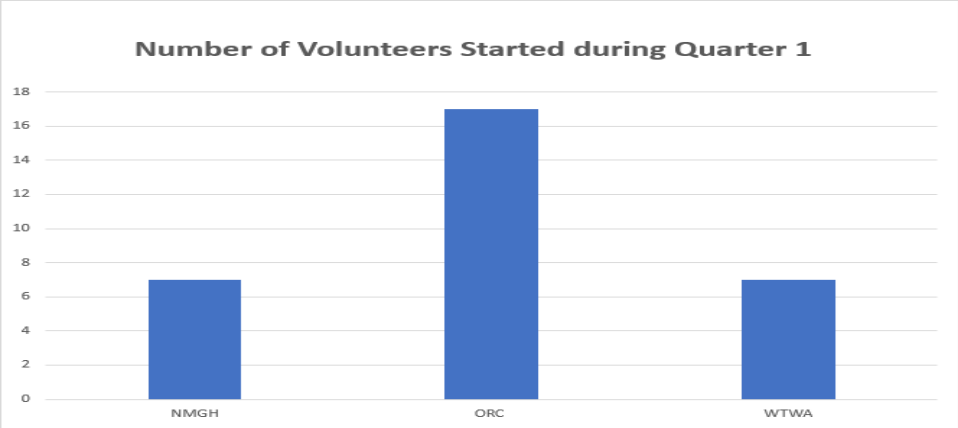
17. Volunteer Recruitment and volunteering undertaken.

17.1 In Q1, 69 applicants were shortlisted, of which 42 were successful. **Table 12** below shows MFT's volunteering recruitment figures by site. Further detail is provided in **Charts 1, 2, 3 and 4, Appendix 1.**

Site	Shortlisted	Successful	Interviewed	Successful	Started
NMGH	17	12	8	6	7
Oxford Road Campus (ORC)	34	30	37	26	17
Wythenshawe, Trafford, Withington , Altrincham (WTWA)	18	15	11	10	7
Grand Total	**69**	**57**	**56**	**42**	**31**

Table 12: Recruitment Activity by site.

Graph 17 below demonstrates the number of new volunteers commencing in their volunteering role by site during Q1. ORC had the greatest number of new volunteers.



Graph 17: Number of new volunteers commencing in role by site, Q1 2023/34.

17.2 During Q1, 4526 volunteering hours were undertaken. Of the 4,526 hours the greatest were undertaken at ORC. **Table 13** below demonstrates the number of hours

volunteered across the sites during Q1. Further detail is provided in **Chart 5, Appendix 1.**

Site	Hours	Volunteers	Average
NMGH	1107	35	32
ORC	1849	103	18
WTWA	1570	97	16
Grand Total	**4526**	**235**	**66**

Table 13: Number of hours volunteered, by the number of volunteers.

17.3 **Tables 14, 15 and 16** below show the distribution of the hours volunteered for the areas within each of the Hospital sites. Overall, the greatest number of volunteering hours relates to 'Meet and Greet' across all sites, however, there is also a marked number of voluntary hours for Macmillan Counselling/Counselling.

Activity	Hours	Volunteers	Average
Complex Patient Programme	4.52	2	2.26
Critical Care	38.94	2	19.47
Meet and Greet	1136.86	129	40.55
Paediatric Theatre	25	1	25
Ward 78	49.16	2	24.58
Ward 84	6.38	1	6.38
Ward 85	15.36	2	7.68
Chaplaincy	24.37	2	12.18
Macmillan Meet and Greet	2	1	2
Pets as Therapy Volunteer	20.23	2	10.11
PLACE	15.95	3	5.32
Volunteer Office	11.38	1	11.38
Adults A&E	6	2	3
Project RED -Meet and Greet	85.53	3	28.51
Cleaning of Lime Display Cabinets	4.66	1	4.66
International Day of the Midwife	1.85	1	1.85
Wellbeing Session for CICU staff	5.65	1	5.65
EPL Counsellor	111.18	6	18.53
SPOONS Volunteer	55.42	4	13.85
Face to Face Fire Safety	28.75	25	1.15
Hand Massage Training	9.49	6	1.58
Counselling Volunteer	190.76	8	23.85
Total	**1849.44**	**334**	

Table 14: Number of hours volunteered by role at ORC.

Activity	Hours	Volunteers	Average
Administration	52.00	2	26.00
Meet and Greet/Face Mask Distribution	664.24	41	16.20
Patient Dining Companion	7.05	1	7.05
Prevent Breast Cancer	5.00	1	5.00
Volunteers Week 23	38	19	2

Face to Face Fire Safety Training	3.15	2	1.58
Chaplaincy	169.40	11	15.40
Emergency Department	64.20	2	32.10
Macmillan- Complementary Therapy	4.30	1	4.30
Macmillan Counsellors, TGH	374.5	20	18.73
Macmillan Gardening	46.35	3	15.45
Pets As Therapy	5.50	2	2.75
Ticker Club	134.05	13	10.31
Trafford Macmillan Information Centre	2.00	1	2.00
Total	**1569.74**	**119**	

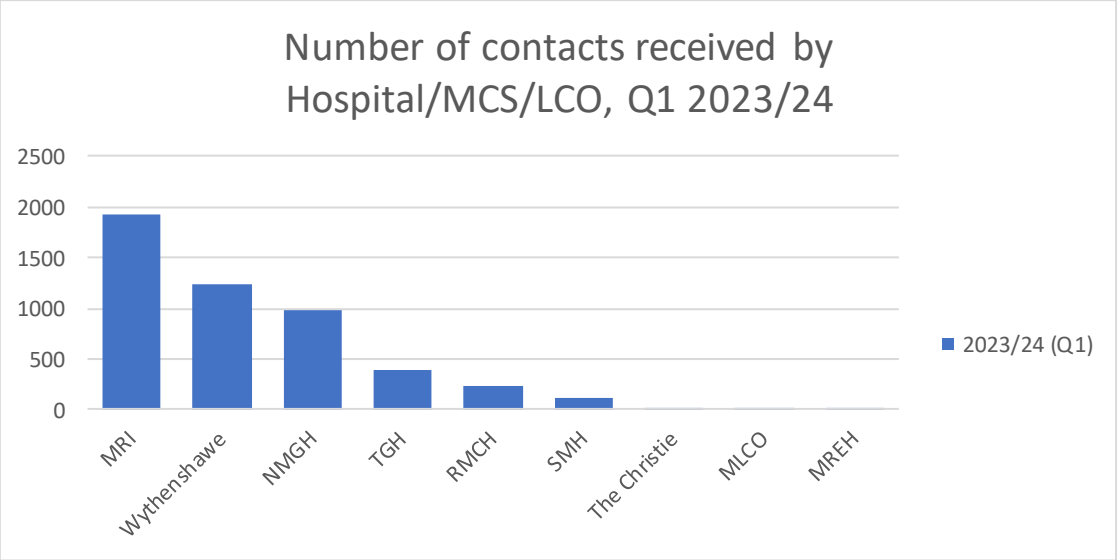
Table 15: Number of hours volunteered by role at WTWA.

Activity	Hours	Volunteers	Average
Ward H4	37.50	2	18.75
Chaplaincy	10.00	1	10.00
Pets As Therapy	8.50	1	8.50
Reception Desk	1046.00	32	32.69
Face to Face Fire Safety	5.00	5	1.00
Total Hours	**1107**	**41**	

Table 16: Number of hours volunteered by role at NMGH.

18. Chaplaincy and Spiritual Care contacts

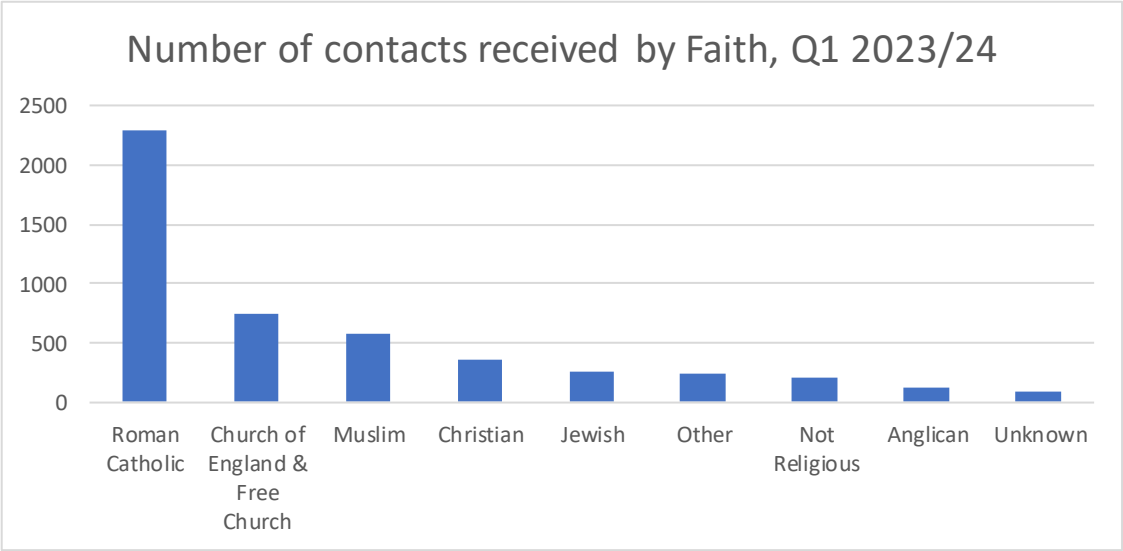
18.1 4,883 contacts were received in Q1. **Graph 18** below shows the number of contacts received from each Hospital/MCS/LCO in Q1. MRI received the greatest number of contacts. Further detail is provided in **Table 16, Appendix 1**.



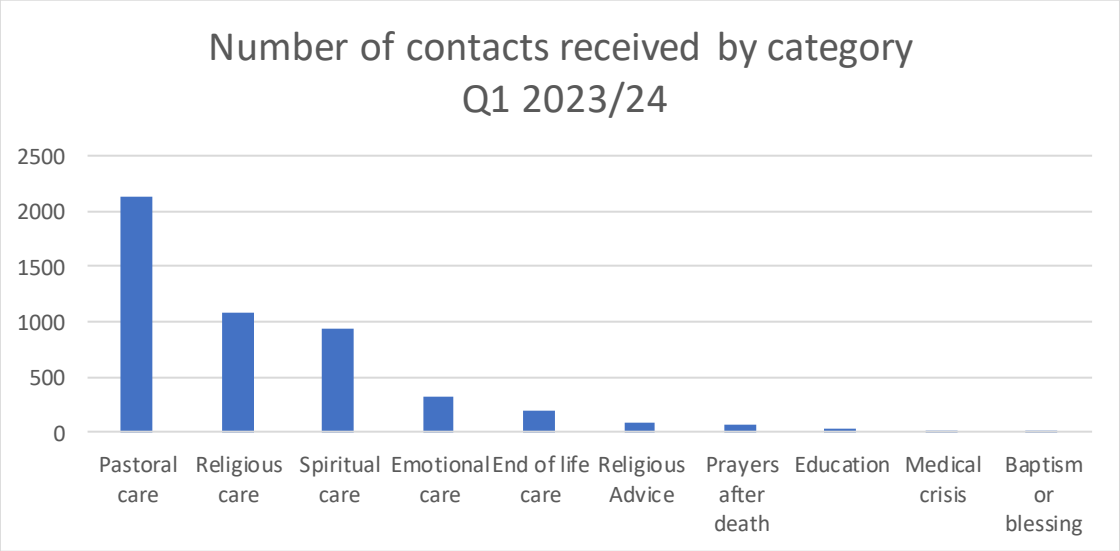
Graph 18: Number of contacts received by Hospital/MCS/LCO, Q1, 23/24

18.2 **Graph 19** below illustrates the number of contacts by Faith during Q1. Of the contacts 47% related to Roman Catholic faith. Further detail is provided in **Table 17, Appendix**

1. During Q1, the top primary support category for contacts/referrals was 'Pastoral Care' **(Graph 20)**

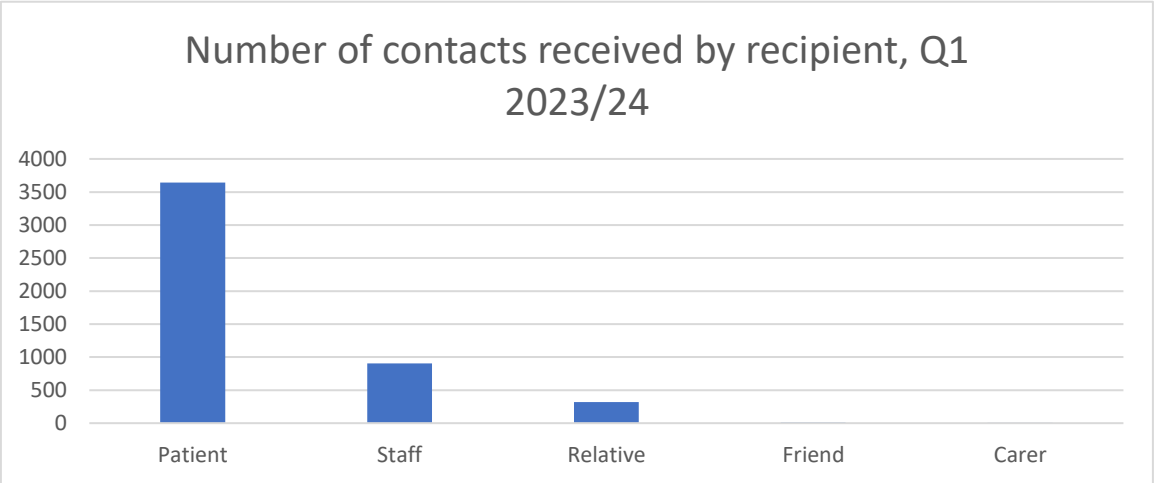


Graph 19: Number of contacts received by Faith, Q1, 23/24



Graph 20: Number of contacts received by Faith, Q1, 23/24

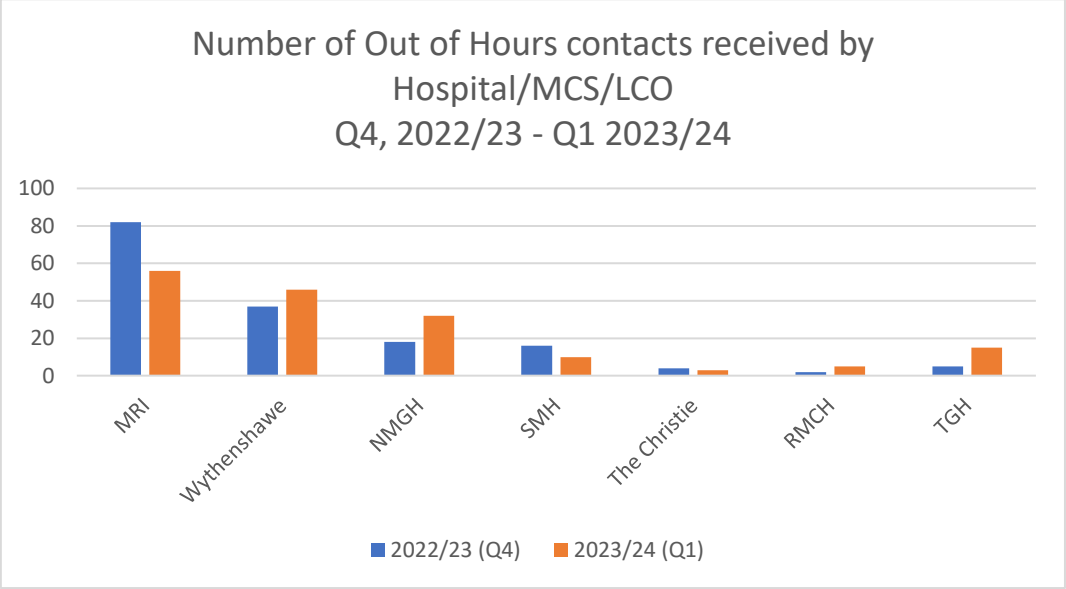
18.3 **Graph 21** below shows the number of contacts by recipient. Of the 4,883 contacts received 74.5% related to patient contact.



Graph 21: Number of contacts received by Recipient, Q1, 23/24

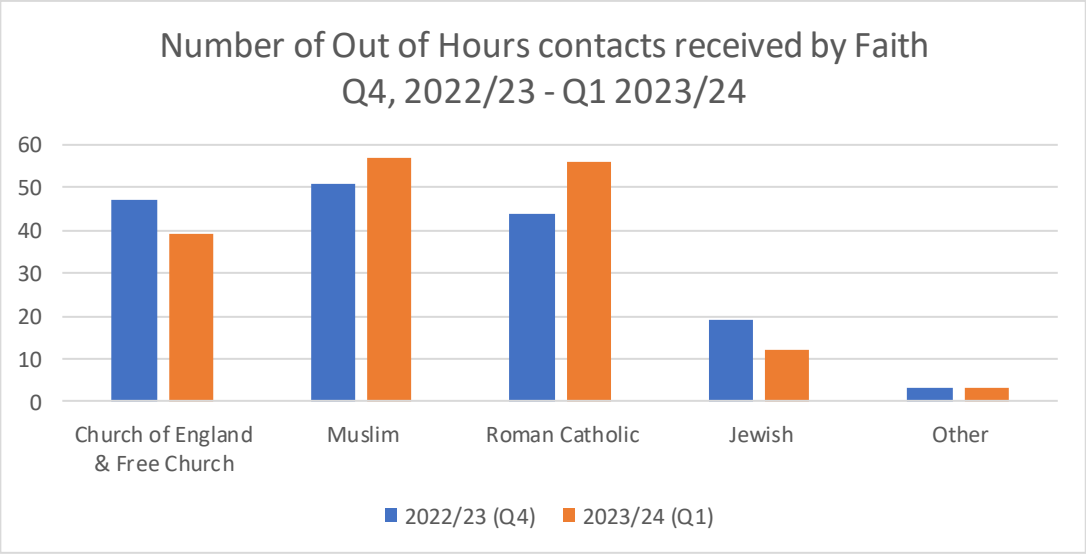
18.4 It is generally recognised that normal working hours for the Chaplaincy and Spiritual Care team are 08:00 – 16:00 hours, Monday to Friday and Sundays for Christian chaplains. All other times are considered out of hours (OOH's) on call chaplaincy provisions where appropriate and the Trust's Chaplains will visit a ward, patient area out of hours because of an emergency call out request.

18.5 In Q1 the Trust saw an increase in the number of OOH's contacts with 167 being received. Graph 22 below shows the number of out of hours contacts received from each Hospital/MCS/LCO. MRI received the greatest number of OOH's contacts. Further detail is provided in **Table 18, Appendix 1.**



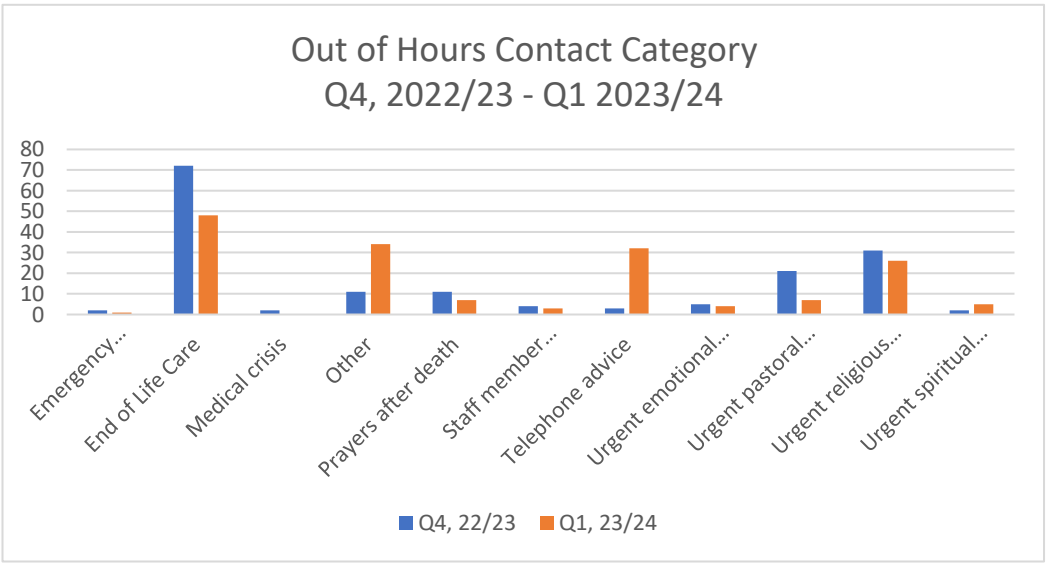
Graph 22: Chaplaincy and Spiritual Care OOH Contacts by Hospital/MCS/LCO

18.6 **Graph 23** below illustrates the number of OOHs contacts by Faith during Q1. Of the 167 OOHs 34% related to Muslim faith. Further detail is provided in **Table 19, Appendix 1**. It is important to note that the faith recorded is that of the patient, not of the chaplain responding. OOH Muslim faith specific support is provided Friday evening to Monday morning only. At other times the on-call chaplain will respond accordingly.



Graph 23: Number of Out of Hours contacts by Faith, Q4, 22/23 – Q1, 23/24

18.7 During Q1, as in Q3 and Q4 the top primary support category for OOHs contacts was 'End of Life Care' **(Graph 24).** Further detail is provided in **Table 20, Appendix 1**.

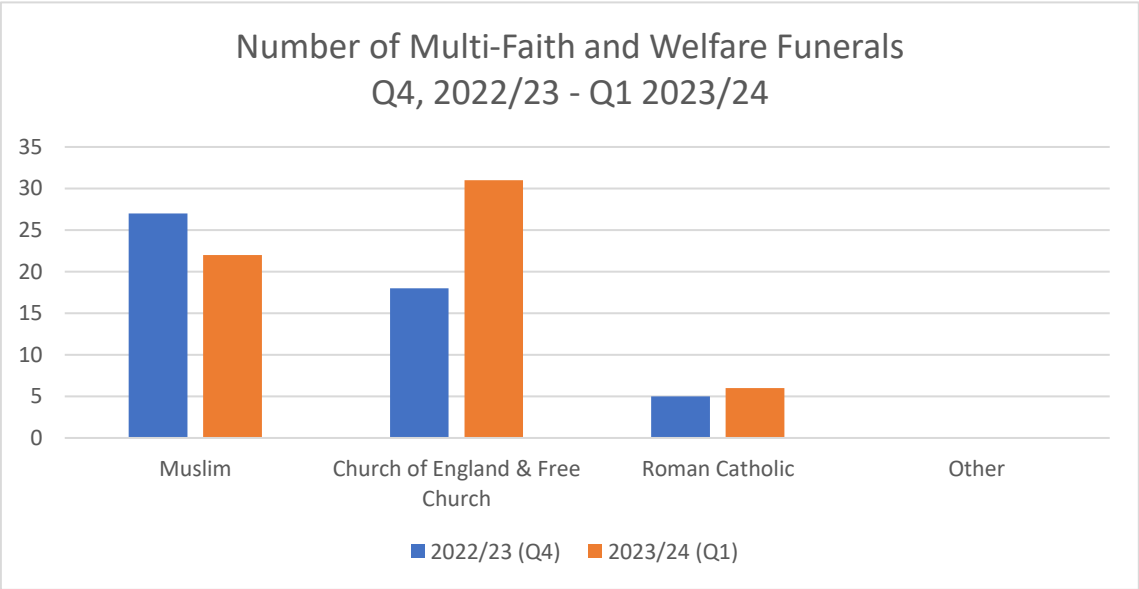


Graph 24: Primary Out of Hours Contact Category, Q4, 22/23 – Q1, 23/24

19. Multi-Faith and Welfare Funerals

19.1 The Trust's Chaplaincy and Spiritual care team provides welfare funerals. These are conducted according to faith and circumstances and provide support to those patients with no next of kin, or relatives or friends available to arrange a funeral – in these instances, the Trust pays for a cremation service..

19.2 During Q1, 59 welfare funerals were held, of which, Church of England and Free Church received the greatest number. This compares to 50 in Q4. Overall, the greatest decrease in funerals was the Muslim faith with a 18.5% (5) decrease being noted compared to Q4, 22/23. Further detail is provided in Graph 25 below and **Table 21, Appendix 1.**



Graph 25: Number of Multi-Faith and Welfare Funerals, Q4, 22/23 - Q1, 23/24

20. Accreditation outcomes

20.1 The Accreditation process is part of MFT, assurance mechanism for ensuring high-quality care and the best possible patient experience. The Accreditation process is aligned to the Care Quality Commission's (CQC) Key Line of Enquiry Standards (KLOE) which are (Safe, Effective, Responsive, Caring and Well Led). The new revised accreditation rota commenced in April 2023, there have been a total of **37 accreditations undertaken** during Quarter 1 2023/24 with **21 validated results** from the start of the rota to end of June 2023.

20.2 Overall Accreditation Results Quarter 1.

- 2 Gold awards
- 12 Silver awards
- 7 Bronze awards
- 0 White awards (Table 22)

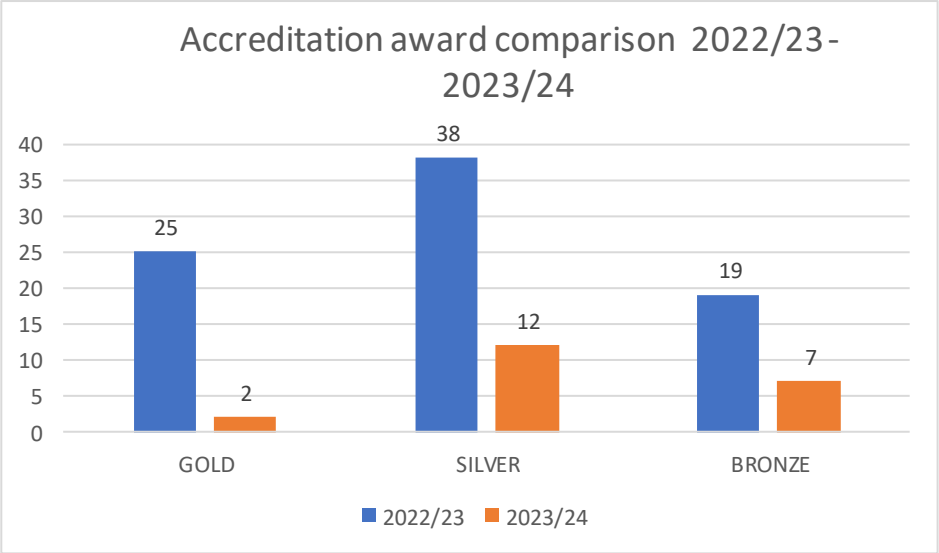
20.3 This is in comparison to eighty-two accreditations during Quarter 1 in the previous year. The significant increase in 2022/23 accreditations was deliberate to front load the accreditations at the start of the rota, to accommodate standing down accreditations during the HIVE digital launch in September 2022.

Distribution of Awards 2022/23 vs 2023/24		
	2022/23	2023/24
Gold	25	2
Silver	38	12
Bronze	19	7
White	0	0
Total	82	21

Table 17 Distribution of awards 2022/23 compared to 2023/24

20.4 Whilst it is worth noting the accreditation numbers for Quarter 1, 2022/23 it is not comparable to Quarter one accreditations 2023/24 due to the significant difference in numbers for this quarter for the reasons stated above **(Table 17).**

20.5 The distribution of Accreditation awards during Quarter 1 2023/24 demonstrates 33% (7) achieved Bronze, 57% (12) achieved Silver and 10% (2) achieved Gold **(Graph 26).**

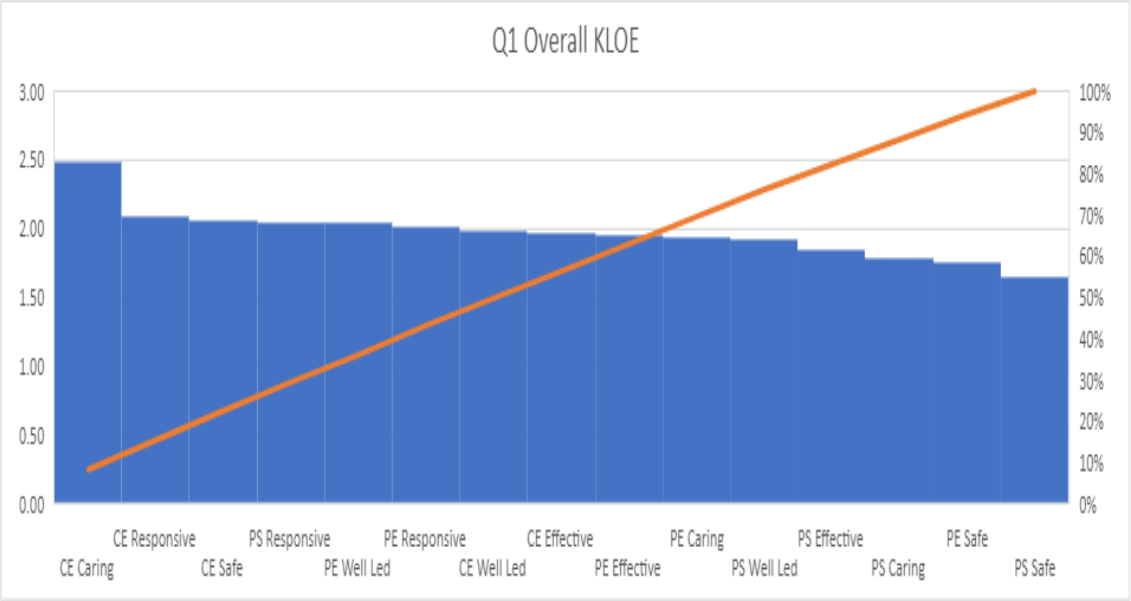


Graph 26: Areas of Success in the Accreditation Programme 2022-23

20.6 Further analysis indicates that the three that achieved the highest score more frequently were Clinical Effectiveness-Caring (relating to staff wellbeing), Clinical Effectiveness-Responsive, relating to support of students and Clinical Effectiveness-Safe which refers to safeguarding and mental capacity **(Graph 27).**

20.7 In contrast, the three standards that received the lowest scores were Patient Experience-Safe which addresses meals and pain management, Patient Safety-Caring relating to information governance and Patient Safety-Safe which refers to medication storage and management. (Graph 27). In response to the low score for patient experience of the MFT meals service, the Professional Practice Service will commence a Mealtime Standard Improvement Programme in September 2023. Please see Section 24.1 for further information in relation to this programme.

20.8 The Accreditation process has also identified a theme relating to transporting of medication with patients at the point of transfer. A working group has been set up supporting the Trusts Medicines Safety Committee, which will commence in September to help understand how a change in practice or process would help improve patient experience and safety. Please see section 23.2 for further information



Graph 27: Overall KLOE scores achieved during Quarter 1

21. Interpretation and Translation Service (ITS)

21.1 During Quarter 1 2023/24, ITS was accessed a total of 27,864 times. Telephone Interpreting (TI) being the most accessed service used 17,112 which is 61.41% of all usage of ITS **(Chart 6).**

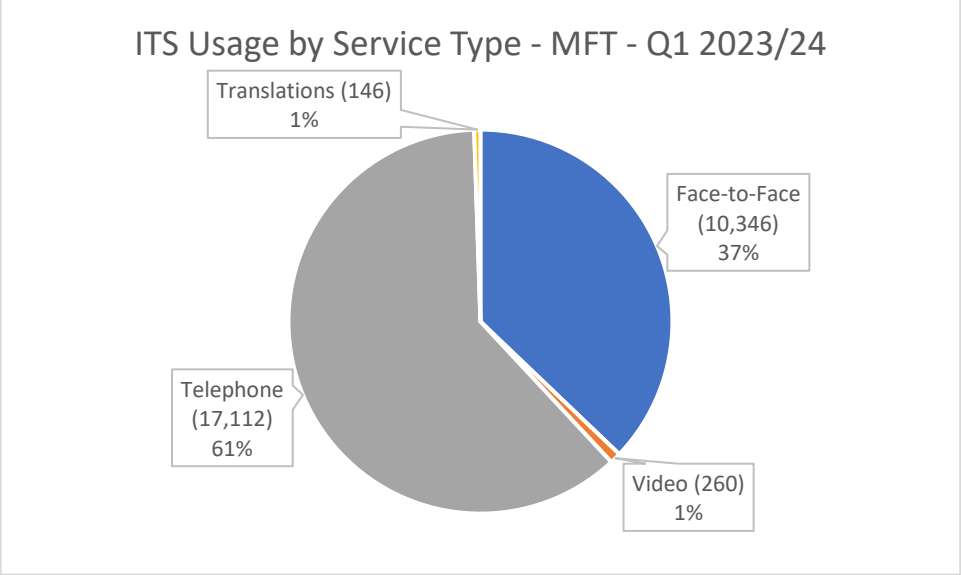
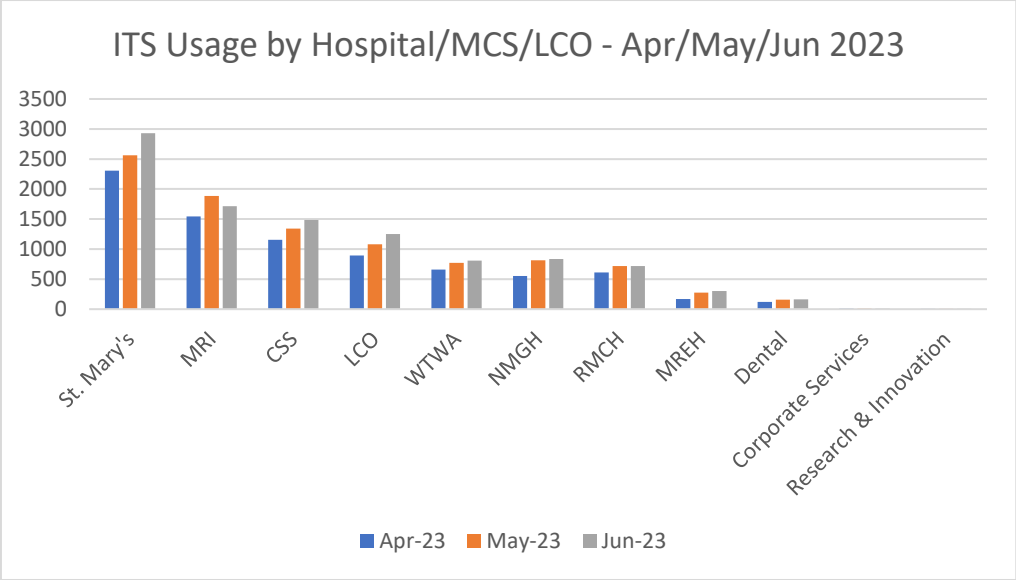


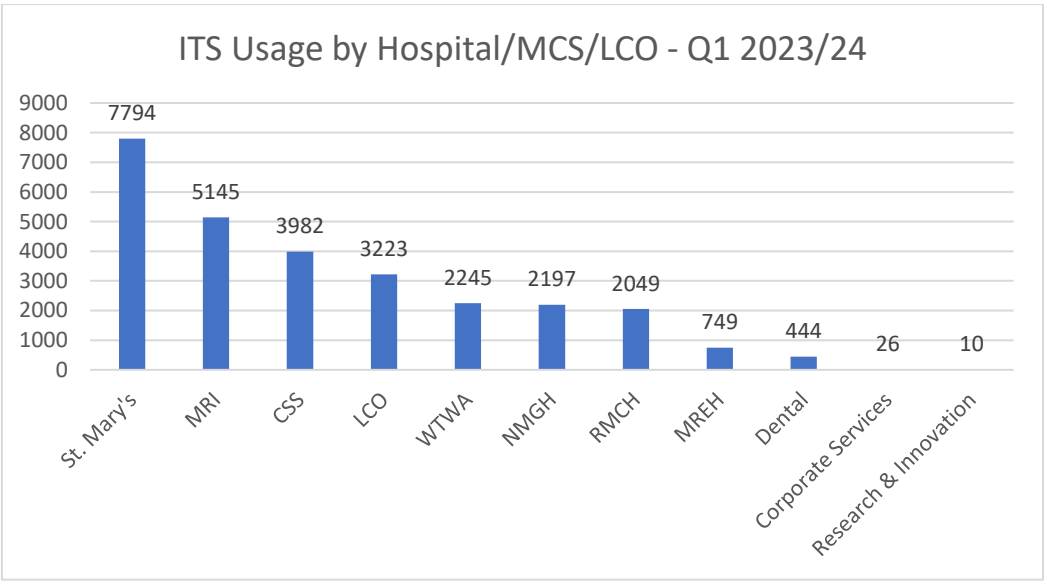
Chart 6. Distribution of ITS methods used in Q1 April 1st, 2023-June 30th, 2023

21.2 In April 2023, ITS was accessed a total of 8,025 times across the Trust. This increased in May 2023, to 9,608, and to 10,231 in June 2023. Nine out of 11 of the Hospitals/MCSs/LCO, have seen an increase in their usage of ITS month-on-month during Quarter 1 **(Graph 28).**



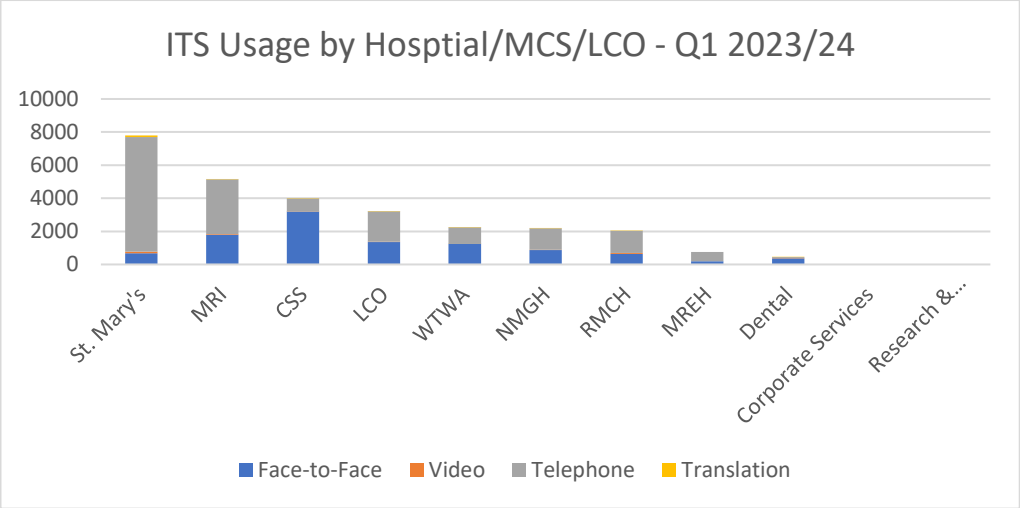
Graph 28: Interpretation & Translation Service Usage by Hospital/MCS/LCO, April, May, June 2023.

21.3 Analysis of usage from all Hospitals/MCSs/LCO indicate that SMH have used ITS most during Quarter 1. SMH have accessed the service 7,794 times, this represents 27.97% of all usage during Quarter 1 **(Graph 29)**.



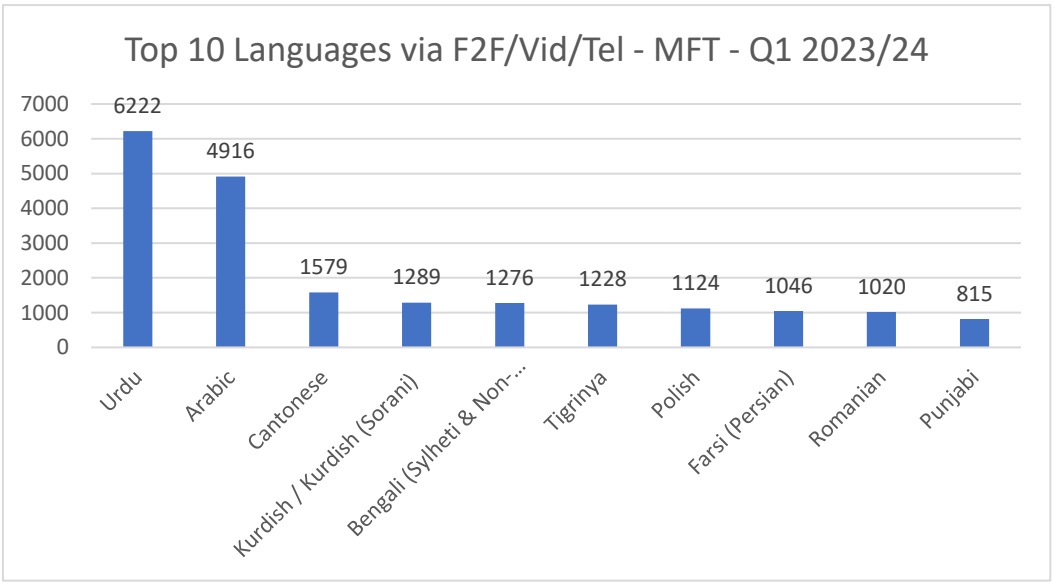
Graph 29: Interpretation & Translation Service Usage by Hospital/MCS/LCO, Q1 2023/24.

21.4 As well as accessing ITS most often, SMH are the highest users of telephone interpretation, 6,931 times (88.93%) of their overall usage during Quarter 1 **(Graph 30).**



Graph 30: Distribution of Service Type Usage by Hospital/MCS/LCO, Q1 2023/24.

21.5 Analysis of Face-to-Face, Video and Telephone requests from all Hospitals/MCSs/LCO indicate that Urdu and Arabic were the most requested languages across the Trust in Q1. Urdu was requested 6,222 times and Arabic 4,916 times. Urdu and Arabic accounted for 40.18% of all requests in Quarter 1 **(Graph 31).** Please refer to **Appendix 1**, **Charts 7** to **17** for further information in relation to usage across the Hospitals/MCSs/LCO.



Graph 31: The Top 10 Languages requested Face-to-Face/Video/Telephone, MFT, Q1 2023/24.

22. Quality Improvements that have taken place in Q1 2023/24 included:

PALS and Complaints

- Re-opening of the PALS office at Trafford General Hospital.

Patient Experience

- Development of a Patient Stories database.

Voluntary Services

- Embedding of the Volunteer Futures Programme.

- Commencement of pilot 12-month St John Ambulance NHS Cadets.
- Commencement of Pets as Therapy ward visits at NMGH.

Chaplaincy

- Re-commencement of pastoral reflective practice groups.
- Participation at the Macmillan and Palliative Care – Dying Matters at Work events.
- Delivery of mindfulness sessions to staff across the Trust.
- Provision of grief and emotional support groups to families and relatives on NICU.
- Renewal of wedding vows for a patient with terminal bowel cancer.

Quality Improvement Team

- Re-introduction of face-to-face Bee Brilliant events - 4466 staff members attended the events on three dates across ORC, Wythenshawe and NMGH.
- 9 successful applications for Small Change Big Difference funding.

23. Future Developments required for the year ahead

23.1 Accreditation data in Q1 identifies, the three standards that received the lowest scores. These were Patient Experience-Safe which addresses meals and pain management, Patient Safety-Caring relating to information governance and Patient Safety-Safe which refers to medication storage and management. The Professional Practice Service plan to address this by the development of the MealTime Standards Improvement Programme. A working group will start in September 2023.

23.2 The Trust Medicines Safety Committee reported an increase in incidents where patients are transferred to different wards/hospitals with the wrong medication. These incidents impact on patient safety and experience. In response to this, the Professional Practice Team are working with the Medicine Safety Officer to develop a working group to address the issues commences in September 2023.

23.3 The Accreditation data suggests that there is a clear correlation between the knowledge of IQP methodology, leadership, and the Accreditation outcome. Training packages are planned for Quarter two 2023/24 for ward managers and team leads to address the turnover of new ward managers across the Trust; training will continue to be rolled out over the year. In addition, the IQP team plan to continue to deliver IQP training across the trust to ensure the methodology is disseminated to address areas for improvement identified during the Accreditation Programme.

23.4 Staff wellbeing can be directly linked to better patient experience and positive patient outcomes. Positive scores related to staff wellbeing have been witnessed during Q1 accreditations. To build on this momentum, a PNA strategy focus group has been initiated with the first planning meeting to be held September 2023. This will be held virtually to support maximum attendance with all qualified and trainee PNAs invited to contribute and co-produce.

23.5 Bee Brilliant is integral to the Accreditation Programme and provides an opportunity to strengthen a community of practice by focusing on themes that support excellence in patient care and staff wellbeing. It is intended that the role of the PNA and the support available through RCS will be introduced during Q4 of the Bee Brilliant event in October 2023 which focuses its theme on staff wellbeing.

23.6 The Customer Services Manager is working with the Patient Safety and Compliance Teams, to develop a process map and SOP for aligned working for the Patient Safety and Complaints Processes. This will improve delays in responding to complaints, when there is a linked incident, and ensure the patient/family receive a holistic response to all of their concerns.

23.7 PALS and Complaints Team are working with the Patient Experience Team, to create a Patient and Public Involvement Group. This will provide an opportunity for patients and members of the public to provide qualitative feedback on current MFT services and to input and affect future service changes and improvement projects.

23.8 Re-establishing the Voluntary Services post COVID-19. This work will include opening up of roles across all sites, supporting the re-establishment of partnership charitable organisations, recruitment to current vacancies and development of the team.

23.9 Development of a Chaplaincy Policy and Strategy, including increasing the number of Chaplaincy Volunteers in all faiths, to widen the service offering across the Trust. This also includes exploring offering additional Islamic prayer space at Trafford General Hospital.

23.10 Re-introduction of Adult/Baby/Children's Memorial Services and Chaplaincy Ward rounds on wards. Chaplaincy also exploring the introduction of spiritual care boxes for all wards, to ensure simple resources (such as rosemary beads or Quran cubes) are available for all patients at all times.

24. Equality and Diversity Monitoring Information

24.1 The collection of Volunteer and Complaint EDI data is shown in Appendix 1, Tables 25, 26, 27, 28 and Graph 32. The collection of this information improved during Q1 2023/24 following the implementation of an updated Complaints EDI form and the information being pulled from HIVE, when patients are raising complaints about their own care.

24.2 Despite the improvements in data collection for complaints, there is still an ongoing need to improve reporting on 'disability', 'religion' and 'sexual orientation', with only 30%, 33% and 29% being received respectively, due to patients and their representatives opting not to declare this. To address this, the Customer Services Manager is attending the Trust's Disabled People's User Forum and working closely with the Equality and Diversity Lead, to gather feedback on barriers to submitting a complaint so the service can be made more accessible to all patients and the public going forward.

24.3 It is evident that most volunteers are female across all sites and the majority of volunteers describe themselves as "White British".

25. Conclusion and recommendations

25.1 The themes identified from patient feedback (FFT, WMTM, National Surveys) also correlate to the themes identified through complaints. The most common themes identified for improvement across the trust in Q1 are waiting, appointment delays and cancellations, treatment/procedure, medication safety and mealtime standard issues.

25.2 Our responses invariably outline actions that have or need to be taken in response to the concerns and complaints, feedback, and accreditation outcomes received, and it is clear that the Trust still has further work to do to ensure that we are truly listening and acting on feedback. This includes ensuring workstreams addressing mealtime standards and safe transfer of medication, as well as supporting updates to appointment letters and patient information leaflets, to manage expectations regarding waiting times.

25.3 However, during Q1 2023/2024 there has been an improvement in communication for the last two quarters, with a reduction in complaints and negative feedback. The Corporate Patient Services teams have been pivotal in driving improvements, via Bee Brilliant and PALS and Complaints Training.

25.4 The Corporate Patient Services teams will continue to focus on further improving the triangulation of valuable sources of data available to each of the teams. In addition, the teams will work together to implement new initiatives to ensure all the teams proactively listen and act on feedback provided in a timely manner.

25.5 The Trust is grateful to those patients, families and carers who have taken the time to raise their concerns, complaints and provide feedback, as the Trust acknowledges their contribution to improving services, patient experience and patient safety.

25.6 The Board of Directors is asked to note the content of this Quarter 1, 2023/24 Quality and Patient Experience Report and the ongoing 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

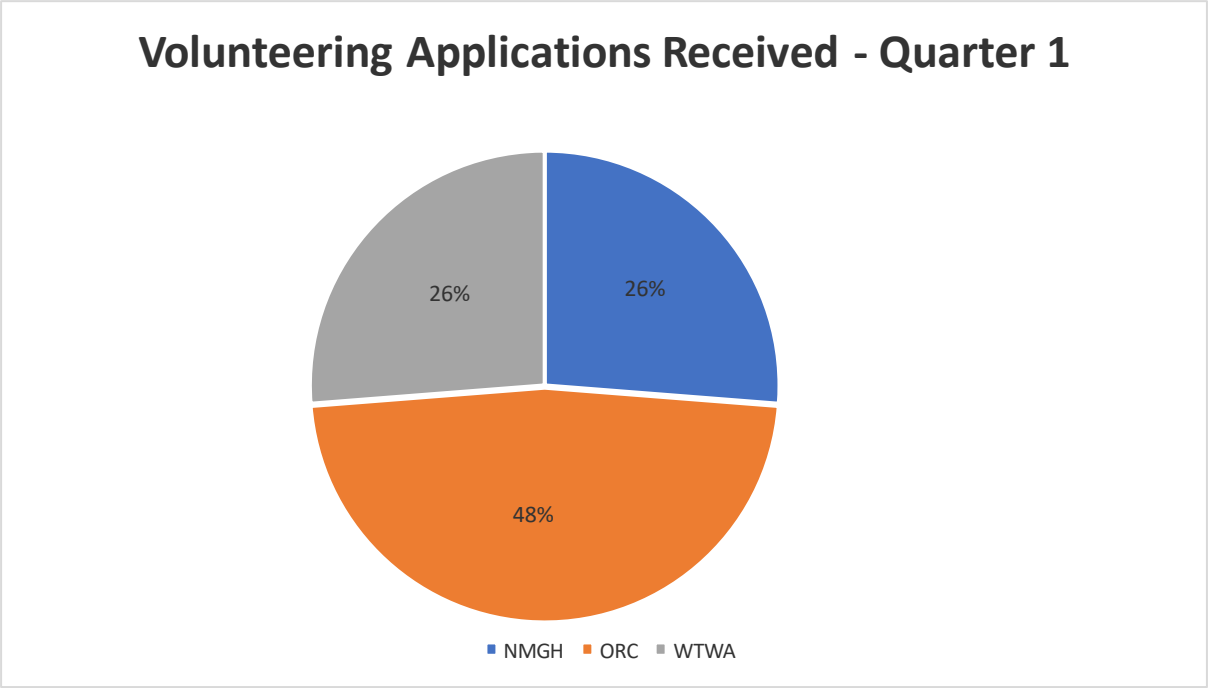


Chart 1: Percentage of Applications Received by site in Quarter 1.

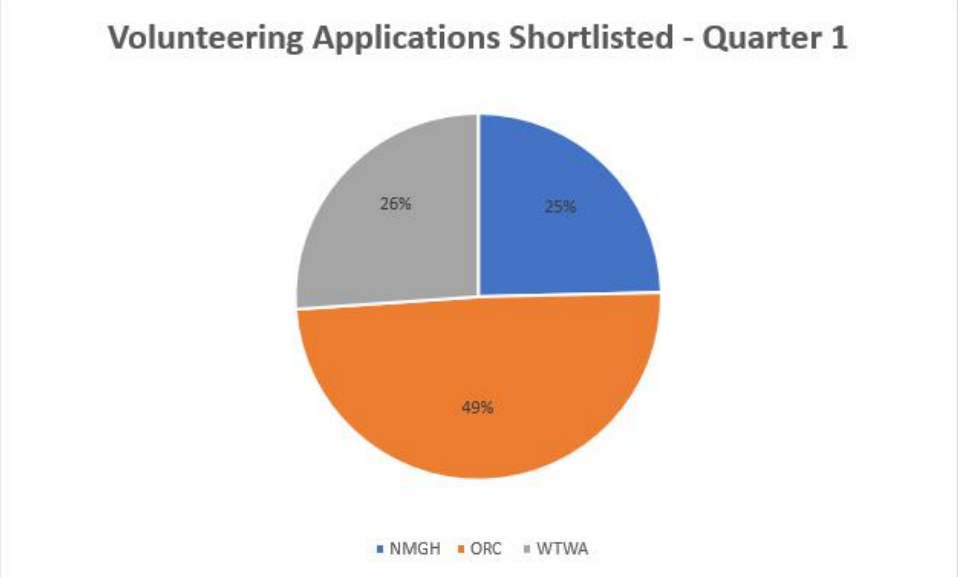


Chart 2: Percentage of Applications Shortlisted by site in Quarter 1.

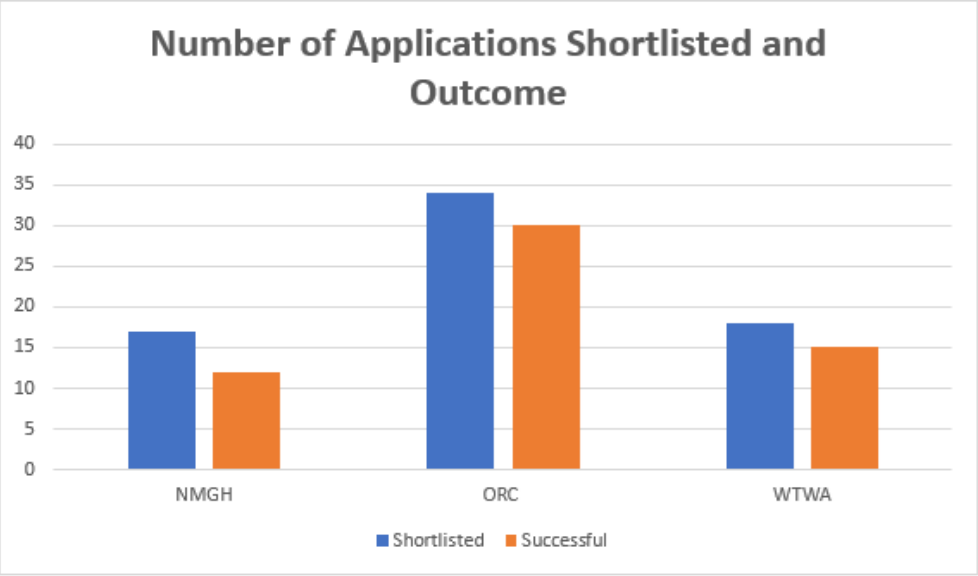


Chart 3: Number of applicants shortlisted and outcome by site, Quarter 1.

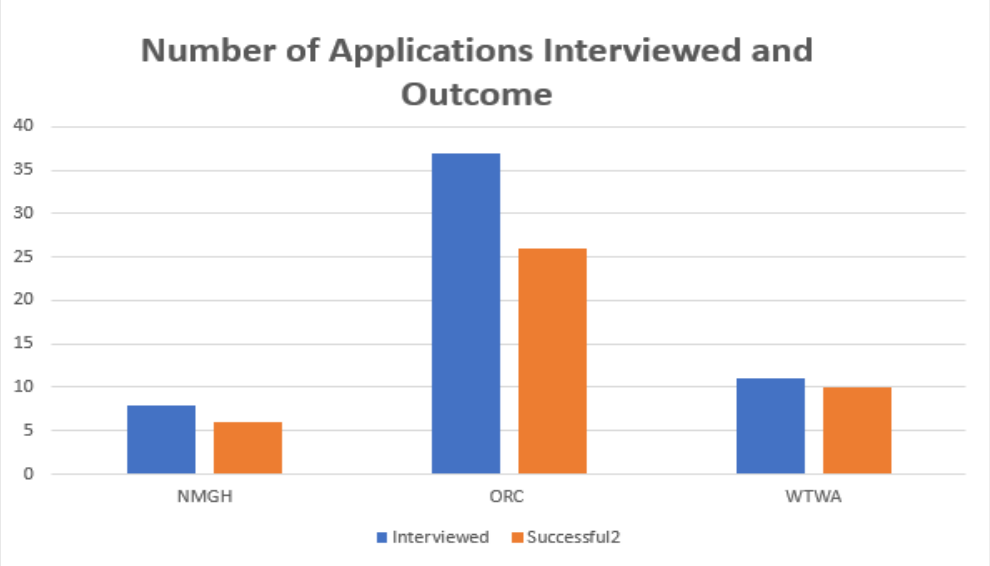


Chart 4: Number of applicants interviewed and outcome by site, Quarter 1.

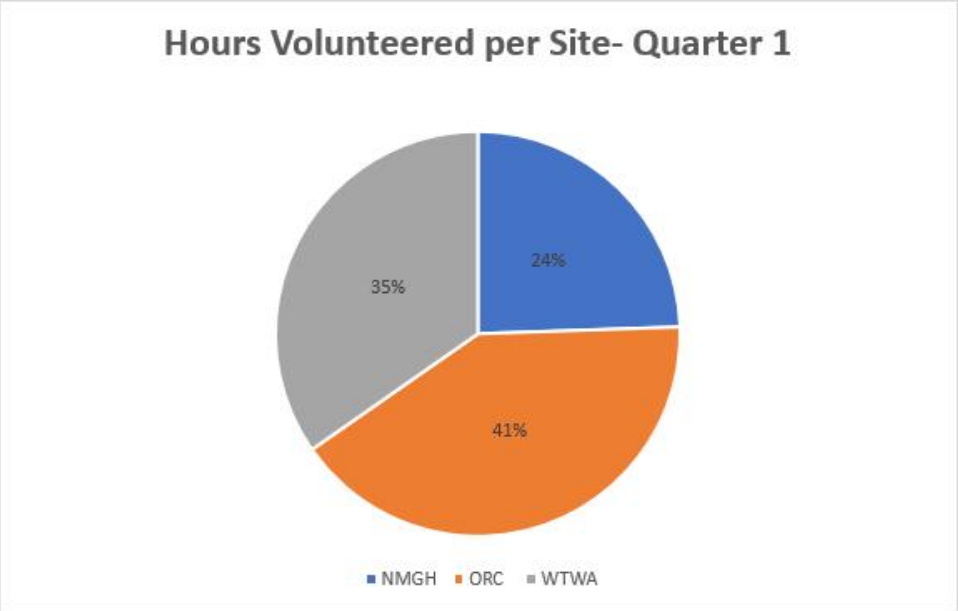


Chart 5: Percentage of hours volunteered by site, Quarter 1.

	2023/24 (Q1)	Chaplain	Volunteer
MRI	1928	1965	63
Wythenshawe	1233	838	395
NMGH	986	976	10
SMH	113	113	0
The Christie	1	1	0
RMCH	230	230	0
TGH	383	383	0
LCO	3	1	2
MREH	6	6	0
Total	**4883**	**4513**	**470**

Table 16: Number of contacts received by Hospital/MCS/LCO, Q1, 2023/24

	2023/24 (Q1)
Roman Catholic	2291
Church of England & Free Church	750
Muslim	569
Christian	364
Jewish	263
Other	239
Not Religious	204
Anglican	113
Unknown	90
Total	**4883**

Table 17: Number of contacts received by Faith, Q1, 2023/24

	2022/23 (Q3)	2022/23 (Q4)	2023/24 (Q1)
MRI	78	82	56
Wythenshawe	38	37	46
NMGH	19	18	32
SMH	19	16	10
The Christie	7	4	3
RMCH	6	2	5
TGH	2	5	15
Total	**169**	**164**	**167**

Table 18: Number of Out of Hours contacts received from each Hospital/MCS/LCO, Q3, 2022/23 – Q1, 2023/24

	2022/23 (Q3)	2022/23 (Q4)	2023/24 (Q1)
Church of England & Free Church	62	47	39
Muslim	49	51	57
Roman Catholic	36	44	56
Jewish	15	19	12
Other	7	3	3
Total	**169**	**164**	**167**

Table 19: Number of Out of Hours contacts received by Faith, Q3, 2022/23 – Q1, 2023/24

	2022/23 (Q3)	2022/23 (Q4)	2023/24 (Q1)
Emergency Baptism/blessing	1	2	1
End of Life Care	25	72	48
Medical Crisis	0	2	0
Other	0	11	34
Prayers after death	5	11	7
Staff support	1	4	3
Telephone advice	0	3	32
Urgent Emotional Care	1	5	4
Urgent Pastoral Care	2	21	7
Urgent Religious Care	10	31	26
Urgent Spiritual Care	0	2	5
Grand Total	**45**	**164**	**167**

Table 28: Number of Out of Hours Contact Category, Q3, 2022/23 – Q1, 2023/24

Funerals	2022/23 (Q3)	2022/23 (Q4)	2023/24 (Q1)
Muslim	23	27	22
Church of England & Free Church	20	18	31
Roman Catholic	4	5	6
Other	0	0	0

Grand Total	**47**	**50**	**59**

Table 21: Number of Multi-Faith and Welfare Funerals Q3, 2022/23 – Q1, 2023/24

	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Q1 23/24
Disability					
Yes	28	32	27	46	55
No	17	17	11	69	97
Not Disclosed	390	472	513	388	352
Total	**435**	**521**	**551**	**503**	**504**
Disability Type					
Learning Difficulty/Disability	1	0	0	1	1
Long-Standing Illness or Health Condition	13	20	19	14	21
Mental Health Condition	5	7	5	3	10
No Disability	0	0	1	1	0
Other Disability	3	9	5	2	4
Physical Disability	6	7	8	14	10
Sensory Impairment	1	5	5	8	7
Not Disclosed	406	473	508	460	451
Total	**435**	**521**	**551**	**503**	**504**
Gender					
Man (Inc Trans Man)	184	201	226	206	208
Woman (Inc Trans Woman)	247	315	318	290	288
Non-binary	0	0	0	0	0
Other Gender	0	1	4	1	2
Not Specified	4	2	3	5	5
Not Disclosed	0	2	0	1	1
Total	**435**	**521**	**551**	**503**	**504**
Sexual Orientation					
Heterosexual	58	129	92	97	126
Lesbian/Gay/Bi-sexual	9	3	5	6	10
Other	7	16	14	1	2
Do not wish to answer	9	11	18	14	7
Not disclosed	352	362	422	385	359
Total	**435**	**521**	**551**	**503**	**504**
Religion/Belief					
Buddhist	0	0	1	0	1
Christianity (All Denominations)	48	75	54	62	90
Do Not Wish To Answer	6	16	4	10	5
Muslim	5	11	11	11	18
No Religion	43	53	59	44	46
Other	3	3	6	2	3

Sikh		1	1		
Jewish		4	3	2	3
Hindu	3	1	3	3	1
Not disclosed	327	356	407	369	336
Humanism	0	0	1	0	0
Paganism	0	0	1	0	1
Total	**435**	**520**	**551**	**503**	**504**
Ethnic Group					
Asian or Asian British - Bangladeshi	1	3	1	0	0
Asian or Asian British - Indian	5	6	2	5	3
Asian or Asian British - Other Asian	4	5	5	6	5
Asian or Asian British - Pakistani	6	10	11	9	15
Black or Black British – Black African	8	6	6	4	3
Black or Black British – Black Caribbean	11	5	7	9	4
Black or Black British – other Black	4	1	2	2	4
Chinese or Other Ethnic Group - Chinese	0	0	1	2	0
Mixed - Other Mixed	1	1	4	1	2
Mixed - White & Asian	0	3	2	0	1
Mixed - White and Black African	1	1	0	0	0
Mixed - White and Black Caribbean	1	2	4	1	2
Not Stated	85	112	109	98	116
Other Ethnic Category - Other Ethnic	5	4	8	10	6
White - British	145	180	202	196	203
White - Irish	6	3	4	6	7
White - Other White	11	10	7	8	6
Not disclosed	141	169	176	146	127
Total	**435**	**521**	**551**	**503**	**504**

Table 25: EDI data collection for complaints received Q1 2022/23 – Q4 2023/24

	16-18	19-24	25-29	30-39	40-49	50-59	60-69	70+	Total
NMGH	13	5	2	3	2	1	5	4	35
ORC	37	11	4	14	12	10	7	8	103
WTWA	20	3	1	3	12	12	14	32	97
Grand Total	70	19	7	20	26	23	26	44	235

Table 26: Number of active volunteers by age and site over the months April-June 2023.

	Male	Female	Other	Non-Binary	Prefer not to say	Unknown	
NMGH	9	26	0	0	0	0	**35**
ORC	26	76	0	0	1	0	**103**
WTWA	14	52	0	0	1	30	**97**
Grand Total	**49**	**154**	**0**	**0**	**2**	**30**	**235**

Table 27: Gender of active volunteers during Quarter 1 across sites.

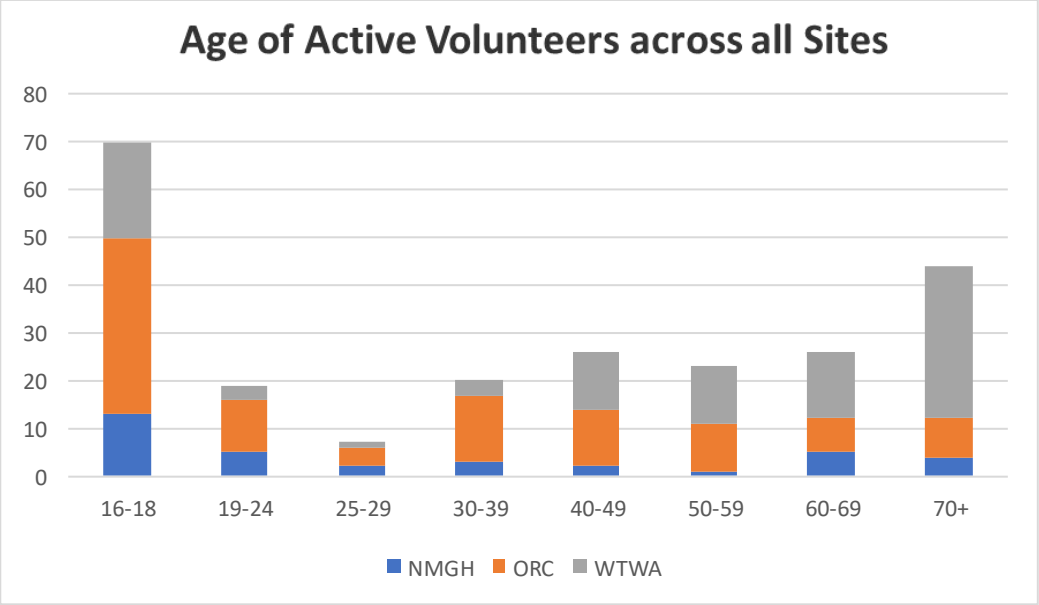
	ORC	NMGH	WTWA	Grand Total
White British	38	10	29	**77**
Any other white background	2	1	3	**6**
Mixed White+ Black Caribbean	0	0	0	**0**
Mixed White + Black African	0	1	0	**1**
Mixed White+ Asian	2	0	2	**4**
Any other mixed	1	1	0	**2**
Indian	0	0	0	**0**
Chinese	2	0	0	**2**
Black	0	0	0	**0**
Black African	12	6	2	**20**
Black Caribbean	0	0	0	**0**
Asian Pakistani	13	9	7	**29**
Asian Indian	8	1	4	**13**
Asian Bangladeshi	2	0	0	**2**
Asian	0	0	0	**0**
Arab	3	0	4	**7**
Unknown	7	0	43	**50**
Prefer not to say	2	6	0	**8**
Other ethnic group other	11	0	3	**14**
Total	**103**	**35**	**97**	**235**

Table 28: Ethnicity of active volunteers across sites during Quarter 1.

Reason for complaint	Action Taken
Concerns received regarding lack of communication regarding referral waiting times, signposting to other services, and lack of knowledge of treatment plan and care journey.	Communication strategies developed to manage waiting time expectations with patients and families. Patients now informed of change of case manager via a letter. Improved information/letters being explored, to ensure patients are fully informed prior to attending appointments in relation to being their treatment plans being goal focused. Service Manager educated staff of provision of information of internal and external services that patients and their families can access.
Concerns regarding patient managing to self-harm in the Emergency Department, following a long wait to be seen and use of restraint.	ED Tracker Role now in place 24 hours a day, to support with escalation to specialities and to track patients' progress within the department. Patients experiencing a long-wait to see the Mental Health Liaison Team are now re-assessed based upon on their presentation, and tracked through HIVE, with a rollcall to ensure they are checked-upon. Re-design of MRI Emergency Department will include a dedicated Mental Health Area. Staff made aware not to leave sharps, such as scissions, unattended when seeing patients and restraint training and policy under review, in accordance with the Restraint Reduction Network, Trust's Security and Safeguarding Teams and Greater Manchester Police. Education programme for Mental Health awareness for staff on the Trust's learning hub, with attendance monitored. MRI Mental Health Care Group established, with a focus on the current risk, workforce, education and training.
Concern regarding delay in correct treatment of a fracture	Review of training needs for new overseas doctors to NHS and a revised induction programme being implemented, ahead of September 2023 changeover for doctors-in-training. Robust HIVE training in place for all new staff.
Concerns raised in respect of poor communication, decision-making and lack of appropriate support both pre and post-birth of twins	All parent information leaflets being reviewed to ensure they are up-to-date and Medical Team made aware of the information available to share with families. Leaflets available on the website via a QR code, and in different languages. Member of staff to be identified to be the designated point of contact for the parent(s)

	and parents to be allowed to transfer with their baby/babies, when moving units, to empower the parents and provide assurance that their baby/babies is being cared for. Clear and robust process developed to ensure families are supported in the contribution to the Perinatal Mortality Review Tool (PMRT) process. SMH working with Chaplaincy Team to enhance bereavement support.

Table 29: Examples of lessons learned and actions from complaints Q1, 2023/24



Graph 32: Age of active volunteers by site.

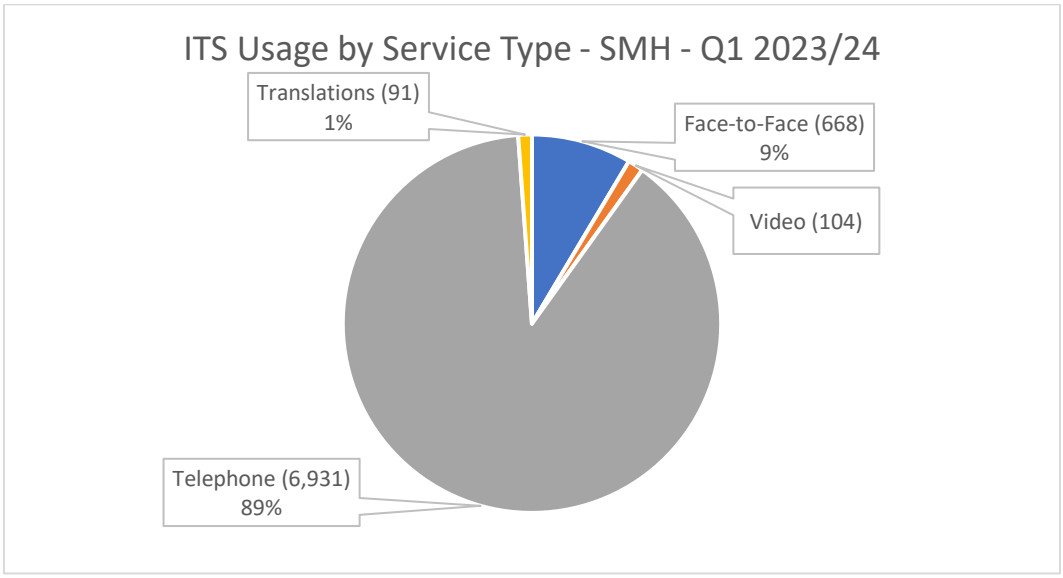


Chart 7: Distribution of Service Type Usage, St. Mary's Hospital, Q1 2023/24

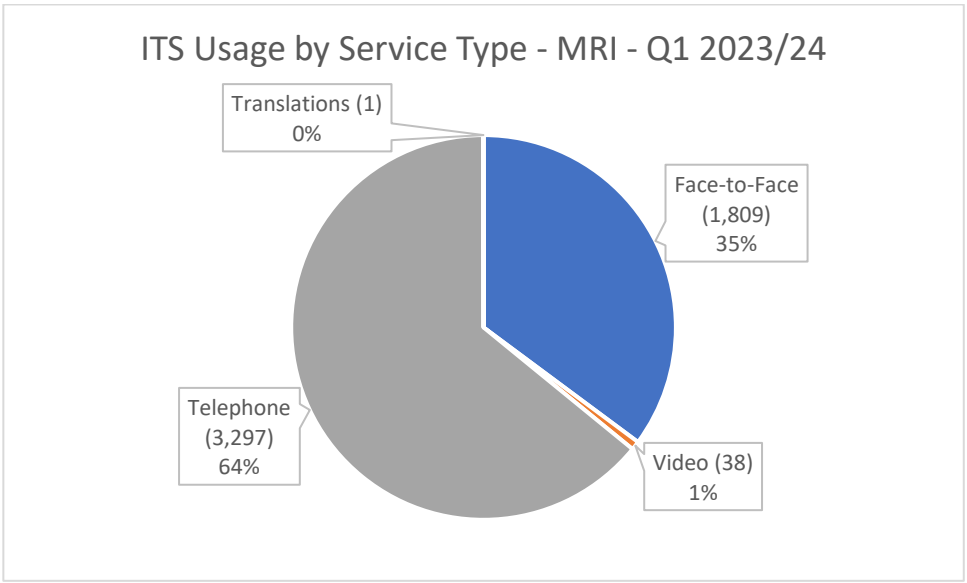


Chart 8: Distribution of Service Type Usage, Manchester Royal Infirmary, Q1 2023/24

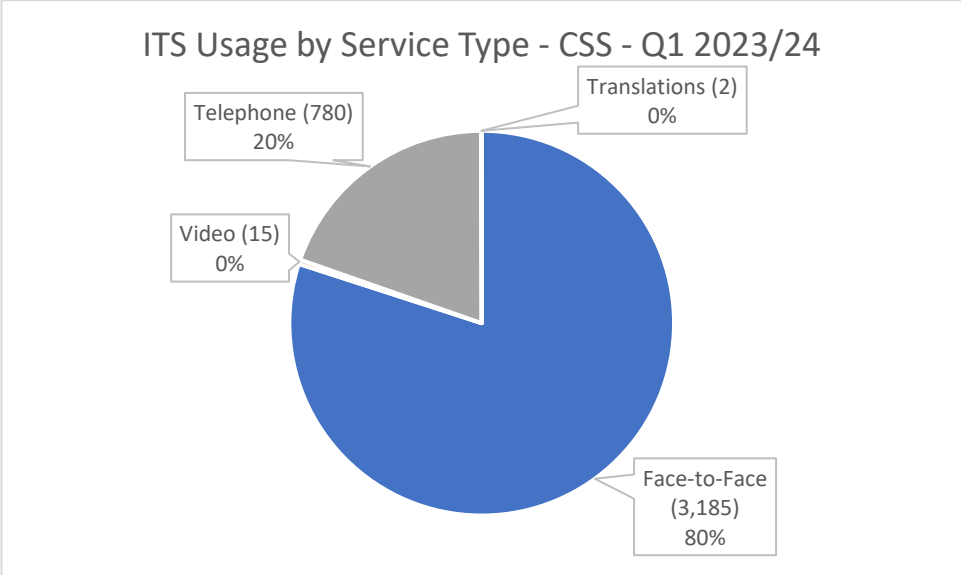


Chart 9: Distribution of Service Type Usage, Clinical & Scientific Services, Q1 2023/24.

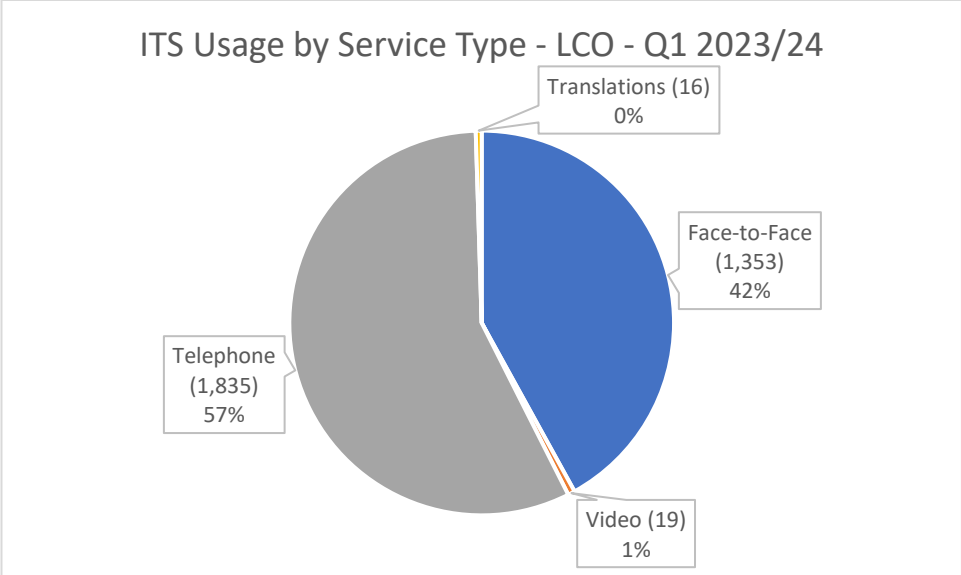


Chart 10: Distribution of Service Type Usage, Local Care Organisation, Q1 2023/24.

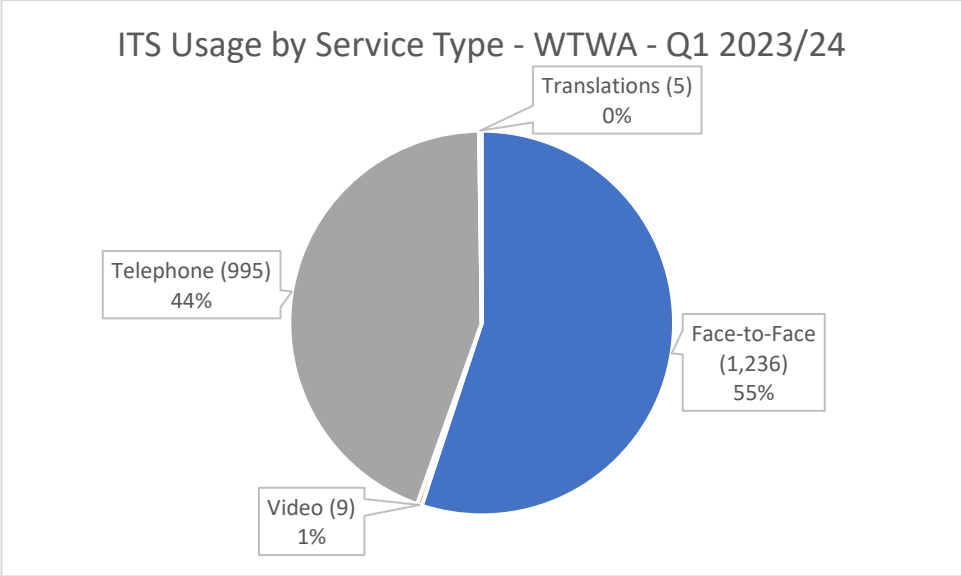


Chart 11: Distribution of Service Type Usage, Wythenshawe/Trafford/Withington/Altrincham, Q1 2023/24

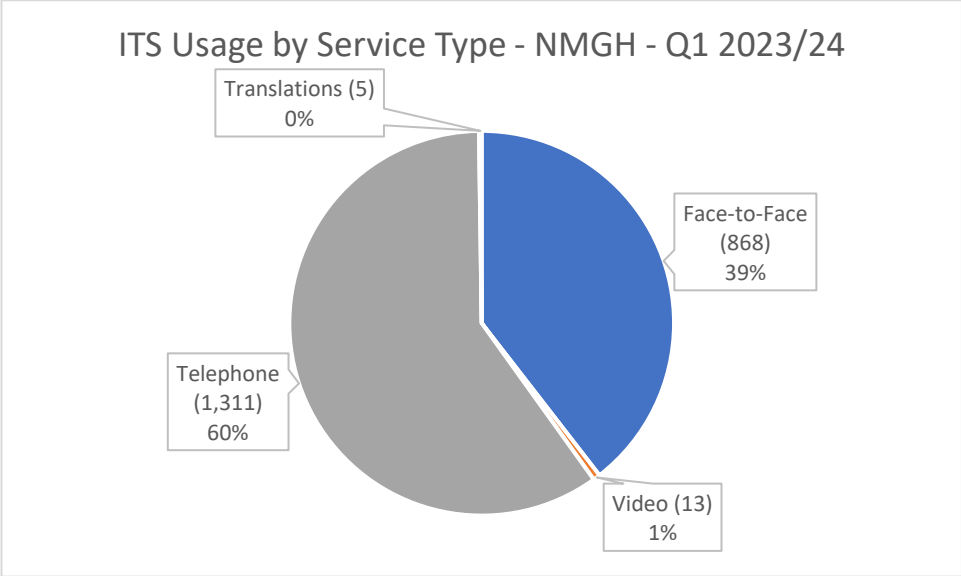


Chart 12: Distribution of Service Type Usage, North Manchester General Hospital, Q1 2023/24.

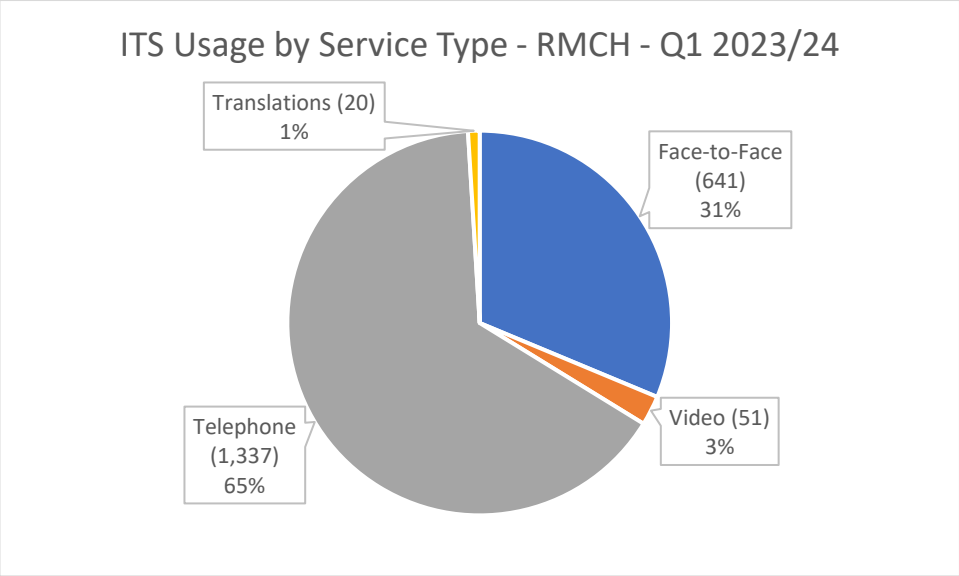


Chart 13: Distribution of Service Type Usage, Royal Manchester Children's Hospital, Q1 2023/24.

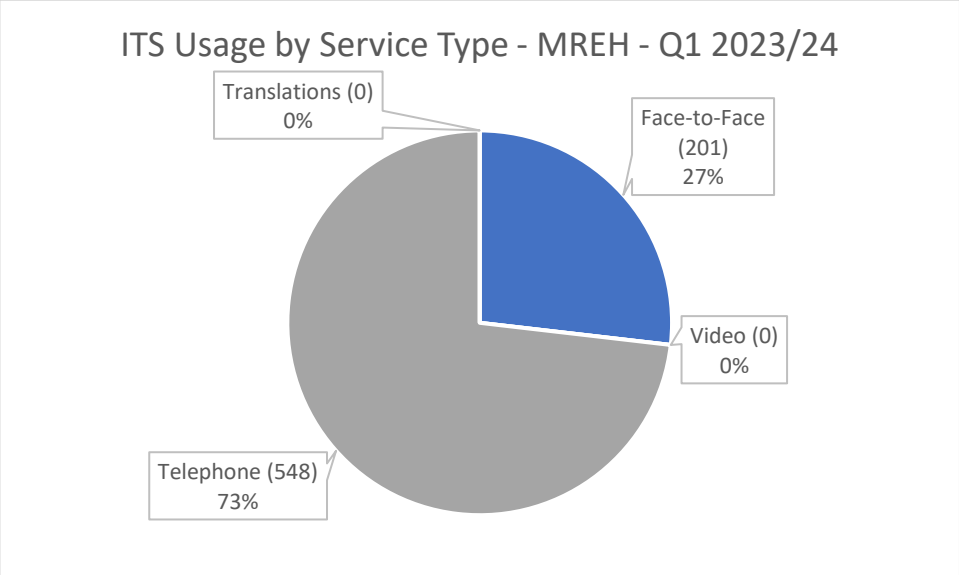


Chart 14: Distribution of Service Type Usage, Manchester Royal Eye Hospital, Q1 2023/24.

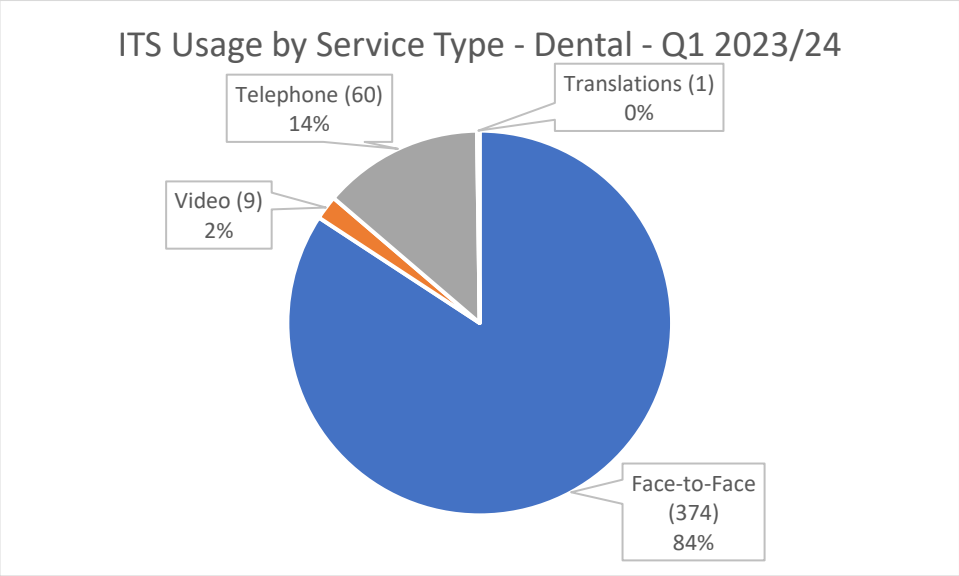


Chart 15: Distribution of Service Type Usage, University Dental Hospital of Manchester, Q1 2023/24

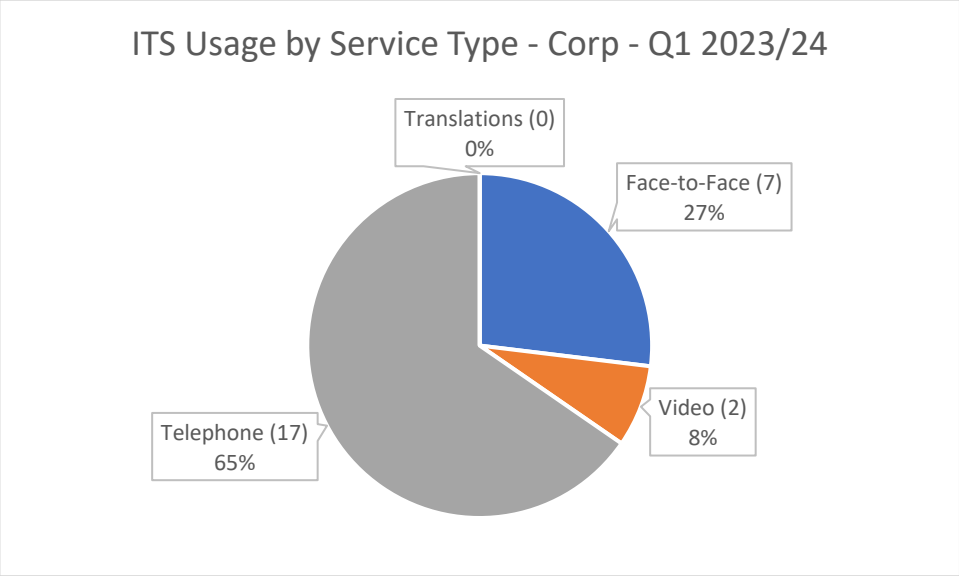


Chart 16: Distribution of Service Type Usage, Corporate Services, Q1 2023/24.

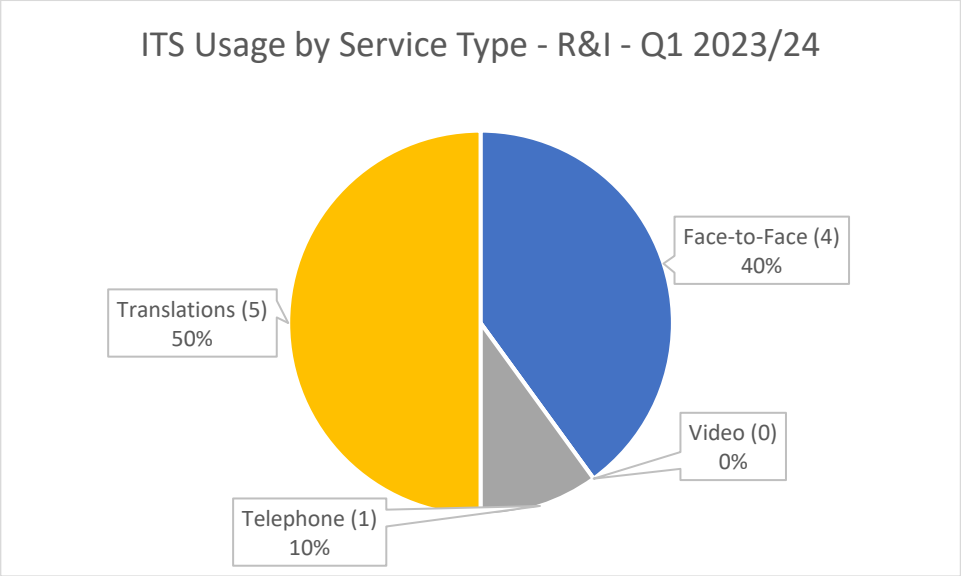

ITS Usage by Service Type - R&I - Q1 2023/24
Face-to-Face (4)
40%
Translations (5)
50%
Video (0)
0%
Telephone (1)
10%

Chart 17

Agenda Item 11.5

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Joint Group Medical Director
Paper prepared by:	Dr Tanya Claridge, Group Patient Safety Specialist
Date of paper:	September 2023
Subject:	Patient Safety Incident Response Policy
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:	To focus relentlessly on improving access, safety, clinical quality and outcomes To improve continuously the experience of patients, carers and their families
Recommendations:	The Board of Directors is asked to: • Ratify the Trust's Patient Safety Incident Response Policy as recommended by the Quality Performance and Scrutiny Committee • Note that there is a planned approach to ensure that the policy is accessible to the population that the Trust serves, through publication on the external website, with a summary document, translations and easy read versions • Note the progress that the Trust is making towards the implementation of the national Patient Safety Incident Response Framework
Contact:	Name: Dr Tanya Claridge, Group Patient Safety Specialist Tel: 0161 276 8764

Manchester University
NHS Foundation Trust

Patient safety incident response policy 2023-24

Manchester University NHS Foundation Trust

Title:	**Patient Safety Incident Response Policy- 2023-24**
Version:	1
Supersedes:	Version 1. Patient Safety Insight, Learning and Response Policy
Changes from the last version	The Trust Policy has been amended to align to the requirements of the Patient Safety Incident Response Framework (2023) and has been restructured based on a national template
Application:	This policy applies to all members of Manchester University NHS Foundation Trust staff, volunteers and contractors

Originated /Modified By:	Dr Tanya Claridge
Designation:	Group Patient Safety Specialist
Ratified by:	Board of Directors
Date of Ratification:	

Issue / Circulation Date:	
Circulated by:	
Dissemination and Implementation:	
Date placed on the Intranet:	

Planned Review Date:	01/08/2024
Responsibility of:	Group Joint Medical Director

Minor Amendment (If applicable) Notified To:	
Date notified:	

EqIA Registration Number:	71/10

Contents

1. Introduction

1.1 The NHS's vision is to 'continuously improve patient safety', building on two foundations: patient safety culture and a patient safety management system. The National Patient Safety Strategy[1] describes three strategic aims to support the development of both foundations.

- improving understanding of safety by drawing intelligence from multiple sources of patient safety information, with a clear focus on listening to information directly from patients, and making patient safety data count (Insight)
- equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (Involvement)
- designing and supporting programmes that deliver effective and sustainable change in the most important areas (Improvement)

1.2 This policy, which describes the Trust's response to patient safety incidents, is one of a suite of interdependent policies, strategies and plans designed to support the implementation of our Trust-wide Patient Safety Management System. These Policies, Strategies and Plans are:

- Patient Safety Insight, Oversight, Learning and Improvement Policy 2023
- Patient Safety Partner Policy 2022
- Engaging and involving patients and families following a patient safety incident guideline, 2023
- Duty of Candour Policy 2023
- Just Culture Guidance 2023
- Risk Management Framework and Strategy 2022-25
- Assurance Framework and Map 2023
- Quality and Safety Strategy 2022-25
- Trust- wide Patient Safety Plan (Annual)
- Site/Managed Clinical Services/Local Care Organisations Patient Safety Incident Response Plans (Annual)
- Learning from Deaths Policy 2023

1.3 This policy directly supports the requirements of the Patient Safety Incident Response Framework (PSIRF)[2] and sets out Manchester University NHS Foundation Trust's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

1.4 The PSIRF describes a co-ordinated and intelligence-driven response to understanding patient safety and responding to patient safety incidents. It is designed to help us to make sure that our response to patient safety incidents

[1] https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/
[2] https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-1.-PSIRF-v1-FINAL.pdf

is proportionate and considered in a system-focused way and is linked to our patient safety improvement priorities.

1.5 Our Patient Safety Insight, Learning and Improvement Policy, our Trust-wide Patient Safety Plan and our 'Patient Safety Partner Policy' provide the details of the approach that we take to ensuring that we engage effectively with patients to ensure that our patient safety intelligence and approach to patient safety improvement is relevant and meaningful.

1.6 Our approach to making data count, and the effective use of our data to understand our improvement priorities, and the effectiveness of our safety improvement actions is described in our Patient Safety Insight, Learning and Improvement Policy, our Trust-wide Patient Safety Plan

2. Purpose

2.1 This Policy outlines the process for identifying, reporting, managing, investigating, and learning from patient safety incidents.

2.2 Aligned to the four key aims of the PSIRF, it is designed to support a systematic, compassionate, and proficient response to patient safety incidents: with a clear focus on the principles of involvement, openness, fair accountability, learning and continuous improvement. This policy describes.

- the approach and measures in place to ensure that the Trust is prepared for patient safety incidents (so that staff know what to do and how to behave when an incident does occur),
- how the Trust will respond to patient safety incidents using a range of system-based approaches to support learning
- the oversight of patient safety incidents
- the governance arrangements (including key organisational roles and responsibilities) to ensure an effective response.

2.3 The implementation of the policy is directly supported by the Trust's,

- Patient Safety Management System
- Patient Safety Specialist Network
- Human Factors Academy

3. Scope

3.1 This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across Manchester University NHS Foundation Trust.

3.2 Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial

inquests and criminal investigations, exist for the purpose of determining liability or preventability of an incident, or for instance the cause of death of a patient. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

3.3 Information from a patient safety incident response process can be shared with those leading other types of reviews or investigations, but other processes should not influence the remit of a patient safety incident response.

4. Our patient safety culture

4.1 Our safety culture is our core values and behaviours that stem from our collective commitment to emphasise and prioritise patient safety.

4.2 We recognise the following traits that specifically define our safety culture, helping us describe patterns of thinking, feeling and behaving that emphasise safety (see table 1)

4.3 The Trust recognizes the diversity of the different Sites/MCS/LCOs and acknowledges that some have already spent significant time and resources in the development of a positive safety culture. It is the Trust's expectation that all individuals, teams, and the Sites/MCS/LCO should take the necessary steps to promote a positive safety culture by fostering these traits, within their overall organisational culture workstreams as they apply to their environments.

Table 1: Safety Culture traits

Trait	Description
Leadership: Commitment to overall continuous improvement	Leaders demonstrate a commitment to safety in their decisions and behaviours
Leadership: Priority given to safety	Issues potentially impacting safety are promptly identified, fully evaluated, and promptly addressed and corrected commensurate with their significance.
System and individual responsibility	The process of planning and controlling work activities is implemented so that safety is maintained. All individuals take personal responsibility for safety.
Recording incidents and best practice	Individuals avoid complacency and continually challenge existing conditions and activities in order to identify discrepancies that might result in error or inappropriate action.
Evaluating incidents and best practice	System thinking underpins any patient safety incident evaluation, with using a range of tools to support professional curiosity and patient engagement
Learning and effecting change	Opportunities to learn about ways to ensure safety are sought out and implemented.
Communication about safety issues	Communications maintain a focus on safety.
People and safety issues	A safety conscious work environment is maintained where staff feel free to raise safety concerns without fear of retaliation, intimidation, harassment or discrimination.
Staff education and training	Staff are enabled to have 'time to think', and can access education and training about safety that is tailored to their role
Teamwork	Team characteristics (communication, teamwork and personal behaviour) support safe, effective and efficient interprofessional care
Patient and Public Involvement	Patients are involved in the safety of their care. Patients are privileged witnesses in patient safety incidents. Patients, communities and patient representatives are meaningfully involved in patient safety and its governance

5. Patient safety partners

5.1 Part B of the National Patient and Public Involvement in Patient Safety Framework (July 2021)[3] 'Patient safety partner (PSP) involvement in

[3] https://www.england.nhs.uk/wp-content/uploads/2021/06/B0435-framework-for-involving-patients-in-patient-safety.pdf

organisational safety' relates to the role that patients, carers and other lay people can play in supporting and contributing to a healthcare organisation's governance and management processes for patient safety.

5.2 To effectively deliver the requirements of the Patient and Public Involvement in Patient Safety Framework the Trust will demonstrate:

- **A commitment to involving PSPs in patient safety:** The Trust should express a commitment to the involvement of PSPs and promote their recognition throughout the organisation.
- **The Creation of a framework to develop and support PSP involvement:** There is no contract of employment between PSPs and the organisation. Instead, the relationship is based on mutually agreed expectations about the role.
- **An inclusive approach to attracting PSPs:** The Trust must work to involve stakeholders in the attraction, recruitment, and retention of Patient Safety Partners
- **Development of PSP roles and task profiles:** The Trust will develop appropriate roles for PSPs in line with its aims and objectives, which are consistent with national guidance, and which are valued by the PSPs in those roles.
- **Safeguarding PSPs, staff and patients:** The Trust will ensure that, as far as possible, PSPs are protected from any emotional and financial impact arising from their role.
- **Recruiting PSPs:** The Trust will use fair, efficient and consistent recruitment procedures for all potential PSPs.
- **Induction and training for PSPs:** The Trust will have clear procedures that are followed when inducting new PSPs to their role, the organisation and relevant policies.
- **Supporting PSPs:** The Trust will take account of the varying support needs of PSPs and provide for them.
- **Valuing and recognising PSP contributions:** The Trust will demonstrate an overall awareness that PSPs, and their contribution need to be given recognition.

5.3 The Trust will have an approved Patient Safety Partner Policy, Role Description (aligned to national standards) and 'Partnership model', which will be implemented and monitored through the work of the Patient and Public Involvement in Patient Safety Sub-Group of the Group Patient Safety Committee

6. Addressing inequality

6.1 The Trust will address inequality in patient safety through the implementation of the principles of the National Patient Safety Strategy, through insight, involvement and improvement.

6.2 Insight into the actual and potential impact of inequality on patient safety will be achieved through the flexible and innovative use of patient safety intelligence, including our own data, external data and information we routinely analyse (See Patient Safety Insight, Learning and Assurance Policy)

6.3 This insight will be considered at the weekly Patient Safety Oversight Panel (Trust-wide) and proactively used to inform our patient safety incident response.

6.4 The high impact learning from this insight will be used to directly influence the approach we take to developing, implementing, and reviewing our PSIRPs.

6.5 We will use the support of our developing Patient Safety Partner Partnership to support our understanding of inequality, but also how we better engage with patients about their safety.

6.6 The Trust has developed an inequality trigger tool that can be used at any stage of a patient safety learning response, with its initial use at the High Impact Learning Assessment

6.7 All patient safety incident learning responses will be supported by the application of Just Culture and will all use an explicit system-based methodology (see point 7.13)

6.8 The Trust recognises that we do not yet fully understand the impact of inequality on patient safety, and as such the Human Factors Academy has a specific strategic delivery unit, designed to enable the oversight of research publications, the application of human factor and system thinking to safety improvement plans and to ensure that learning in relation to inequality is translated into education and training.

6.9 All safety improvement plans will be subject to the IFACES[4] evaluation tool, which ensures the consideration of the impact of the action on inequality.

7. Engaging and involving patients, families and staff following a patient safety incident

7.1 The PSIRF identifies that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident

[4] https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf

response system[5] that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff)[6]. This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

7.2 The Trust recognises that demonstrating openness and transparency are fundamental when engaging with those affected by an incident. Apologising and being open about what happened can help patients and their families begin to overcome the emotional and physical effects of incidents. All health care professionals have a professional responsibility to be honest with patients when things go wrong. All staff should adhere to the 'Being open' principles, and these principles should be reflected in any patient safety training. The Principles of Being Open are described in the Trust's Duty of Candour Policy.

7.3 Regulation 20 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014 introduced a statutory Duty of Candour for the NHS. This was a direct response to recommendations outlined in the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust. The intention of this regulation is to ensure that providers are open and transparent with people in relation to care and treatment, and specifically when things go wrong with care and treatment, and that they provide people with reasonable support, truthful information, and an apology.

7.4 Individual health professional bodies also incorporated the Duty of Candour into their own standards. As such, those professionals will also be accountable to their own professional body.

7.5 The Trust's 'Duty of Candour Policy' should be followed for all 'notifiable incidents. The Trust interprets 'notifiable incidents' as those graded with a level 3 or above harm, the incident causing moderate or severe harm or death.

7.6 It is expected that patients/relatives/carers have the opportunity to be fully involved in any patient safety incident learning review, for instance in agreeing the terms of reference, providing an insight into their experience and its impact and supporting the development of action plans. It is expected that the voice of those involved in the incident is listened to during the investigation/review and heard throughout the investigation report and that this will be facilitated through an appointed Single Point of Contact.

7.7 The Trust recognises that the Single Point of Contact is a vital role in the effective engagement of patients, their families, and carers, and as such has developed specific guidance, role description and Trust- wide support

[5] https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf
[6] https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-2.-Engaging-and-involving...-v1-FINAL.pdf

network for the staff that undertake this role (Engaging and involving patients and families following a patient safety incident guideline, 2023)

7.8 The Trust will routinely seek feedback from patients, families, and carers to determine how well it is upholding the principles of openness and transparency. This feedback will be sought both through conversations with staff supporting those affected or be retrospectively sought from patients/relatives themselves after an organisation concludes its response to an incident.

7.9 Patients, relatives and or carers affected by a patient safety incident should be able to say,

- we were treated with respect.
- we were supported appropriately.
- we were given meaningful, truthful, and clear answers and information in response to all our queries and concerns in a timescale that was agreed with us
- where our expectations were not met or we were not satisfied, we were given a meaningful, truthful, and clear explanation for why this was not possible.
- our questions or challenges to the organisation never inhibited its efforts to engage with us.

7.10 The Trust's "Project 2v" has ensured that a range of resources are available to engage and support staff following an incident and continues to work to develop those resources.

7.11 As described in PSP SOP 04 'Immediate practical actions after an incident' an opportunity for staff to be involved in an effective debrief is essential immediately following an incident. The Trust has identified a standard approach to debrief following an incident (PSP SOP 07 Process for Hot Debrief@MFT). In addition to this debrief, managers must consider what support staff on duty may require (e.g., additional staffing, counselling or support from Employee Health and Well Being (EHWB) or Human Resources (HR)). All the associated resources are available on the intranet page 'It happened to me'.

7.12 As is made clear in The NHS Patient Safety Strategy, a systems approach to improving the safety of healthcare should be adopted. Most incidents are caused by weaknesses in systems which lead to conditions that make it difficult for individuals to do the right thing. However, sometimes it may be necessary to understand and act upon the actions of individuals involved in an incident.

7.13 The Trust has adopted a 'Just Culture' to ensure that we guard against bias: staff involved in similar actions or decisions leading to a patient safety incident should be treated in the same way, irrespective of whether the

patient was or was not harmed (outcome bias) and their grade or professional group risk of discrimination, by ensuring that:

- those involved in making decisions about referring staff for disciplinary professional regulation or individual training and reflection are trained in equality and diversity and the risks of unconscious bias.
- the protected characteristics of staff referred to other bodies, particularly professional regulators, are recorded so that this data can be analysed, and any patterns reviewed and addressed.
- procedures are consistently reviewed, and steps taken to understand and resolve inequality and potential unfair treatment.

7.14 The Trust's 'Just Culture Guide' should be used when assessing concerns about individuals to ensure they are treated consistently, constructively, and fairly. Such assessments must be:

- used only when there is reason to believe the deliberately malicious, negligent, or incompetent actions or decisions of an individual contributed to an incident, and not routinely whenever an incident is reported, or an investigation is conducted.
- managed completely separately from any activity to examine an incident for the purposes of learning and improvement.
- led by a colleague of appropriate seniority and with relevant human resources, individual management review or fitness to practice investigation training.

7.15 The Trust recognises that inappropriate blame is extremely damaging to individuals and an organisation's safety and culture. Staff should never be automatically suspended, or their duties restricted or changed unless that is required to support their wellbeing or to protect patients, irrespective of whether they have been involved in other patient safety incidents. These actions should only be taken after a skilled assessment demonstrates they are necessary to protect staff or patients. Involvement in more than one patient safety incident does not mean an individual is at fault. It is also unsafe to keep the focus on individuals in a non-punitive way, such as by recommending individual training and self-reflection without evidence showing that an individual's behaviour or inadequate training was the reason behind any problems.

7.16 Those responsible for undertaking Patient Safety Incident Learning reviews must ensure that recommendations drive a systems approach to improvement by

- appropriately training staff in investigation or review of patient safety incidents for learning and giving them enough time to conduct a meaningful PSII or review of system safety.
- ensuring the Board and leaders throughout the organisation constructively challenge the strength and feasibility of recommendations to improve underlying system issues.

7.17 A memorandum of understanding' (MoU) sets out how health and care organisations, police and regulatory, investigatory, and prosecuting bodies in England will work together in cases where criminal activity in a health or care setting is suspected to have led to a person's death or life-changing harm.

7.18 The Trust is committed to ensuring that its' staff involved with and affected by a patient safety incident should be able to say:

- we were treated with respect.
- we were supported appropriately.
- we were given meaningful, truthful, and clear answers and information in response to all our queries and concerns in a timescale that was agreed with us.
- where our expectations were not met or we were not satisfied, we were given a meaningful, truthful, and clear explanation for why this was not possible.
- our questions or challenges to the organisation never inhibited its efforts to engage with us.

8. Patient Safety Incident Response Planning

8.1 PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations should explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

8.2 As described in the Patient Safety Insight, Learning and Assurance Policy, the Trust will use a variety of methods to:

- **look for and learn from positive outcomes** through continuously surveying all patient safety intelligence looking for examples of learning events where outcomes have been positive for staff or patients, for instance through the effective delivery of patient safety projects, ward accreditation, patient stories, compliments, and also considering examples of good practice found during incident investigations.

- **Understand essential system functions** through using a range of quantitative and qualitative methods to understand essential system functions, including appreciative enquiry, ethnography and safety conversations. The Human Factors Academy has a portfolio of resources for staff to use and will offer bespoke training as required. The Trust will also use Functional Resonance Analysis Method (FRAM; Hollnagel, 2012) as its standard more objective methodology to understand the variability within its systems.

- **Focusing on frequent events** through alignment to the implementation of the

Patient Safety Incident Response Framework the Trust will focus its attention on events which happen regularly and focus on learning from these events based on their frequency rather than their severity. All hospitals/MCS/LCOs will, as part of their routine surveillance element of the safety oversight system (as described in the Patient Safety Learning Insight and Response Policy) have a range of frequently reported incident types/categories. They will use statistical process control to review progress with prioritized learning and improvement, through the implementation of their Patient Safety Incident Response Plan. The Trust recognises that the potential for learning is not proportional to the severity of the incident or accident. This forms the basis of the Patient Safety Incident Response Framework.

- **Remaining sensitive to the possibility of failure** through the continued expectation that staff report incidents, which are responded to with a learning focus and through the implementation of the Trust's Risk Management Strategy and Framework (RMFS) 2022-25 (which describes the importance of ongoing assessment, management and escalation of risk to health care system reliability. The RMFS makes it clear that all staff have a responsibility to identify, escalate and manage risk to patient safety. The response of the Trust to a patient safety incident is described in sections 12- 19 of this policy.

- **Learn** through the established patient safety knowledge management framework supporting integrated learning which is embedded within the patient safety management system and the development of a strategic approach to learning about patient safety through the development of the Trust-wide Quality and Safety Strategy and the Trust's Patient Safety Plan (Annual).

- **Improve** through a clearly defined strategic approach to patient safety improvement within its Quality and Safety Strategy and Patient Safety Plan. This will be supported through the work of the Human Factors Academy, Quality Improvement Teams and the Patient Safety Specialist Network. Using appropriate analytics patient safety data (both qualitative and quantitative) will be used to demonstrate the effectiveness of patient safety improvement intervention and support the creation of a virtuous cycle (continually building on success) of improvement and assurance.

- **Assure** through strong and consistent governance relating to patient safety, organised around the following principles:
    - Did we provide safe care yesterday?
    - Are we providing safe care today?
    - Are our systems and processes reliable?
    - Will we provide safe care in the future?
    - Are we continuously improving?

  In addition, the Trust will routinely seek focused assurance in relation to:
    - Notifiable patient safety incidents

- Learning events where the learning is high impact and transferable.
- Responding to Coroner's recommendations (including Prevention of Future Deaths Notifications)

All of these will be subject to a proportionate risk and assurance assessment process. The Trust will proactively identify gaps in assurance, for instance in relation to compliance with National Patient Safety Alerts, or the reliability of our systems and processes (such as compliance with national guidance) through the scrutiny of our patient safety data and ensure these are escalated and closed with appropriate and proportionate actions. The Trust will integrate the approach to assurance across all key elements of this Policy through the work of the Safety Management System and Quality oversight across the Trust.

9. Resources and training to support Patient Safety Incident Response

9.1 The Trust has aligned the resources and training provided to support an effective response to patient safety incidents to the nationally specified patient safety incident response standards[7]

9.2 During the PSIRF preparation phase it was identified that the Trust required to support the initial PSIRF implementation

- 1 Executive Director Sponsor
- 1 Group Patient safety Specialist
- 3 Patient Safety Specialists at each site/MCS/LCO
- 4 Patient Safety Specialists in specialist roles (medicines safety, medical devices, procurement and safeguarding)
- 20 Patient engagement advocate lead roles (at least 2 in each site/MCS/LCO)
- 70 Patient engagement advocates (number varies depending on site/MCS/LCO)
- 80 Learning response leads (number varies depending on site/MCS/LCO
- 1 Group level Patient Safety Partner (with a plan to recruit a further to support individual sites/MCS/LCO.

9.3 All sites/MCS/LCO will undertake an annual workforce gap analysis aligned to their Patient Safety Incident Response Plan and the outcome of that considered at the Group Patient Safety Committee in relation to resource and training provision, with a commitment to improve capacity to meet national requirements as required.

[7] https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf

9.4 The national training requirements for identified learning response leads, patient engagement advocate leads, Board members and Patient Safety Specialists will all be met, and appropriate records kept.

9.5 All staff will be encouraged to complete the national level 1 and level 2 Patient Safety Training through their line managers, a record of staff who have undertaken that training will be kept.

9.6 In addition, a range of scheduled, bespoke and responsive training and education opportunities will be provided for staff across the Trust by the Human Factors Academy, this includes the commitment to train 48 members of staff a year in Functional Resonance Analysis Methodology (FRAM) (See Patient Safety Insight, Learning and Assurance Policy)

9.7 Patient engagement advocates will be supported with a specific Trust education programme, peer support and a Community of Practice.

9.8 Learning Response leads will be supported with a specific Trust education programme, peer support and a Community of Practice.

9.9 Patient Safety Specialists have an established network for support, information sharing and innovative practice.

9.10 The Group Patient Safety team will support the overall co-ordination of Trust-wide patient safety resource and training, predominantly through the work of the Human Factors Academy.

10. Our Patient Safety Incident Response Plan (PSIRP)

10.1 The Trust has a Quality Safety Strategy (2022-25) with an associated Patient Safety Plan which is updated annually based on the insight and patient safety priorities (a Trust-wide Patient Safety Incident Response Plan) provided by the PSIRPs developed by each Site/MCS/LCO.

10.2 Our PSIRPs are developed using patient safety intelligence from multiple sources, for instance, patient safety incidents, claims, inquests, complaints, externally published prevention of future death notices, regulator information, data about the effectiveness of care and our risk register. They are developed with the support of our Patient Safety Partnership and with engagement with both local and regional stakeholders.

10.3 Our plans set out how we intend to respond to patient safety incidents over a period of 12 to 18 months. The plans are designed to enable our responsiveness to change, and the active surveillance of patient safety

intelligence through our oversight system (See section 8 and the Trust's Patient Safety Insight, Learning and Assurance Policy)

10.4 Our PSIRPs are approved through Site/MCS/LCO quality governance and the relevant management Board, through Group Quality Governance (including non-executive director chaired Committee) and the Board of Directors.

10.5 Our PSIRPs are published on our website.

11. Reviewing our Patient Safety Incident Response Policy and Plan (PSIRP)

11.1 This Patient Safety Incident Response Policy will be reviewed annually during the first 4 years of the implementation of the PSIRF to enable learning from the initial stages to be incorporated routinely, and any outcomes of Internal Audit of the effectiveness of the controls in place responded to.

11.2 The Trust's Patient Safety Profile (bi-monthly profile) will support the contemporaneous review of the progress the Trust is making in relation to the areas of Patient Safety Prioritisation, and also support the identification of potential emergent risk that may indicate that a full review of a specific or all PSIRP is required.

11.3 The PSIRPs will be formally reviewed every 18 months to ensure that our focus remains up to date, as with ongoing improvement work our priority areas are likely to change.

11.4 Updated plans will be published on our website, replacing the previous version.

11.5 A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

12. Responding to patient safety incidents: Immediate practical actions following identification

12.1 For the purpose of this policy a “patient safety incident” includes any unintended or unexpected event which caused, or may have caused e.g., a near miss, harm or injury to patients. Patient safety incidents are learning events which, if identified, responded to and managed effectively can lead to the opportunities for change and improvement in the safety and quality of both clinical and non-clinical services.

12.2 Patient safety incidents, or prevented patient safety incidents, can be identified through various routes including:

- During the provision of healthcare (patient safety incidents or adverse clinical outcomes)
- Allegations made against, or concerns expressed about, the organisation by a patient or third party.
- Through the initiation of other investigations for example: Serious Case Reviews (SCRs), Safeguarding Adult Reviews (SARs)
- During, or on completion of, an internal Mortality Review or Structured Judgement Review (SJR) e.g., if the reviewers identify that a harm has occurred which had not been previously reported.
- Through the PALS, Complaints, Claims and Inquest processes.
- Through the Medical Examiner
- During external reviews, accreditation visits or inspections by third parties e.g., CQC, Ofsted
- Through freedom to speak up or whistle blowing
- During Health & Safety (H&S) inspections & walkabouts
- During routine operational management validation processes (for instance of patients waiting for access to services)

12.3 The Trust has a Standard Operating Procedure which clearly defines the immediate practical actions that must be taken by staff following the identification of an incident (PSP SOP 04 Immediate actions to be taken following the identification of a patient safety incident) to ensure that as soon as a patient safety incident is identified the following actions should follow:

- identification of all patients who have been harmed and arrangement of their ongoing clinical care.
- immediate remedial action to reduce the imminent risk of any further harm to the patient or others.
- identification of others who may have been affected by the incident, including families, other patients and staff.
- acknowledgment of the incident and apology to those affected – the professional duty of candour provides information to support this. Obligations relevant to the Duty of Candour must be upheld where required.
- identification of a suitable named point of contact to support those affected.
- depending on the nature of the incident, several organisations may need to contact those affected, with the need to do so clearly explained to them. The partner agencies should agree a coordinated approach and which of them should take the lead in discussions with those affected, where appropriate

- if the incident affected a large population or has the potential to undermine public confidence, a clear communication and media management plan will be needed, enacted by teams with relevant skills and experience. A spokesperson may need to be assigned (usually the chief executive supported by communication and media management teams)
- identification and ongoing review of the equitable support needs of those affected – responsibility for this must be clearly assigned.
- the support for staff involved to document personal memory captures of the event supporting their involvement in any learning response should be in place.

13. Responding to patient safety incidents: Reporting arrangements

13.1 All staff (including temporary staff, those working as part of shared services agreements and agency/third-party contractors) are required to record and share information about:

- hazards, risks and/or incidents (including those that do not result in harm) in their work environments.
- good practice and actions taken to avoid incidents (near misses) so that this practice can be explored and used to prevent incidents or improve the quality of patient care elsewhere.

13.2 Notifying others and recording and sharing relevant information are crucial to an effective and coordinated response to patient safety incidents. The following must happen as soon as possible:

- Staff who identified the incident should also inform their line managers so they can ensure clinical staff involved in or responsible for the patient's care are given relevant information, inform other care providers who need to know about the incident, particularly of any implications for care and how they can support patients and families emotionally and practically as require and liaise with other healthcare providers and commissioners where a cross-system response may be required.
- Management teams should ensure internal and external notification and recording procedures are followed. Communication channels may also need to be established between providers and relevant regulatory and/or oversight bodies to ensure a coordinated response to the incident.
- A clear record of what happened should be documented in the patient's clinical record and Ulysses (This should be a factual account based on what is known at the time. Records should then be updated as required.)
- Information and physical evidence (such as equipment, pictures of the area, etc.) likely to be useful in any subsequent learning review or PSII should be obtained and stored securely.

13.3 The principles and process of recording a patient safety incident on Ulysses are described in the Trust's Standard Operating Procedure 'Reporting a patient safety incident' (PSP SOP 05) and is supported by a user guide. Patient safety incidents must be addressed through the Trust's incident response pathway, regardless of how they were first raised or reported, this means, for instance that staff managing complaints and patient safety incidents should work closely together to ensure that any patient safety incident identified in a complaint is managed as per the incident response pathway (See 'Complaints policy')

13.4 Patients, families, carers, and the public should be actively encouraged and informed how to record and share information about patient safety incidents.

- All patient safety incidents recorded on Ulysses require validation by the hospitals/MCS/LCO. The process for validation of an incident is described in PSP SOP 06 Incident Management on Ulysses and escalation to Strategic Executive Information System (StEIS). Validation is the process by which the Trust:
    - Ensures and assures good data quality and integrity in the incident report.
    - Confirms whether the incident is or is likely to be notifiable (where Duty of Candour will apply)
    - Confirms whether the incident is externally reportable.
    - Identifies whether the category incident falls into one of their/or trust wide priority areas as defined within their PSIRP.

13.5 Freedom to Speak Up offers an alternative channel to report concerns about patient safety incidents when other routes feel too challenging or have failed. Ulysses does not accommodate anonymous reporting, however if an incident is extremely sensitive and/or the reporter wishes to raise the issues in confidence or anonymously then Freedom to Speak Up can offer confidential support and advice. The Freedom to Speak Up Guardian can be contacted directly via email F2SUguardian@mft.nhs.uk Staff can also contact any of the Freedom to Speak Up Champions across the Trust for support and advice to raise a concern. Further information on this service is available on the internal intranet site.

13.6 Some patient safety incidents, either due to the harm they have caused or due to the type of incident that they are, will require reporting externally to the Trust (as defined in the Patient Safety Incident Response Framework), for instance:

- All patient safety related incidents are uploaded to the incident system (Learning from Patient safety Events LfPSE)
- Specific incident categories are reportable to NHS England and the CQC by uploading onto the Strategic Executive Information System (StEIS)
- The death of a patient detained under the Mental Health Act, must be reported directly to CQC.

- Certain Health & Safety (H&S) incidents must be reported to the Health and Safety Executive (HSE) under the Reporting of Injuries, Diseases & Dangerous Occurrence Regulations (RIDDOR) 2013.
- Maternity incidents (See Appendix 3 for more information)

13.7 There are many other external reporting requirements and where external reporting is required this will be the responsibility of the relevant specialist team/service. A list of incidents with external reporting requirements is contained within Appendix 1.

13.8 The Trust must respect confidentiality and protect data but not allow these concerns to unnecessarily undermine openness and transparency, particularly when working with other agencies. The Trust's 'Information Governance Policy' and Caldicott Guardian and/or data protection officer can advise on concerns about accessing and/or sharing information.

14. Responding to patient safety incidents: Decision making

14.1 All patient safety incidents which fall into the categories described in Appendix 2 must be subject to an immediate high impact learning assessment (HILA) (See PSP SOP 08 Immediate High impact learning assessment) and the defined actions undertaken and confirmed within the HILA tool. The response to all these incidents will be specifically monitored by site/MCS/LCO governance processes and escalated for oversight to the Group Patient Safety Panel. This process should be undertaken within 5 working days of the incident and should involve the relevant members of the multi-disciplinary team. The team should include subject matter experts (for instance medicines management and safeguarding) where appropriate.

14.2 A HILA can be conducted for any other patient safety incident, or patient safety learning event identified through the processes for 'work went well' and outstanding practice described in the Patient Safety Insight, Learning and Assurance Policy.

14.3 The focus of the HILA is to

- confirm the basic facts of the incident/event.
- confirm immediate actions to respond to the incident have been completed and are effective and being monitored.
- confirm arrangements for supporting and involving patients/relatives and carers (including Duty of Candour disclosure) are in place, are effective and are being monitored.
- confirm arrangements for supporting and involving staff are in place, are effective and are being monitored.
- ensure full contextualization of the incident based on the categories described in Appendix 3, (ensuring any external reporting has been completed as

required) and any other intelligence about the patient safety profile of the site/MCS/LCO.2
- enable the early identification of high impact learning.
- recommend the most appropriate method and focus of investigation/review of the incident/event to optimise learning in relation to system influences on the incident.

14.4 Appendix 3 provides a summary of the specific approach to managing maternity and neonatal patient safety incidents.

15. Responding to patient safety incidents: Optimising learning

15.1 A patient safety incident investigation (PSII) is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning. Investigations explore decisions or actions as they relate to the situation. The method is based on the premise that actions or decisions are consequences, not causes, and is guided by the principle that people are well intentioned and strive to do the best they can. The goal is to understand why an action and/or decision was deemed appropriate by those involved at the time.

15.2 There are several other types of investigation which may be conducted for or around individual patient safety events. Examples include complaints, claims, human resource, professional regulation, coronial or criminal investigations. In addition, there are a number of specialist reviews for instance Structured Judgement Reviews, Learning Disability Mortality Review (LeDeR) reviews and perinatal mortality review (See the Learning from Deaths Policy) that are undertaken. As the aims of each of these investigations differ, they need to continue to be conducted as separate entities to be effective in meeting their specific intended purposes.

15.3 In view of the above, the selection of incidents for investigation is based on the:
- actual and potential impact of the incident's outcome (harm to people, service quality, public confidence, etc.)
- likelihood of recurrence (including scale, scope and spread)
- potential for new learning in terms of enhanced knowledge and understanding of the underlying factors of improved efficiency and effectiveness (control potential)
- opportunity to influence wider system improvement.

15.4 Figure 1 summarises the stages of a patient safety incident investigation, for all nationally reported incidents the investigations will be commissioned by the Group Serious Incident Requiring Investigation Panel

(SIRI Panel). For all other incidents these investigations will be commissioned by the Site/MCS/LCO Patient Safety Incident Panels.

15.5 The Patient Safety Policies SOP 10: Patient Safety Learning response; Preparing to respond provides details of the planning phase of the incident investigation.

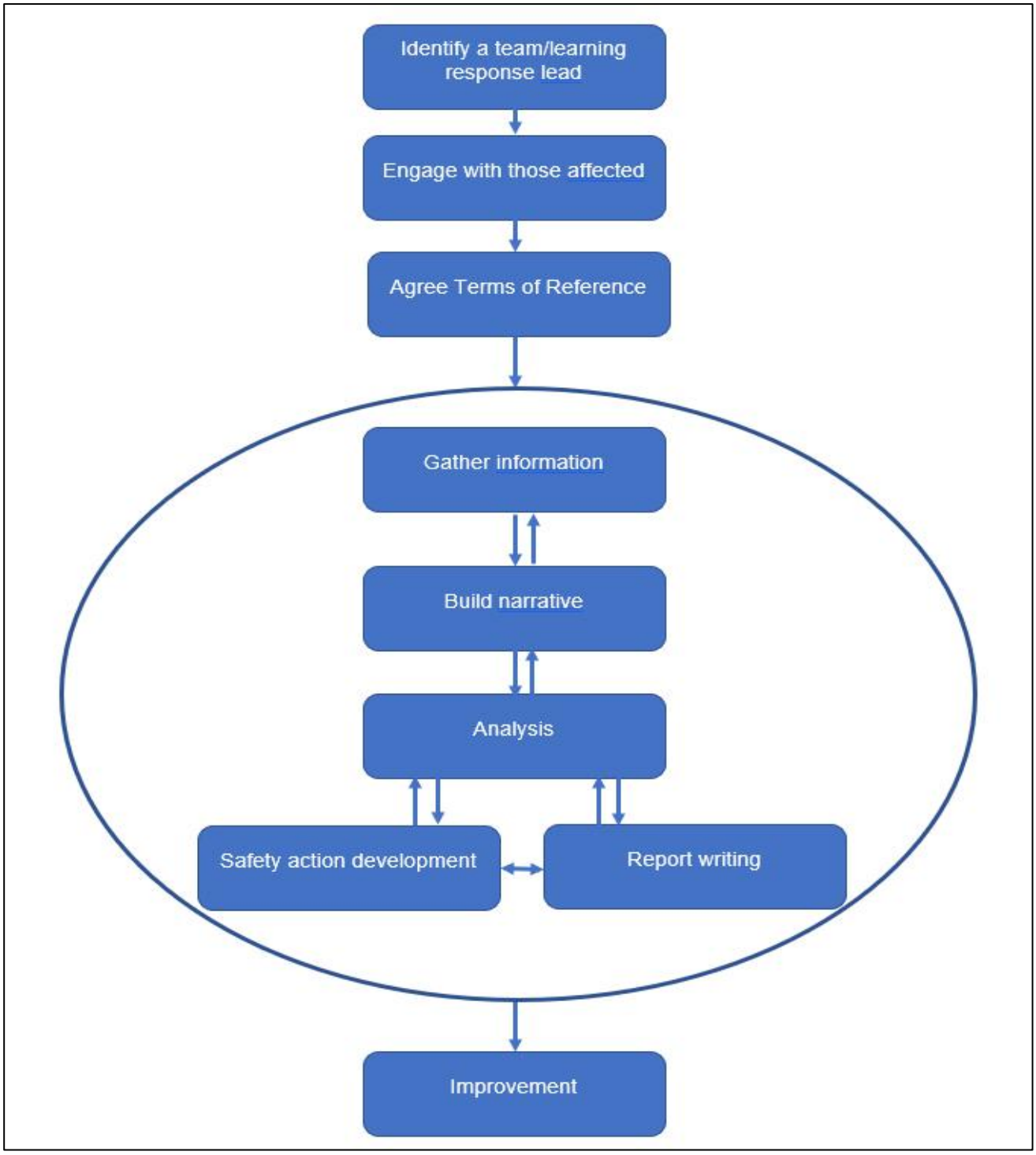
15.6 The Patient Safety Policies SOP 11: Patient safety Learning Response: synthesis provides details of the investigation process and investigation tools and techniques available.

15.7 The Patient Safety Policies SOP 12: Patient Safety Learning Response: turning learning into patient safety improvement provides the expected approach to identifying areas for improvement, developing action plans and their associated measures of success (See section 18)

15.8 Some patient safety incidents will not require a PSII but may benefit from a different type of learning response to gain further insight or address queries from the patient, family, carers or staff. It is important that a clear distinction is made between the activity, aims and outputs from reviews and those from PSIIs.

15.9 Different review techniques can be adopted, depending on the intended aim and required outcome and the chosen response methodology should be identified as part of the high impact learning assessment. The Trust's Patient Safety Intranet provides details of different techniques that are recommended and details of the support that can be provided by the Human Factors Academy Team

Figure 1: Incident learning response process



15.10 Recommended methodologies include:

- ‘Being open’ conversations (Open disclosure). To provide the opportunity for a verbal discussion with the affected patient, family or carer about the incident (what happened) and to respond to any concerns.
- Case record/note review (Clinical documentation review). To determine whether there were any problems with the care provided to a patient by a

particular service. (To routinely identify the prevalence of issues; or when bereaved families/carers or staff raise concerns about care.)

- Incident timeline (Incident review) To provide a detailed documentary account of an incident (what happened) in the style of a 'chronology'.
- Transaction audit (Audit) To check a trail of activity through a department, etc., from input to output.
- Process audit (Audit) To determine whether the activities, resources and behaviours that lead to results are being managed efficiently and effectively, as expected/intended.
- Outcome audit (Audit) To systematically determine the outcome of an intervention and whether this was as expected/intended.
- Clinical audit (Outcome audit) A quality improvement cycle involving measurement of the effectiveness of healthcare against agreed and proven standards for high quality, with the aim of then acting to bring practice into line with these standards to improve the quality of care and health outcomes.
- Risk assessment (Proactive hazard identification and risk analysis) To determine the likelihood of an identified risk and its potential severity (e.g., clinical, safety, business).
- Human Factors Classification System review: To understand the incident/event based in a human factors classification system.
- Functional Resonance Analysis (work as imagined vs work as done analysis) To understand the complexities of service delivery in a structured way.
- Failure Modes and Effects Analysis (FMEA). A proactive method for evaluating a process to identify where and how it might fail and to assess the relative impact of different failures, in order to identify the parts of the process that are most in need of change.

15.11 A valuable and thorough way of accomplishing thematic analysis of PSII findings is to select a few (three to six) recent and very similar incidents and investigate each individually with skill and rigor to determine the interconnected contributory and causal factors. The findings from each individual investigation are then collated, compared to identify common causal factors and any common interconnections or associations upon which effective improvements can be designed. Thematic analyses should be commissioned and monitored through site/MCS/LCO quality oversight systems and the outcomes reported through their Quality and Safety Committees, or if at Group level, through the Group Safety Oversight Panel process. The Trust has developed an incident 'thematic analysis to support patient safety learning toolkit', and a toolkit to support responsive reviews where a more in depth and contextualised approach to exploring the potential for learning.

16. Responding to cross-system incidents/issues

16.1 Learning responses should be managed as locally as possible to facilitate the involvement of those affected by and those responsible for delivery of the service in which the incident or issue relates to.

16.2 However, where a response involving multiple providers and/or services across a care pathway is too complex for a single provider to manage, the Trust will seek support from the ICB to support the co-ordination of cross-system response.

16.3 The Trust will use the HILA process and the stakeholder mapping stage of the preparing to respond phase of the incident investigation process to recognise incidents or issues that require a cross-system learning response. The stakeholder mapping stage will enable the Trust to ensure learning responses are co-ordinated at the most appropriate level of the system.

16.4 If it is determined that there is insufficient capacity and/or capability to undertake a complex investigation, the Trust will engage proactively with the ICB, standards).

16.5 The Trust/ICB can also engage with NHS England regional teams to ensure that such responses are delivered as required.

17. Timeframes for learning responses

17.1 Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified. PSIIs should ordinarily be completed within one to three months of their start date. In exceptional circumstances, a longer timeframe may be required for completion. In this case, any extended timeframe should be agreed between the Trust with the patient/family/carer.

17.2 No local PSII or PSIR should take longer than six months. A balance must be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant. (Where the processes of external bodies delay access to some information for longer than six months, a completed PSII can be reviewed to determine whether new information indicates the need for further investigative activity.)

18. Safety action development and monitoring improvement.

18.1 Learning generated from PSIIs, patient safety learning reviews, the reviews of patient safety learning events that did not result in patient harm, thematic analyses of incident reviews or responsive reviews focusing on a

patient safety learning question will routinely be presented at the end of any report as areas for improvement.

18.2 These areas for improvement will then be translated into objectives to support the development of an action plan, which will be presented on the standard template (See PSP SOP 12 Turning patient safety learning into patient safety improvement). Actions should be developed based on human factors science, ensuring that actions to support the maturation of patient safety culture are included.

18.3 Areas for improvement, where possible should be developed with the involvement of patients/carers/relatives involved in the incident, staff involved in the incident and staff whose work will be affected. Actions, based on objectives derived from the learning, should be SLIM (Specific, Learning-orientated, Impactful and Measurable) and developed in collaboration and consensus with the teams involved.

18.4 Transferable learning and recommendations should be routinely escalated through the existing site/MCS/LCO quality governance infrastructure and to the Group Patient Safety Oversight Panel.

18.5 Monitoring arrangements, providing assurance in relation to the effectiveness of safety actions should be determined at the outset, on a risk and scale basis- local actions should be monitored within the clinical service governance arrangements, using established escalation routes as required. Actions involving more than one specialty should be monitored within the site/MCS/LCO governance arrangements, and Trust wide safety actions monitored within the Group Quality Governance infrastructure.

19. Safety improvement plans

19.1 Safety improvement plans bring together findings from various responses to patient safety incidents and issues. They can take different forms. For example,

- creating an organisation-wide safety improvement plan summarising improvement work
- creating individual safety improvement plans that focus on a specific service, pathway or location.
- collectively reviewing output from learning responses to single incidents when it is felt that there is sufficient understanding of the underlying, interlinked system issues
- creating a safety improvement plan to tackle broad areas for improvement (i.e., overarching system issues).

19.2 To support accelerated improvement through corporate accountability, to ensure organisational processes are in place to manage situations where resources are insufficient to robustly implement actions or influence

improvement, (e.g., where an investment in technology or a widespread/systemic change may be the better option) and to ensure opportunities for transferable learning are identified and appropriate safety improvement plans are in place:

- The reports, recommendations and action plans associated with all investigations/reviews related to incident categories described in Appendix 2 undertaken within sites/MCS/LCOs require site/MCS/LCO Director level (Director of Nursing/Medical Director) approval and ratification at Group Patient Safety Panel.
- All thematic analyses/responsive reviews undertaken within Sites/MCS/LCOs should be presented to and approved at the appropriate Site/MCS/LCO Quality and Safety Committee.
- Incident investigation/incident review reports undertaken at Group level require approval by the Group Patient Safety Panel and the Group Medical Director(s)/Chief Nurse.
- The reports of thematic analysis/responsive reviews undertaken across the patient safety profile of the Trust require approval and the recommendations require monitoring at the Group Patient Safety Committee.

19.3 The Trust has several processes in place to support the assurance that there is accelerated, and effective improvement generated from patient safety learning (detailed in PSP SOP 13 Smart Assurance about Patient Safety Learning) including:

- The use of the Trust's patient safety investigation outcome profiling tool
- Routine focused assurance review of all actions relating to incidents falling into the categories described in Appendix 2.
- The use of SPC analysis of patient safety incident and reliability data to enable the routine surveillance of incident categories and the scrutiny of that data for special cause variation (in terms of improvement or deterioration)
- The use of a suite of human factors-based assessment tools that support both safety improvement planning and assurance.
- The formal risk assessment of an incident reoccurring during the HILA process, following the conclusion of the investigation review, and following completion of the investigation to demonstrate a reduction in risk.
- The use of safety culture assessments, staff survey, patient/carer/relative survey feedback in relation to the incident investigation/review process and outcomes
- The generation of Patient Safety Incident Response Plans (PSIRPS) to identify priority areas for safety improvement within each site/MCS/LCO and Trust-wide.

19.4 Safety improvement plans will be monitored in relation to their effectiveness and impact at Site/MCS/LCO Quality and Safety Committees, with report provided to the Group Patient Safety Committee. An exception report in relation to assurance and progress will be reflected in the Group Integrated Performance Report, which is received at each meeting of the Group Board of Directors.

20. Oversight Roles and Responsibilities: Individual roles and teams

20.1 The roles and responsibilities described in this policy have been aligned to those described in the Oversight Roles and Responsibilities Specification[8]

20.2 All employees have a responsibility to:

- Focus on continuously improving the safety of the care provided to patients, including reporting situations where 'work went well' where expected patient outcomes were achieved or where care was 'outstanding' and exceeded expectations.
- Take appropriate action (in line with this Policy) when they witness or experience any patient safety incident or near miss, irrespective of severity.
- Report patient safety incident details accurately onto Ulysses within 24 hours of the date of the incident identification
- Co-operate fully with incident investigation procedures, which may include supporting the Immediate High Impact Learning Assessment process, the agreed investigation process (supporting focus group discussions) and supporting the development of recommendations and actions.

20.3 The Group Chief Executive is accountable for:

- Ensuring that the overall management and investigation of patient safety incidents is delegated to an appropriate Group Executive Lead

20.4 The Group Medical Director has delegated overall accountability for:

- Ensuring that a framework is in place which meets legal, regulatory and contractual requirements in relation to the management of incidents across the Group.
- Reporting to the Board of Directors on all applicable serious incidents/patient safety events with high impact learning are reported to the Strategic Executive Information System (StEIS)

20.5 The Group Director of Clinical Governance is responsible for:

- Overseeing the implementation of Trust-wide Patient Safety Policies and ensuring that local procedures for managing incidents are in accordance with the national regulations. This includes ensuring that:
    - All related policy and procedures reflect national regulations and guidance.
    - Local systems and processes are sufficient to provide the Chief Executive with assurance that robust arrangements are in place.
    - The Trust meets all performance standards in respect of the management of incidents.

[8] https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-4.-Oversight-roles-and-responsibilities-specification-v1-FINAL.pdf

- Systems are in place to ensure that the Board of Directors, Chief Executive and managers throughout the Trust receive regular reports on key performance indicators and are made aware of trends in incidents so that they can take action through the relevant clinical governance and risk management processes.
- A programme of staff training in patient safety is developed and implemented across the Trust.
- Chairing the Trust's Integrated Governance and Risk Committee
- Overseeing the assurance processes with regards to compliance with this policy

20.6 The Group Patient Safety Specialist is responsible for

- The co-ordination of a network of Patient Safety Specialists across the Trust, ensuring each site is represented.
- Influencing and having direct access to their executive/leadership team, including access at no notice to escalate immediate risks or issues about patient safety.
- Having an overview of and ability to influence and interact with all patient safety processes within the organisation, including the management of teams that lead on patient safety processes, such as patient safety incident reporting, risk management and investigation.
- Curating the Trust's Annual Patient Safety Plan
- Integrating learning about patient safety from multiple sources, and presenting routine reports within the quality governance infrastructure
- Developing the Trust's approach to patient and public involvement in patient safety and directly supporting and developing the Trust's patient safety partners
- The operation of the Group Safety Oversight and management systems
- The declaration of Serious Incidents on StEIS
- The management of the Group Patient Safety Panel process

20.7 Group Head of Patient Safety (Incident Response) is responsible for:

- Ensuring this policy meets statutory, regulatory and contractual requirements and is monitored appropriately.
- Reviewing, revising and updating this policy as and when required
- Monitoring contractual targets for completion of patient safety investigations
- Liaison with the Integrated Care Board regarding Group incident management
- Supporting the development of systems for the dissemination and sharing of lessons learned and for ensuring that these are embedded across the Group.
- Ensuring all deceased patient investigations are reviewed in line with coronial requirements.

20.8 Group Patient Safety and Risk team is responsible for:

- Ensuring that the Ulysses System effectively supports the reporting and management of learning events and incidents as per this Policy.
- Providing information/reports as required utilising the information within the Ulysses System

- Ensuring that there is an adequate training programme in place for staff across the Trust in relation to the use of the Ulysses System
- Liaison with the ICB regarding incident management for the Group
- Supporting the development of systems for the dissemination and sharing of lessons learned and assurance in relation to any actions taken.

20.9 Group Head of Health and Safety is responsible for:

- Supporting the Sites/MCS/LCO in ensuring the procedures for the management an investigation of H&S incidents involving patients are embedded.
- Supporting nominated staff to undertake Health & Safety and RIDDOR Investigations including those relating to patients.
- Monitoring performance for the investigation of health and safety incidents involving patients, including the quality and completion of reports, via the Group Strategic Health & Safety Committee
- Quality assuring RIDDOR investigation reports relating to incidents involving patients prior to sign off to ensure that the report is sufficiently robust should it be required by the Health & Safety Executive
- Supporting Sites/MCS/LCO within their area to develop systems for the dissemination and sharing of lessons learned related to patient safety and health and safety.

20.10 Hospital Site/MCS/LCO Chief Executives are accountable for

- Ensuring that the oversight and management of patient safety is delegated to an appropriate Hospital Site/MCS/LCO Medical or Nursing Director

20.11 Hospital Site/MCS/LCO Medical and Nursing Directors are responsible for:

- Oversight of the patient safety processes within the Hospital Site/MCS/LCO ensuring that patient safety learning and patient safety incidents are managed in line with this Policy.
- Ensuring all patient safety related investigations are completed within their agreed timescales.
- Approving all patient safety investigation reports requiring submission to the Group Patient Safety Panel
- Approving all patient safety investigation reports which are required to be shared with patients/relatives/representatives following a Duty of Candour disclosure.
- Ensuring Duty of Candour regulations are complied with.
- Ensuring that there are appropriately trained senior managers /clinicians to undertake investigations and act as Duty of Candour leads with patients/relatives/representatives.
- The development of the Site/MCS/LCO PSIRP

20.12 Hospital Site/MCS/LCO Quality/Clinical Governance leads are responsible for

- Overseeing compliance with the policy within their organisation

- Receiving assurance regarding the operation of the policy within their organisation
- Identifying themes that arise from patient safety information and ensure action is taken as appropriate.
- Identifying a Learning Response lead and Duty of Candour lead/Patient engagement and advocacy lead for all notifiable incidents
- Undertaking daily triage of incidents reported into the Ulysses system for their area of responsibility and escalating as appropriate.
- Monitoring the progress of investigations to ensure that they are proceeding within appropriate timescales and escalate as appropriate.
- Supporting staff to ensure that the procedures for the management and investigation of incidents are embedded within their area.
- Supporting the assigned Learning Response Lead and Duty of Candour Lead/Patient Engagement and Advocacy Lead for all investigations within their area of responsibility
- Supporting and advising ward / department managers within their area on the use of Ulysses
- Quality assuring investigation reports prior to formal sign off to ensure that the report is sufficiently robust to pass through the sign off process.
  Supporting the development of systems for the dissemination and sharing of lessons learned and for ensuring that these are embedded across their areas (escalating potential group learning to Group Head of Patient Safety through the Group Safety Oversight System)
  Supporting the Learning Response Led to ensure that High Impact learning assessments are completed within 5 working days and that any remedial actions or learning are identified and uploaded onto Ulysses.
  Ensuring all relevant information (e.g., dates) and documents (e.g., report and relevant correspondence) is uploaded onto Ulysses.

20.13 Hospital Site/MCS/LCO Clinical Service/Business Units are responsible for

- Ensuring that this Policy is adhered to within their Division/Service
- Ensuring that there are processes in place within the Division/Service for monitoring the quality and performance of incident reporting, investigation and for dissemination of learning.
- Ensuring all investigations are completed within their agreed timescale. Where this is not possible, escalate this at the earliest opportunity to the Clinical Governance leads.
- Quality assuring all investigation reports prior to submission to the Hospital Site/MCS/LCO Directors for approval.

20.14 Patient Safety Incident Learning Response Leads are responsible for:

- Having attended a theory and practical PSII training course which is compliant with PSIRF requirements.
- Conducting at least 2 learning reviews/investigations each year
- Consider completing advanced training within three years of the initial course to advance their skills in the above and in complex safety investigations

spanning different care or organisational boundaries; engaging patients and staff in PSIIs; incident analysis; improvement science; and report writing.

20.15 Patient engagement advocates/Duty of Candour Leads are responsible for

- Having attended a theory and practical training course which is compliant with PSIRF requirements.
- Supporting the engagement with at least 2 patients/families each year
- Consider completing advanced training within three years of the initial two-day course to advance their skills, for instance in relation to empathetic engagement, appreciative enquiry and conflict resolution.

21. Oversight Roles and Responsibilities: Quality Governance

21.1 The Board of Directors is accountable for

- The approval and oversight of the implementation of this policy
- Ensuring (through the work of the Quality and Performance Scrutiny Committee)
  - Incident response and learning is integrated within governance & risk management processes and systems for improving the safety of the care provided.
  - The prioritisation and optimisation of the identification and effective management of learning events through the implementation of this policy
  - Receiving Maternity Service-related Serious Incident Reports for scrutiny and assurance

21.2 The Group Quality and Safety Committee is responsible for

- Receiving and scrutinising patient safety reports and reports from the safety oversight and learning systems.
- Receiving and managing escalations from the Patient Safety Committee in relation to themes and trends from the Trust-Wide Patient Safety Profile
- Receiving and assuring reports from significant patient safety incident investigations as escalated by the Group Patient Safety Panel
- Recommending an assurance focus for the meetings of the Quality Performance and Scrutiny Committee

21.3 The Group Patient Safety Committee is responsible for

- Considering intelligence, evidence and assurance associated with the following questions:
  - Did we provide safe care yesterday?
  - Are we providing safe care today?
  - Are our systems and processes reliable?
  - Will we provide safe care in the future?
  - Are we continuously improving?

- Ensuring the implementation of the Patient and Public Involvement in Patient Safety Framework
- Ensuring that the data used to understand patient safety is effective in understanding risk and improvement.
- The identification of integrated learning
- The identification of gaps in assurance
- The identification of gaps in controls
- The proportionate escalation of issues and risks for consideration at the Group Quality and Safety Committee
- The review and assurance associated with the outcome of thematic analyses of incidents and responsive reviews.

21.4 The Group Risk Oversight Committee is responsible for

- The oversight of patient safety risks that without Executive leadership would present a direct and significant risk to the Trust delivering its strategic objectives related to patient safety.

21.5 The Group Integrated Governance and Risk Committee is responsible for

- The integration of Group/Site/MCS/LCO patient safety risk profiles with regulatory standards and the identification of additional control mechanisms/assurance
- The scrutiny and integration of all risks being mitigated and their implications for patient safety across the Trust.
- Ensuring the controls described in the Trust's Risk Management Strategy are effective and providing assurance to the Group Risk Oversight Committee

21.6 The Group Patient Safety Panels (SIRI and IRIS) are responsible for.

- The oversight and scrutiny of all incident investigations/ reviews within categories described in Appendix 2 (SIRI)
- The oversight and scrutiny to the response to high impact learning identified through the analysis of safety II specific data (IRIS)

21.7 The Group Patient Safety Oversight System is responsible for

- The integration of patient safety intelligence (quantitative and qualitative) across the Trust and ensuring an appropriate and proportionate response and escalation

21.8 Hospital site/MCS/LCO Management Boards are accountable for

- Ensuring (through the work Site/MCS/LCO Quality and Safety Committee) that incident management, particularly lessons learned, is integrated within governance & risk management processes and systems for improving the safety of the care provided.
- The prioritisation and optimisation of the identification and effective management of learning events through the implementation of this policy
- Receiving Maternity Service-related Serious Incident Reports for scrutiny and assurance (SM MCS)

21.9 The Hospital site/MCS/LCO Quality and Safety Committees are accountable for

- Receiving and scrutinising patient safety reports and reports from the site/MCS/LCO quality oversight and learning systems.
- Receiving a site/MCS/LCO patient safety profile
- Receiving and assuring reports from significant patient safety incident investigations as escalated by the Quality Oversight System
- Identifying gaps in assurance and emergent, actual or latent risks

22. Complaints and Appeals

22.1 A Trust Patient engagement advocate and/or Duty of Candour Lead will be allocated to all patients/families as required to support their full engagement in the patient safety investigation or review, with the full involvement in the development of the terms of reference and ongoing involvement in the investigation, that concerns raised will be able to be managed proactively.

22.2 However, if a patient or their relative (or a member of staff) is dissatisfied with the approach to, conduct or outcome of the investigation, a local resolution meeting will be organised, with the consent of the patient/family, to discuss the issues raised and identify if any further review/investigation is required.

22.3 If this approach does not meet the needs of the patient/family, they will be encouraged to use the Trust's Complaints Policy to seek formal resolution.

23. Policy Governance

Equality Impact Assessment

23.1 Manchester University NHS Foundation Trust is committed to promoting equality and diversity in all areas of its activities. In particular, the Trust aims to ensure that everyone has equal access to its services and that there are equal opportunities in its employment and procedural documents, and decision making supports the promotion of equality and diversity. An Equality Impact Assessment has been undertaken prior to developing this policy, and the issues identified were incorporated as part of the policy. The Trust undertakes Equality Impact Assessments to ensure that its activities do not discriminate on the grounds of:

- Religion or Belief
- Age
- Disability
- Race or ethnicity
- Sex or gender
- Sexual orientation

- Marriage or Civil Partnership
- Pregnancy or Maternity

We also consider the impact on socially excluded groups and the impact on human rights. An equality impact assessment was completed with input from the Trust Equality and Diversity Lead.

Consultation, approval and ratification process

23.2 The Group Quality and Safety Committee received a paper in December 2020 which described the move to a more systematic approach to patient safety learning and improvement, aligned to the development of this policy. Subsequently, the original policy was developed in consultation with the Group Patient Safety Committee, the Site/MCS/LCO Governance leads and the Group Patient Safety Specialist Network. The Policy has been updated to support the launch of PSIRF in September 2023.The Policy is reviewed by the Group Patient Safety Committee and the Group Quality and Safety Committee. The Group Quality Performance and Scrutiny recommends its approval by the Board of Directors

Dissemination and implementation

23.3 This policy will be disseminated throughout the Trust through established mechanisms (including publication on the staff intranet policy page, the creation of links on staff intranet pages to the policy and through the Trust's Quality Governance infrastructure. In addition, the supporting Standard Operating Procedures will be subject to routine tabletop testing to ensure that they provide effective and efficient guidance in relation to compliance with the requirements of this policy.

Monitoring Compliance

23.4 Compliance with this policy will be routinely monitored through the Group-wide Safety Management System, specifically through the work of the Group Safety Oversight System, the Patient Safety Committee and the Group Integrated Governance and Risk Committee. Compliance with this policy should be subject to regular Internal Audit assurance processes.

Key performance indicators

23.5 The following key performance indicators will be monitored by the Patient Safety Committee

- The existence of a consistent and inter-related Patient Incident Response Plan at Group and Site/MCS/LCO
- Monthly exception report in a patient safety profile received by the Patient Safety Committee aligned to the requirements of this policy, including conduct of incident investigation and assurance in relation to actions taken to ensure patient safety.
- Compliance with external and mandatory reporting requirements
- Outcome of Staff Survey relating to reporting incidents and near misses
- Increase in reporting of work went well/outstanding practice.

- Reduction in conversion rate of patients/relatives receiving a Duty of Candour disclosure to them making a formal complaint.

Patient Safety Policy Standard Operating procedures (SOPs)

23.6 Patient Safety Policy Standard Operating Procedures have been developed to provide practical support in implementing this policy:

PSP SOP 01: The Safety Oversight System (Group)
PSP SOP 02: Reporting Learning Events
PSP SOP 03: Immediate High Impact Learning Assessment (learning event)
PSP SOP 04: Immediate actions to be taken following a Patient Safety Incident
PSP SOP 05: Reporting a Patient Safety Incident
PSP SOP 06: Incident management in Ulysses and escalation to StEIS
PSP SOP 07: Process for hot debrief@MFT.
PSP SOP 08: Immediate High Impact Learning Assessment (Patient Safety Incident)
PSP SOP 10: Patient Safety Learning response; tools, methods and templates
PSP SOP 11: Turning patient safety learning into accelerated patient safety improvement.
PSP SOP 12: Smart Assurance about Patient Safety Learning

Appendix 1: Incidents requiring specific management processes.

Body/Specific Process	Incident Type	Guidance
Care Quality Commission (CQC)	Health and Social Care Act (2012) notifications	Health and Social Care Act (HSCA) notifications must be made by all services registered under the HSCA. These include all NHS trusts. For NHS trusts, statutory notification requirements (with the exception of certain incidents, e.g., deaths of patients detained under the Mental Health Act) are typically met by reporting incidents to the National Reporting and Learning System (NRLS). CQC's notification guidance outlines how each type of notification needs to be made. CQC conducts inspections to assess compliance with fundamental standards and thematic reviews to support system learning – it does not investigate individual patient safety incidents.
Child Death Overview Panel	Child Deaths (see also serious case review guidance)	CDOP conducts case reviews to help prevent child deaths. Organisations must ensure they make appropriate referrals. See Child death overview panels: contacts for contacts. See the guidance Working together to safeguard children.
NHS Digital	Data security and protection-related incidents	The incident reporting tool for data security and protection incidents should be used to report all data security and protection incidents. The incident reporting tool reflects the new reporting requirements of the General Data Protection Regulation (GDPR), and for relevant organisations the Networks and Information System (NIS) Regulations. Reportable data security and protection incidents must be notified through the reporting tool. A tool is available to help organisations assess whether incidents should be reported. All Information Governance Incidents involving patients are managed in line with the Trust's Information Governance Policy
NHS complaints procedures – including reporting to the Parliamentary and Health Service Ombudsman (PHSO)	Complaints (about any aspect of care provision or concerns about the quality or outcome of a PSII arising from any reported route)	All organisations must ensure they comply with relevant complaints legislation. The Trust has a Complaints Policy which should be referred to. All complaints from patients, families or carers which involve a patient safety incident (PSI) should be dealt with and responded to in the same way as a PSI reported by staff to a local risk management system or to the national reporting and learning system and its successor system. Parliament set up the PHSO to help individuals and the public. The PHSO's powers are set out in law and the service is free to everyone. The service looks into complaints where an individual believes injustice or hardship has resulted from an organisation not acting properly or fairly or giving a

Body/Specific Process	Incident Type	Guidance
		poor service and not putting things right. The PHSO also looks into concerns about the quality or outcome of a PSII were deemed appropriate. Organisations must ensure they provide patients/families/carers and the public with relevant information relating to the PHSO.
Controlled Drugs Officer	Incidents involving controlled Drugs	These incidents must be reported to the provider's accountable officer. Reviews and investigations should be undertaken in line with local policy and procedures, which must uphold relevant obligations**.**
Coroner	Deaths where unnatural causes are suspected, and all deaths of detained patients	The treating clinician or medical examiner must report these deaths to the coroner. Note: The coroner's inquest into how a person died is different from any review and/or PSII undertaken as part of the PSIRF (which do not seek to determine cause of death). Every effort must be made to share relevant information with the coroner to support their inquest, and this can include the patient safety incident, review or PSII report. However, the coronial process does not determine the timeframe, methodology or scope of the patient safety incident response or process.
Domestic homicide reviews (DHRs) (overseen by the Community Safety Partnership; CSP)	Death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by: • a relative or a person with whom they were having or had been in an intimate personal relationship; or • a member of the same household as them	DHRs are locally led multi-agency reviews undertaken to prevent domestic violence homicide and improve service responses for all domestic violence victims and their children, through improved intra and inter-agency working. DHRs were introduced by Section 9 of the Domestic Violence, Crime and Victims Act 2004 (DVCA 2004) and came into force on 13 April 2011. The relevant police force will usually inform the local CSP of a domestic homicide. However, any professional or agency can refer a domestic homicide to the CSP, in writing, if they believe important lessons for inter-agency working can be learned. Overall responsibility for setting up a review panel and appointing its chair rests with the chair of the CSP. They must decide whether a DHR should take place within one month of the homicide coming to their attention. Advice about involvement in a DHR can be sought from the relevant NHS England and NHS Improvement Regional Independent Investigation Team (RIIT). Note: Where the victim is under 16, the serious case review process (which applies similar principles) will usually take precedence.
Health Education England (HEE)	Incidents involving trainees who may need support	Directors of education and quality (DEQ) in HEE and its local education and training boards are responsible for the quality of the education and training of medical, nursing, dental and allied health professional students and others, and training grade doctors. Local arrangements are in place to inform DEQs of safety incidents. In cases where the responsible DEQ can help provide support and subsequently help ensure the standards of training are appropriate, the Trust should ensure they are informed of the incident as soon as possible. Information provided through the

Body/Specific Process	Incident Type	Guidance
		patient safety incident reporting route must not invite comment or judgement on the capability of trainees.
Independent Office for Police Misconduct	Indications of misconduct by police officers and police staff Cases where police contact (direct and/or indirect) may have caused or contributed to a person's death or injury	Advice and guidance in relation to this type of incident can be sought from the Trust's Corporate Safeguarding or Patient Safety Teams
Learning Disabilities Mortality Review (LeDeR) Programme		The LeDeR programme supports local areas in England to review the deaths of people with learning disabilities (aged four years and over) using a standardised review process. All organisations must have processes to ensure deaths of patients with learning disabilities are reported and reviewed using the LeDeR methodology. See notification of such deaths.
Learning from Deaths (LfD)	The National Quality Board recommends that all inpatient deaths in the following categories are reviewed: -where the bereaved or staff raise significant concerns about the care -those with learning disabilities or severe mental illness -those in a specialty, diagnosis or treatment group where an 'alarm' has been raised (e.g., an elevated mortality rate, concerns from audit or CQC) -where the patient was not expected to die, e.g., in elective procedures -where learning will inform the provider's quality improvement work A sample of other deaths should be reviewed to clarify where learning and improvement are	The LfD framework introduced specific requirements for NHS acute, mental health and community trusts and foundation trusts, including the need to record deaths and to review certain deaths to support learning and improvement of NHS services. The framework supports existing expectations to report all patient safety incidents to the NRLS to inform national learning or to other relevant agencies/bodies (such as the coroner) as required. The framework outlines which deaths should be reviewed using relevant case note review methodology to determine whether there were any problems in the care the patient who died received, to learn from what happened. Many of these deaths will be reviewed using the structured judgement review (SJR) method unless specific review methods must be followed (such as for the death of patients with learning disabilities, child death, stillbirth and maternal death). Note: If a case note review (using SJR or similar method) identifies that a death was more likely than not due to problems in care, then a PSII (in line with the national PSII standards) must be undertaken.

Body/Specific Process	Incident Type	Guidance
	needed most. If possible, patients who die within 30 days of discharge from inpatient services should be considered in scope for potential review	
Professional Regulators	Professional misconduct/fitness to practise/competency concerns	If grounds for professional misconduct are suggested, the appropriate lead (e.g., the responsible officer/medical or nursing director) in the Trust must be alerted to ensure appropriate referral to the relevant professional regulator. The Trust has a 'Disciplinary Policy' to support management of this type of incident. There are nine professional regulators: General Chiropractic Council, General Dental Council, General Medical Council, General Optical Council, General Osteopathic Council, General Pharmaceutical Council, Health and Care Professions Council, Nursing and Midwifery Council, Pharmaceutical Society of Northern Ireland. Information relating to all statutory regulators and the process for managing professional misconduct can be found in the Statutory Regulators Directory. Concerns about individual practice must be managed completely separately from any patient safety review and/or PSII (as described in Part B of the PSIRF).
Public Health England (PHE)	Incidents in national screening programmes	Screening and immunisation leads must ensure the Screening Quality Assurance Team is notified when incidents occur within screening programmes. The guidance for the management of incidents in national screening programmes must be followed. The Trust has specific protocols in place to ensure appropriate referrals of incidents identified withing screening programmes (e.g., in relation to cervical screening)
Public Health England (PHE)	Incidents potentially and/or adversely affecting the health of a wider population such as decontamination failures; outbreaks of healthcare-associated infections; release/widespread exposure to harmful chemicals or a source of radiation	When such incidents occur the responsible NHS provider must contact the relevant PHE centre through their health protection team and involve PHE as part of the local incident control team. Registered medical practitioners in England and Wales have a statutory duty to notify their local authority or local health protection team of suspected cases of certain infectious diseases. All laboratories in England performing a primary diagnostic role must notify PHE when they confirm a notifiable organism. PHE collects these notifications and publishes analyses of local and national trends every week.
Prison and Probation Ombudsman	Deaths of prisoners, young people in detention, approved premises'	The PPO works with NHS England and NHS Improvement to commission an independent clinical review of the healthcare the person received in custody before

Body/Specific Process	Incident Type	Guidance
	residents and immigration detainees due to any cause, including apparent suicides and natural causes (NB: Services required to be registered with CQC must also notify CQC of the death)	their death.
Perinatal Mortality Review Tool (PMRT)	All stillbirths and neonatal deaths, and the deaths of babies in the post-neonatal period having received neonatal care	This standard review tool supports systematic, multidisciplinary, high-quality review of relevant perinatal incidents.
Health and Safety Executive	Work-related injuries/incidents	Incidents may need to be reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR). The trigger point for RIDDOR reporting is over seven days' incapacitation (not counting the day on which the accident happened). Work-related incidents in which someone dies (or incidents where a person's injuries are so serious that medical opinion is they are likely to die) should be reported under RIDDOR and managed in accordance with the work-related deaths protocol. The Trust's Health and Safety Policy provides detailed information about requirements and process
Mental health-related homicide reviews	Incidents where someone dies as a result of actions by a patient who has been receiving mental healthcare	Incidents may be investigated by the Trust and/or the relevant NHS England and NHS Improvement RIIT. The Group Safeguarding Team should be contacted for advice.
Medicines and Healthcare products Regulatory Agency (MHRA)	Incidents related to medicines and medical devices or to blood and blood components	The Trust reports suspected problems with a medicine or medical device to the MHRA using the Yellow Card Scheme as soon as possible. The UK Blood Safety and Quality Regulations 2005 and the EU Blood Safety Directive require serious adverse incidents and serious adverse reactions related to blood and blood components to be reported to the MHRA, the UK Competent Authority for blood safety. This information is vital to the reports compiled by the Serious Hazards of Transfusion (SHOT). The Trust has corresponding policies to support the external reporting of this type of incident
NHS Counter Fraud Authority	Fraud, violence, bribery, corruption, criminal damage, theft or other unlawful action such as market fixing	The Trust has a policy to support the external reporting of this type of incident.
NHS Resolution	Clinical and non-clinical	NHS Resolution supports the management of clinical and non-clinical negligence

Body/Specific Process	Incident Type	Guidance
	negligence claims Where organisations (and sometimes individuals) have concerns/queries about an individual's practice	claims. Note: All claims are managed outside the patient safety review and/or PSII process. Practitioner Performance Advice (formerly the National Clinical Assessment Service; NCAS) provides healthcare organisations with impartial advice about managing and resolving concerns about the practice of individuals. Note: NHS Resolution has links to the General Medical Council and other professional healthcare regulators to support the delivery of Healthcare Professional Alert Notices.
Police	Evidence or suspicion that the actions leading to harm (including acts of omission) were reckless, grossly negligent or willfully neglectful. Evidence or suspicion that harm/adverse consequences were intended	Incidents of this type will be immediately escalated for management at Director level within each site/MCS/LCO.
Safeguarding adults' reviews (SARs) under the Care Act (overseen by safeguarding adult boards)	Deaths of adults from abuse or neglect, whether known or suspected, and where there is concern that partner agencies could have worked together more effectively to protect the adult	A SAR is a multi-agency review process which seeks to determine what relevant agencies and individuals could have done differently that could have prevented the harm or death, not to apportion blame but to promote effective learning and improvement to prevent future deaths or serious harm. The Trust's Safeguarding Policy provides information about the SAR process.
Serious case reviews (SCRs) (overseen by the local safeguarding children's boards; LSCBs)	Abuse or neglect of a child is known or suspected; and either: (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern about how the authority, its board partners or other relevant persons worked together to safeguard the child	An SCR is a multi-agency review process which seeks to determine what relevant agencies and individuals could have done differently that could have prevented the harm or death, not to apportion blame but to promote effective learning and improvement to prevent future deaths or serious harm. The Trust's Safeguarding Policy provides information about the SCR process.
NHS England and NHS Improvement zero suicide ambition	Inpatient suicides	In 2018, the Secretary of State announced a zero-suicide ambition for mental health inpatients. To support this, NHS England and NHS Improvement national team has committed every mental health trust to develop a plan to implement the zero-suicide ambition and report their inpatient suicides to local risk management systems and the NRLS.

Body/Specific Process	Incident Type	Guidance
MBRRACE UK	UK Maternal mortality UK Maternal morbidity UK Perinatal mortality/morbidity	See Appendix 3. Maternity Incidents.
HSSIB	HSSIB Priority areas	The Health Services Safety Investigations Body (HSSIB), following Royal Assent Health and Care Act 2022 will become a fully independent non-departmental public body, commonly known as an arm's length body (ALB), of the DHSC in October 2023. HSSIB powers are set out in the Health and Care Act 2022.
MNSI Programme	Maternity Incidents	The maternity investigations programme (Maternity and Newborn Safety Investigations (MNSI) programme) will be hosted by the CQC from October 2023

Appendix 2: Incidents requiring national reporting and a PSII to be undertaken.

Category	Action (in addition to HILA and Group Patient Safety Panel Referral
Maternity and neonatal incidents (See Appendix 3)	Incidents which meet the 'Each Baby Counts' and defined maternal deaths criteria must be referred to the Healthcare Safety Investigation Branch (HSIB) for investigation
	All cases of severe brain injury (in line with the criteria used by the Each Baby Counts programme) must also be referred to NHS Resolution's Early Notification Scheme
	All perinatal and maternal deaths must be referred to MBRRACE
Mental health-related homicides by persons in receipt of mental health services or within six months of their discharge	Must be discussed with the relevant NHS England and NHS Improvement regional independent investigation team (RIIT)
Child deaths	Child death review statutory and operational guidance should be followed: incidents must be referred to child death panels for investigation
Deaths of persons with learning disabilities	Incidents must be reported and reviewed in line with the Learning Disabilities Mortality Review (LeDeR) programme if there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS a PSII must be conducted in addition to the LeDeR review
Safeguarding Incidents	Incidents must be reported to the Trust's named professional/safeguarding lead manager and Chief Nurse for review/multi-professional investigation
Incidents in screening programmes:	Incidents must be reported to Public Health England (PHE) in the first instance for advice on reporting and investigation (PHE's regional Screening Quality Assurance Service (SQAS) and commissioners of the service)
Deaths of patients in custody, in prison or on probation where healthcare is/was NHS funded and delivered through an NHS contract:	Incidents must be reported to the Prison and Probation Ombudsman (PPO), and services required to be registered by the Care Quality Commission (CQC) must also notify CQC of the death. Organisations should contribute to PPO investigations when approached. If there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS an investigation should be undertaken
Incidents that meet the criteria set in the Never Events list 2018	Reportable on StEIS. An investigation should be undertaken
Incidents that meet the 'Learning from Deaths' criteria; that is, deaths clinically assessed as more likely than not due to problems in care – using the SJR process	Reportable on StEIS. An investigation should be undertaken
Deaths of persons with mental illness	Reportable on StEIS. An investigation should be undertaken

Category	Action (in addition to HILA and Group Patient Safety Panel Referral
whose care required case record review as per the Royal College of Psychiatrist's mortality review tool and which have been determined by case record review to be more likely than not due to problems in care	
Suicide, self-harm or assault resulting in the death or long-term severe injury of a person in state care or detained under the Mental Health Act.	Reportable on StEIS. An investigation should be undertaken
All notifiable incidents (under Duty of Candour	Reportable on StEIS if reach the threshold as per the definition within PSIRF. Investigation/review should be undertaken

Appendix 3: Maternity Incidents

A3.1 Patient safety incidents requiring referral to HSIB for investigation.
In November 2017, the Secretary of State for Health announced a new maternity safety strategy – and directed the Healthcare Safety Investigation Board (HSIB) to conduct independent safety investigations for cases meeting the 'Each Baby Counts' and maternal deaths criteria listed below.

All cases meeting these criteria should be referred to HSIB through the web portal provided to the Trust.

A3.2 Criteria for HSIB investigations

- Intrapartum stillbirth: the baby was thought to be alive at the start of labour but was born showing no signs of life.
- Early neonatal death: the baby died, from any cause, within the first week of life (0 to 6 days).
- Severe brain injury diagnosed in the first seven days of life and the baby:
  – was diagnosed with grade III hypoxic–ischaemic encephalopathy or
  – was therapeutically cooled (active cooling only) or
  – had decreased central tone, was comatose and had seizures of any kind.
- Maternal deaths:
  – death while pregnant or within 42 days of the end of the pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (excludes suicides).

These investigations replace local patient safety incident investigations (PSIIs) and bring a standardised approach, without attributing blame or liability and making engagement with families an integral part to understand events from their perspective. They are conducted in collaboration with trusts and the staff involved to support wider system learning.

A3.3 Reporting patient safety incidents meeting the 'Each Baby Counts' and maternal deaths criteria.

- Reporting to HSIB

A single reporting portal has been established within maternity to co-ordinate reporting requirements for cases meeting the 'Each Baby Counts' criteria.

- Reporting to the National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS)

As with all other patient safety incidents, those referred to HSIB should be reported to NRLS and StEIS (and their replacements once introduced). Patient safety incidents which meet the 'Each Baby Counts' and maternal deaths criteria and require referral to HSIB are a 'current national priority requiring referral to others for investigation'. Once the HSIB investigation report is finalised and handed back to the provider, the provider can complete the uploading of investigation findings to StEIS for sharing and learning purposes, ahead of closure of the incident.

A3.4 Responsibilities for incidents referred to HSIB under Duty of Candour

- The requirements for Duty of Candour notification remain unchanged for these incidents: that is, the Trust must inform the patient/family/carers of the incident and of any subsequent plans for conducting a patient safety incident investigation (PSII).
- HSIB will provide ongoing communication and involvement of the patient/ family/carers in safety investigations, in collaboration with the provider, and

encourage joint discussions at agreed points in the investigation.

A3.5 Maternity incidents requiring a local response.
Specific maternity incident reporting systems must be adhered to:

- Reporting patient safety incidents to NHS Resolution as part of the Early Notification Scheme
- MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) reporting requirements.

Other maternity-related incidents identified as a 'current local priority for patient safety incident investigation' or an 'emergent risk for which the potential for new learning is so great that it warrants a full investigation' should be investigated in line with national standards for patient safety incident investigation.

A separate local patient safety incident investigation (PSII) would not normally be indicated for incidents that meet the above 'Each Baby Counts' criteria for an HSIB investigation.

However, the Trust should complete:

- Duty of Candour requirements (ahead of handover to HSIB for further involvement of patients/families in the investigation)
- reporting on StEIS (either as a Serious Incident under the Serious Incident Framework (SIF) (2015), or as an incident identified for investigation under the new Patient Safety Incident Response Framework; PSIRF)
- any immediate actions identified as necessary to avoid and/or mitigate further serious and imminent danger to patients, staff and the public.
- the Perinatal Mortality Review Tool (in parallel with and with the assistance of HSIB as it works through its independent investigation).

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A3.6 Maternity unit divert reports.

All instances of maternity unit diversions should be reported on Ulysses and escalated to StEIS.

Agenda Item 11.6

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Joint Group Medical Director
Paper prepared by:	Dr Tanya Claridge, Group Patient Safety Specialist, Associate Director Clinical Governance and Patient Safety
Date of paper:	September 2023
Subject:	Our Trust Patient Safety Plan 2023/24 Safety Differently and Site/MCS/LCO Patient Safety Incident Response Plans
Purpose of Report:	Indicate which by ✓ • Information to note • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Patient safety and clinical quality
Recommendations:	The Board of Directors is asked to: • Approve the Trust's Patient Safety Plan and the Site/MCS/LCO Patient Safety Incident Response Plans aligned to the transition to the Patient Safety Incident Response Framework • Note that the Quality and Safety Strategy, Group Patient safety Plan and associated Patient Safety Incident Response Plans will be refreshed and aligned to the development of the Trust Strategy during Quarters 3 and 4 23/24
Contact:	Name: Tanya Claridge, Group Patient Safety Specialist, Associate Director Clinical Governance and Patient Safety Tel: 0161 276 8764

SAFETY DIFFERENTLY
Our opportunities are endless

Our patient safety plan 2023/24:

Our care is safe: we continuously, systematically and consistently prioritise patient safety in everything we do.

Dr Tanya Claridge, Group Patient Safety Specialist
Updated August 2023

OUR PATIENT SAFETY PLAN 2023/24

AIM

Our care is safe: we continuously, systematically and consistently prioritise patient safety in everything we do

WE

have insight
involve staff and patients in patient safety
improve
make data count
are confident

FOCUS

INSIGHT PRIORITIES
identify unwarranted variation in patient safety outcome with a particular focus on inequalities
identify harm and harm reduction strategies in relation to patients waiting to access our services
identify high impact system reliability measures to support early identification of system resonance in patient safety priority areas supporting active surveillance

FOCUS

IMPROVEMENT PRIORITIES
Optimised system control measures
Patient safety outcomes of people waiting to access our services
Patient safety outcome with a particular focus on inequalities
Maturation of patient safety culture
Optimisation of the ergonomic design of clinical environments
Reduction in the differential between 'work as imagined' **and 'work as done'**
Safe and effective management of medication
Outcome, experience and safety for patients being discharged from our services

FOCUS

ASSURANCE PRIORITIES
management of patients with a mental health concern
management of care for patients with a learning disability
assessment of risk
transfer of patients within and between our services

1. Introduction

The National Patient Safety Strategy provides us with a clear message that we need to rethink and reframe the way we approach patient safety. Our Group Quality and Safety Strategy provides us with the objective to continuously, systematically and consistently ensure that the care we provide for our patients is safe. This plan is therefore written to ensure we deliver what is a transformative approach to

- The insight we have about patient safety,
- How we involve our people, our patients and our communities in patient safety
- Accelerating our patient safety improvement
- Using smarter assurance to understand the safety of our care

As a Trust we continue to work to implement the Patient Safety Incident Response Framework, to ensure we are fully prepared we continue to update the profiling work undertaken last year as part of the development of a Patient Safety Incident Response plan (using the methodology being used by the early adopter sites and the learning available from the pilot scheme). During the past two years we actively started to use our intelligence about patient safety and the resources we have to support our insight, involvement and improvement. It is becoming the 'way we do things around here'.

2. Our approach to developing our Patient Safety Plan

Manchester University NHS Foundation Trust is a group of hospitals, managed clinical services (MCS) and local care organisations (LCO), and we work proactively together at both group and Hospital/MCS/LCO levels to ensure that we understand the safety of the care we are providing and quickly identify opportunities for change and improvement. As an organisation we employ over 28,000 staff and manage patient care across over 150,000 care pathways: from community care to critical care from universal services to tertiary care services.

The complexity of our organisations means that writing a succinct 'pen portrait' of patient safety across our Trust is not without challenge.

However, each site/MCS/LCO has an approved draft Patient Safety Incident Response plan which are routinely updated. In addition to this approach to the prioritisation of patient safety, a patient safety profile of the Trust is iteratively updated through the work of the Patient Safety Committee and will underpin the development of the Trust's PSIRP during early 2023/24. The Profile is designed to enable the identification of areas of focus for accelerated improvement, smarter assurance, but also additional insight.

The Trust specific intelligence, as described above, has been used to identify group wide patient safety priorities and also considered in light of the requirements of the National Patient Safety Strategy, aligned national frameworks and plans and the Trust's Quality and Safety Strategy 2022-25. All of which have been used in an interdependent way to develop this Trust-Wide Patient Safety Plan.

The Trust has in place enabling structures/innovations to support the delivery of this plan, including the Group Patient Safety Specialist Network, the Human Factors Academy and more recently the early development of our Patient and Public Involvement in Patient Safety Board. The principles, progress and plan in relation to these initiatives are presented in Section 6 of this plan.

A ‘plan on a page’ for 23/24 has been developed describing the approach, the mechanisms, the assurance and the governance for each of the objectives defined in our Quality and Safety strategy to ensure that they are achieved.

3. Our Objectives (from the Trust’s Quality And safety Strategy)

3.1 Involvement: Our engagement with people and our communities

- All patients are fully and meaningfully involved in influencing the safety of the care we provide for them, including ensuring they are able to easily report observations and information about the safety of the care they have received
- We are transparent with our patients about the safety of our services which they are accessing, providing meaningful and well described information and data
- We effectively recruit, train and retain Patient Safety Partners, and ensure that their voice is heard systematically throughout our organisation and its governance
- We continuously focus on engaging our people with patient safety, using the principles of our People Strategy, using our Human Factors Academy and Patient Safety Specialist Network
- We have a clearly defined patient safety training, education and development plan predominantly delivered through our Human Factors Academy
- We ensure the meaningful implementation of Just Culture and ensure that staff involved in a patient safety event are supported in a way that is effective for them
- We continuously communicate with our People about patient safety in a way that is meaningful
- We are transparent with our communities about the safety of our care, routinely sharing meaningful patient safety data and information presented in a way that is easy to understand and accessible to all
- We work with our patients and local communities to learn about, understand, influence, and enable equality in relation to patient safety, so that all patients are equally safe

3.2 Insight: Our learning

- Through the work of our Human Factors Academy, we ensure that we have the tools and techniques in place to enable us to understand the maturity of our patient safety culture, and put in place evidence interventions to support the development of our patient safety culture, optimising our readiness and ability to learn
- We effectively integrate safety II and safety I techniques to rethink and reframe the way we identify patient safety learning through our patient safety management system (which will operate throughout the Trust) and the way we approach to understanding what we find and what we need to do to respond to it
- We understand the impact of inequalities in patient safety and take action to address areas where there are opportunities for change and improvement
- We make our patient safety data count, moving our focus from purely being on harm, to an overarching where we seek to understand patient safety risk and opportunities to learn, harnessing all the opportunities the implementation of our EPR will bring
- We have a Group wide Patient Safety Panel every week, at which all organisations who are part of the Manchester University NHS Foundation Trust Group will be representatives and will be active participants where we will seek out opportunities for learning, and make that learning happen in a proportionate and effective way
- We integrate our learning across our organisation, adopting a standardised and continuously improving approach to our knowledge management

3.3 Accelerated Improvement: our breakthrough safety improvement

- Human factors and ergonomic principles underpin all service transformation and quality improvement
- Through our Human Factors Academy, we optimise the implementation of our Simulation Strategy, focusing on maximising transferable learning and developing innovative approaches to delivery of simulation
- The capability and capacity across the Group is developed to be able to implement a wide range of safety improvement tools and techniques
- We learn about the effectiveness of our breakthrough safety improvement programmes through the effective use of qualitative and quantitative data, always considering the impact of improvements on the maturity of our safety culture
- Using our Patient Safety Incident Response Plan we focus our improvement efforts on areas where we have high impact learning in relation to frequently occurring patient safety learning events
- All breakthrough improvement work is planned using safety II and safety I data (qualitative and quantitative) and underpinned by recognised quality improvement methodology
- We have an appetite for patient safety innovation

3.4 We make data count: and we measure for improvement

- We collect useful patient safety data that not only provides a transparent view of our performance and the care we provide but will also inform decision-making on the form of future services and improvement programmes.
- We use data to allow us to identify the needs of our local communities by highlighting inequalities and emerging trends.
- We collect data and join up intelligence, sharing information across our Integrated Care System (including in primary care, community, mental health and secondary care as well as our system partners).
- The information we collect will show that we are making significant progress in removing variation and inequity across the care we provide.
- We use and correlate both qualitative and quantitative data to enable insight, improvement and assurance in relation to the Quality and Safety of the services we provide
- We plot quantitative data so that it emerges over time and tells a story: Statistical Process Control will be our chosen method of understanding the quality and safety of our services through our data
- We actively seek to benchmark our quality and safety data across our Trust, with our peers and nationally
- We present our quality and safety data in a dashboard
- We actively seek opportunities to improve our quality and safety intelligence through the implementation of our Electronic Patient record.

3.5 We are confident that our care is of high quality and we understand, contextualise and manage risk consistently

A virtuous cycle of assurance is evident through our quality and safety management system through:

- Asking curious questions: We routinely and continuously explore innovative approaches aligned to the following questions
    - Did we provide high quality and safe care yesterday?
    - Are we providing high quality and safe today?
    - Are our systems and processes reliable?
    - Will we provide high quality and safe care in the future?
    - Are we continuously improving?
- Seeking focused assurance. All actions associated with the following will be subject to a proportionate risk and assurance assessment process
    - Notifiable patient safety incidents
    - Learning events where the learning is high impact and transferable
    - Responding to Coroner's recommendations (including Prevention of Future Deaths Notifications)
    - Responding to National Patient Safety Alerts
    - National Audits where we are an outlier
    - National guidance where implementation is compromised
    - Responding to Coroner's recommendations (including Prevention of Future Deaths Notifications)
    - Local audits where standards have not been met
    - Outlier status in relation to any effectiveness related data (e.g HSMR/SHMI, readmission rate)
    - Patient Experience measures
    - Ward Accreditation
    - CQC insight and ratings
    - Improving our results in the national and local surveys (inpatient, outpatient, maternity, cancer, paediatric and staff surveys) though our accelerated improvement work
    - Patient Experience measures
    - Performance measures (Including Referral to Treatment Time (RTT), ED 4 hr wait times, Cancer waits)

- Identifying gaps in assurance. We routinely look for any gaps in our assurance through the use of assurance frameworks and maps, for instance in relation to compliance with CQC Fundamental Standards of Quality and Safety and with National Patient Safety Alerts, or the reliability of our systems and processes (for instance compliance with national guidance) and ensure these are escalated and closed with appropriate and proportionate actions

- Integrating our approach to assurance: We routinely integrate our assurance, using standard terminology, across all the areas of focus of this strategy through the work of the Safety Management System and Quality oversight across the Trust

4. Our Trust-Wide Patient safety priorities

Patient Safety Priorities are the 'hub' of this plan, enabling a specific organisational focus on specific elements of safe patient care to support making a tangible difference to patient safety.

The identification of group wide patient safety priorities is directly supported by the work of the Patient Safety Management System and they are developed from the work undertaken to respond to priorities in the 22/23 Patient Safety Plan. As part of developing their PSIRPs

the sites/MCS/LCO will identify their individual priorities, also ensuring that Group wide priorities are considered, and where appropriate included in their plans.

The Group wide patient safety **INSIGHT** priorities have been derived from the active surveillance of patient safety event (patient safety II) data, and are to develop or refine implement methods to:

- Continue to identify unwarranted variation in patient safety outcome with a particular focus on inequalities
- Continue to identify harm and harm reduction strategies in relation to patients waiting to access our services
- identify high impact system reliability measures to support early identification of system resonance in patient safety priority areas and to support areas of active surveillance
- Develop a patient safety dashboard that enables the capture and meaningful presentation of both reliability and risk data aligned to safety II thinking

Our Trust-wide safety **IMPROVEMENT** priorities have been identified through the systematic approach to the review of our data as described in section 2. It should be noted that the patient safety management system supports active surveillance on a routine basis, and therefore changes and additions to the priority areas are likely, ensuring our responsiveness to emergent risk.

- Optimised system control measures, with a clear focus on human system interaction to ensure safe surgery and invasive procedures
- Reduce unwarranted variation in patient safety outcomes of people waiting to access our services
- Reduce unwarranted variation in patient safety outcome with a particular focus on inequalities
- Support the maturation of patient safety culture
- Optimise the ergonomic design of clinical environments
- Reduce the differential between ‘work as imagined’ and ‘work as done’ across all safety critical policies
- Safe and effective management of medication
- To reduce unwarranted variation in outcome, experience and safety across the organisation for patients being discharged from our services.

The Sites/MCS/LCO have identified their local patient safety priorities through analysis of their patient safety data as they implement their PSIRPs, these are presented in a matrix format in Appendix 1 of this plan, ensuring that transferable approaches to insight and learning are optimised. Assurance in relation to progress with PSIRP implementation and the delivery of Group wide priorities will be through the routine Trust Patient safety Profiling methodology. The Site/MCS/LCO plans can be accessed through the following links:

NMGH **MRI** **CSS** **WTWA** **MTLCO**

REH/UDHM **RMCH** **SMMCS**

Key Priorities identified in 2021 and 2022 have been subject to significant and sustained improvement activity and therefore patient safety **ASSURANCE** priorities for 2023/24 are as follows:

- Safety, effectiveness and responsiveness of the management of patients attending to or admitted to our Trust with a mental health concern

- Safety, effectiveness and responsiveness of the management of care for patients with a learning disability
- Safety and effectiveness of assessment of risk (falls, pressure areas, nutrition and hydration, mental capacity etc)
- Safety and effectiveness of transfer of patients within and between our services

5. Enabling and innovating

An overarching 'plan on a page' designed to support delivery of the objectives presented in Appendix 2 of this Plan, it, in turn is supported by a range of detailed plans which are supported through a range of Trust-wide governance and operational structures, for instance the Medicines Safety Committee.

Our Human Factors Academy has been designed to support and enable our implementation of the National Patient Safety Strategy. Working across all sites, MCS and LCOs, it focuses on a suite of seven strategic delivery units

- The integration of safety I and safety II thinking into the way we approach responding, managing and learning about patient safety.
- The implementation of the national patient safety syllabus and designing additional training based on an iterative training needs analysis
- The development of the simulation faculty, to embed learning, good practice and to support the development of an innovative simulation strategy for the Trust
- The development and implementation of a Trust-wide tool to support the assessment of patient safety culture maturity
- The integration of human factors thinking and approaches to system reliability into the way we improve and transform services
- Exploring and optimising the use of human factors psychology in the way we approach equality, diversity and inclusivity
- Exploring and optimising human factors psychology in the way we enable psychological safety and effectively support members of staff who are involved in a patient safety event that has a negative impact on them

The Human Factors Academy is led by the Group Patient Safety Specialist, who is supported by a Steering Group of senior clinical and non-clinical leaders. The Human Factors Academy has also recruited a Research Fellow for three years to support innovations in simulation and the application of human factors within virtual and augmented reality simulation.

We have an established Patient Safety Specialist Network, this network is early in its development but is allowing a Group-wide focus on key safety issues and supporting the interpretation of this focus at a local level within each site/MCS/LCO.

The Trust has a Patient Safety Insight, Improvement and Learning Policy and a Patient Safety Incident Response Policy which is designed to support the transition to, and the implementation of, the National Patient Safety Strategy and to support achieving the National Standards for Patient Safety Investigations.

6. Understanding and assuring our success

The Group Quality and Safety Committee will receive, as part of the routine safety profile and exception report details of progress in delivering our patient safety plan and will receive

escalations where any element of the delivery of the plan is compromised. The Group Patient Safety Committee will, through its routine work, consider

- progress with the implementation of the plan across all the objectives, some of which it will actively support with formal sub-groups
- the development of measures of success, and how appropriate they are
- escalating any concerns in relation to the implementation of the plan to the Group Quality and Safety Committee
- the effectiveness of the implementation of this plan within Sites, Managed Care Services and the Local Care Organisation

7. CONCLUSION

The implementation of the National Patient Safety Strategy provides an unrivalled opportunity for us to think about patient safety differently.

We have used learning from our existing safety management system, our approaches to insight, learning, improvement and assurance to produce this plan, designed to continuously and sustainably transform our approach to patient safety.

During the past 2 years we made huge progress together, during 23/24 our focus will continue to be on strengthening our governance, but most importantly on involvement, our staff and our patients and local communities. We recognise that this is a vital determinant of our success.

#safetydifferently will directly support our innovation and transformation to ensure that our care is safe, and we continuously, systematically and consistently prioritise patient safety in everything we do.

Appendix 1								
Learning Priority areas (23/24 PSIRPS)	Site/MCS/LCO							
	RMCH	WTWA	MRI	SM MCS	NMGH	CSS	MTLCO	REH/UDHM
Medication safety								
Patient care, monitoring and review				Triage				
Access								
Transfer								
Discharge								
Staffing								
Communication								
Diagnosis delay								
Clinical tests: Results management								
Clinical Documentation								
Disruptive aggressive behaviour								
Pressure Ulcers								
Clinical assessment-diagnosis (tests)								
Patient treatment delay								
Infection/sepsis management								
Consent								
Prevention of falls								
Nutrition and hydration								
Procedural safety								
Timeliness of assessment and treatment								
Management of the deteriorating patient								
Ensuring safe and effective follow up of care								
Safe and effective use of the Respect process								
Inequality								
Safeguarding								
End of Life Care								

Annex 2 Group Patient Safety Plan on a Page 23/4							
	Objective Focus	Approach	Group Lead	Operational support	Governance	Action Plan	Completion
1	Involvement: Effective engagement with Patients, public and our communities	Implementation of the national patient and public involvement Framework	Acting Director of Clinical Governance	Sub-Group of the Patient Safety Committee	Patient Safety Committee	Specific group wide action plan	August 23
2	Involvement: Effective Engagement with our People #safety differently	Implementation of PSIRF	Group Patient Safety Specialist	Patient Safety Specialist Network Human Factors Academy SDU (T&E) Human Factors academy SDU (EDI)	Patient Safety Committee	Specific group wide action plan aligned to implementation of PSIRF	April 24
3	Insight: Effective learning	Implementation of the safety management system within sites/MCS/LCO Implementation of the national standards for patient safety event response Safety Culture assessment and actions Implementation of the PSIRF	Group Patient Safety Specialist	Human Factors Academy	Patient Safety Committee	Specific SDUs of the Human Factors Academy Specific group wide action plan in place in relation to national standards Specific group wide action plan in place to implement the PSIRF	September 23
4	Delivering Priorities for Improvement	Sites/MCS/LCO PSIRP and local improvement plans Group insight, improvement and assurance priorities	Acting Director of Clinical Governance	Human Factors Academy, Patient Safety Specialist Network	Patient Safety Committee	Local action plans across each site/MCS/LCO Group-wide action plan for each group-wide priority	April 24
5	Accelerated Improvement: our breakthrough safety improvement	Evidence based action planning Systems theory underpinning actions Measures of success for all improvement areas	Group Patient Safety Specialist,	Human Factors Academy (Strategic delivery unit)	Patient Safety Committee	Group wide action plan relating to accelerated improvement and effective action planning	April 24
6	Improvement: Optimise the implementation of the simulation strategy	A strategic deliverable of the Human Factors Academy	Group Patient Safety Specialist	Simulation Faculty/Human Factors Academy	Patient Safety Committee	Simulation Strategy and business case	April 24
7	Improvement: training, education and support	A strategic deliverable of the Human Factors Academy	Group Patient Safety Specialist	Human Factors Academy (Strategic delivery unit)	Patient Safety Committee	Specific SDU of the Human Factors Academy Specific group wide action plan in place to implement the national training requirements	December 24
8	Confidence	The implementation of a Trust-wide approach to assurance mapping and the application of an assurance framework aligned to the Risk management framework and strategy	Associate Director of Clinical Governance	Compliance team	Integrated Governance and Risk Committee	Specific group wide action plan in relation to assurance mapping Specific group wide action plan in relation to the assurance associated with enduring alerts	March 24
9	Making our data count	Development of Trust-wide and local patient safety dashboards aligned to reliability metrics derived from FRAM/systems analysis	Group Patient Safety Specialist/ Associate Chief Informatics Officer	Sub-Group of the Patient Safety Committee	Patient Safety Committee	Group wide action plan	April 24

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NHS
Manchester University
NHS Foundation Trust

Manchester Royal Infirmary

Patient Safety Incident Response Plan

2022-2025

Safety Differently

Effective date: August 2023
Estimated refresh date: August 2024

	Name	Title	Signature	Date
Author	Claire Powell	Associate Director, Assurance and Risk Management		
Reviewer	Dawn Pike	Director of Nursing		
	Leonard Ebah	Medical Director		
Authoriser	Vanessa Gardener	Chief Executive		

Forward

As the CEO of Manchester Royal Infirmary, I am delighted to be able to share our first published Safety Differently/Patient Safety Response Framework and Plan. As a hospital we are committed to delivering services for our patients and their families which meet their individual needs ensuring everything we do for our patients is grounded in best practice evidence and we are continually striving to learn and develop our services.

We have a well embedded Governance Framework supported by frameworks which provide oversight in terms of performance, improvement and research all underpinned by our Patient Involvement Plan. Safety of our services is the key driver of everything we do, and we are committed to creating and maintaining a culture of listening, learning and change to ensure that we Achieve Excellence for our patients, their families, and our staff.

Our plan outlines how we will continue to change the way we respond and review patient safety incidents ensuring that we continue to have a culture which is a compassionate and supportive response with our staff and demonstrate learning and improvements for our patients, families, and services.

Mrs Vanessa Gardener, Chief Executive

We are delighted to share our Safety Differently PSIRF framework and plan which will support our ongoing commitment to safety for our patients and staff within our services. Working collaboratively to learn from our incidents alongside our commitment to celebrate and take forward learning from our successes will enable us to always deliver safe effective responsive care to our patients and their families.

Mrs Dawn Pike, Director of Nursing

Dr Leonard Ebah, Medical Director

Introduction

The Patient Safety Incident Response Framework (PSIRF) (Figure 1)sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety and replaces the Serious Incident Framework (2015).

The Patient Safety Incident Response Framework (PSIRF) fundamentally shifts how the NHS responds to patient safety incidents for learning and improvement.
PSIRF is not an investigation framework that prescribes what to investigate, instead, PSIRF:

- Advocates a co-ordinated and data-driven approach to patient safety incident response that priorities compassionate engaement with those affected
- Embeds patient safety incident response within a wider system of improvement
- Prompts a significant cultural shift towards systematic patient safety management
- Allows for a propertionate and considered learning response to patient safety incidents.

Figure 1

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

Within Manchester University NHS Foundation Trust, the approach has been aligned to our focus on Safety Differently which will be delivered through and overarching MFT approach and individual hospital/MCS Safety Differently/PSIRF delivery plans.

This document sets out how **Manchester Royal Infirmary (MRI)** will respond to patient safety incidents reported by staff and patients, their families, and carers as part of our continuous work to improve the quality and safety of the care we provide and strive to achieve excellence in everything that we do.

Our Services

The Manchester Royal Infirmary is located within the Manchester City Centre and is part of the Manchester University Hospitals NHS Foundation Trust.

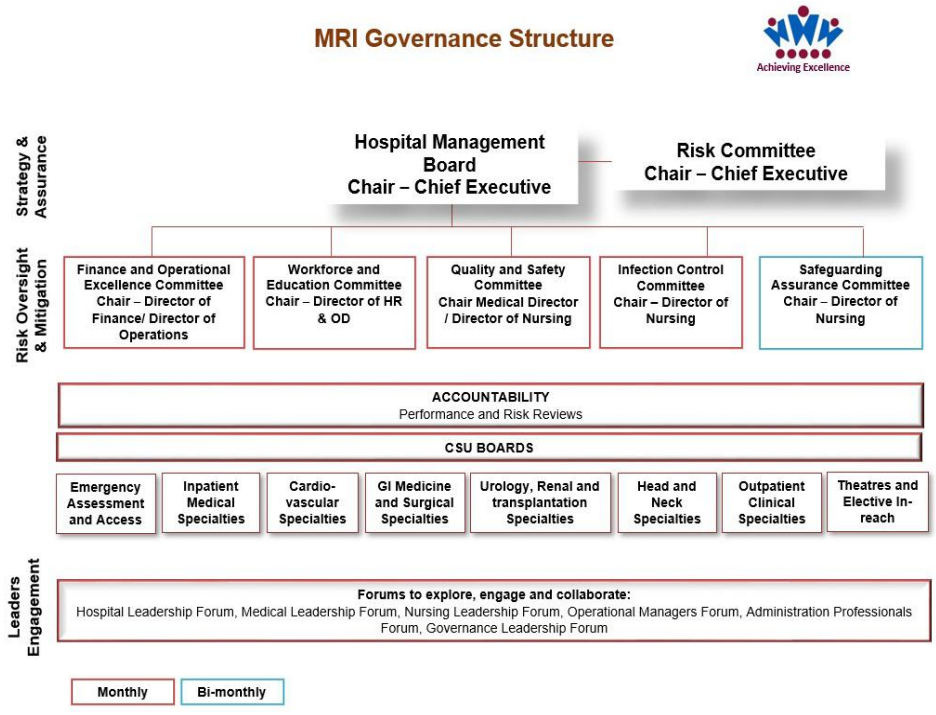
Manchester Royal Infirmary is located within the Manchester City Centre and is part of Manchester Foundation Trust, providing a range of local and tertiary services to Greater Manchester and the surrounding area.

Founded in 1752, the MRI has grown to become a major research and teaching hospital working with Manchester University's Medical School and a regional and national centre for services as diverse as kidney and pancreas transplants, haematology, vascular, major trauma, liver and pancreas surgery, rheumatology, and HIV care. Around 145,000 patients visit our Accident and Emergency Department each year.

The MRI has expanded from having just 12 beds in 1752 to 724 in 2003 and is currently undertaking a £40m refurbishment of our Emergency department and expansion of operating theatres.
Our many leading roles include providing Major Trauma Services, running the largest home kidney dialysis programme in the country, being the first to provide closed loop insulin pumps for patients with diabetes and in the first group of hospitals to provide the revolutionary CAR T cell therapy for blood cancers.

Patient care and service delivery within the MRI is delivered through eight Clinical Service Units. The services that sit within each CSU are described as below.

Emergency Access and Assessment	In Patient Medical Specialities	Cardiovascular Specialities	GI Medicine & Surgical Specialities	Urology, Renal & Transplantation Specialities	Head & Neck Specialities	Outpatient Clinical Services	Theatres & Elective In-Reach
Emergency Care Ambulatory Care Acute Medicine Orthopaedic Wards Fracture Clinic	Respiratory Medicine Complex in Pt. Palliative Care & Oncology Haematology	Vascular Surgery Hypertension Heart Care	Gastroenterology HPB Colorectal Surgery Endoscopy	Renal Urology Transplant Dialysis Units	ENT Maxillo-Facial H&N Cancer ENT Outpatients Audiology	Endocrinology Diabetes Metabilisim Rheumatology Immunology/Allergy Sexual Health/HIV Main Outpatients SMDU	Pre-op Assessment Day Case Theatres DSD



The hospital has a clear MRI Governance Framework which underpins the hospital delivery of our commitments through the Annual Planning Processes.

Scope

There are many ways to respond to an incident which occurs involving a patient, family member of a member of our staff. This document covers responses conducted solely for the purpose of systems-based learning and improvement. There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement.

Other types of response exist to deal with specific issues or concerns. Examples of such responses include complaints management, claims handling, human resources investigations into employment concerns, professional standards investigations, coroners' inquests, or criminal investigations. The principle aims of each of these responses differ from the aims of a patient safety response and are outside the scope of this plan.

This Plan explains the scope for a systems-based approach to learning from patient safety incidents. We will identify incidents to review through nationally and locally defined patient safety priorities. An analysis of which for the Manchester Royal Infirmary is explained later within this document. For this document patient safety incidents are defined as:

any unintended or unexpected incident which could have or did lead to harm for one or more patient's receiving care.

The plan is based on the Manchester Royal Infirmary core commitments and will remain flexible and responsive and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Our Commitments

We have clear commitments published for patients, staff, services and for the Hospital

To be effective in meeting their specific intended purposes, responses that are not conducted for patient safety learning and improvement are separate entities and will be appropriately referred as follows:

- Human Resources (employee relations) team for conduct competency issues and if appropriate referral to professional regulator.
- Legal Teams for the oversight and management of clinical negligence claims.
- Medical Examiners and if appropriate engagement with coroner's office where issues may be related to a death.
- Police for concerns related to potential/actual criminal activity.

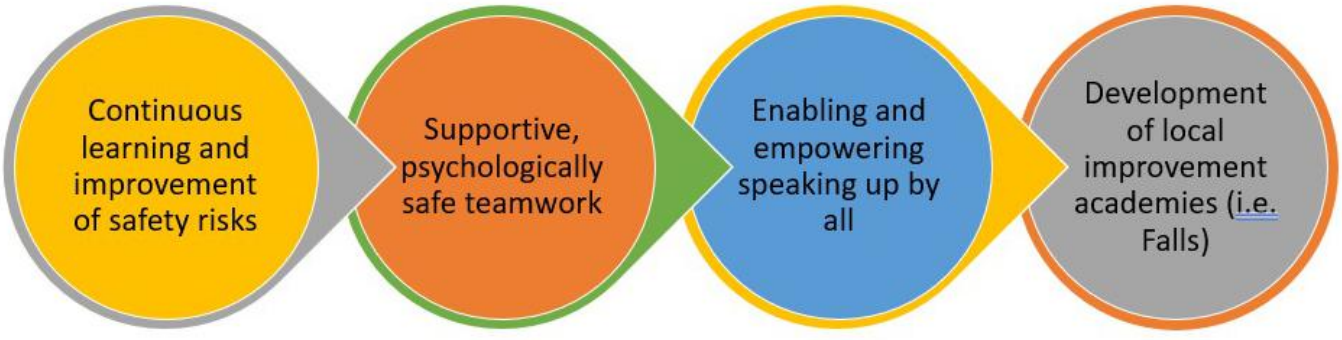
Defining our Patient Safety Incident Profile

We used a thematic analysis approach to determine which areas of patient safety activity we focussed on to identify our patient safety priorities. Our analysis used additional sources of patient safety insights, beyond that of incidents which resulted in severe harm or death. Our used several sources of information, to enable us to identify the patient safety priorities described in this plan.

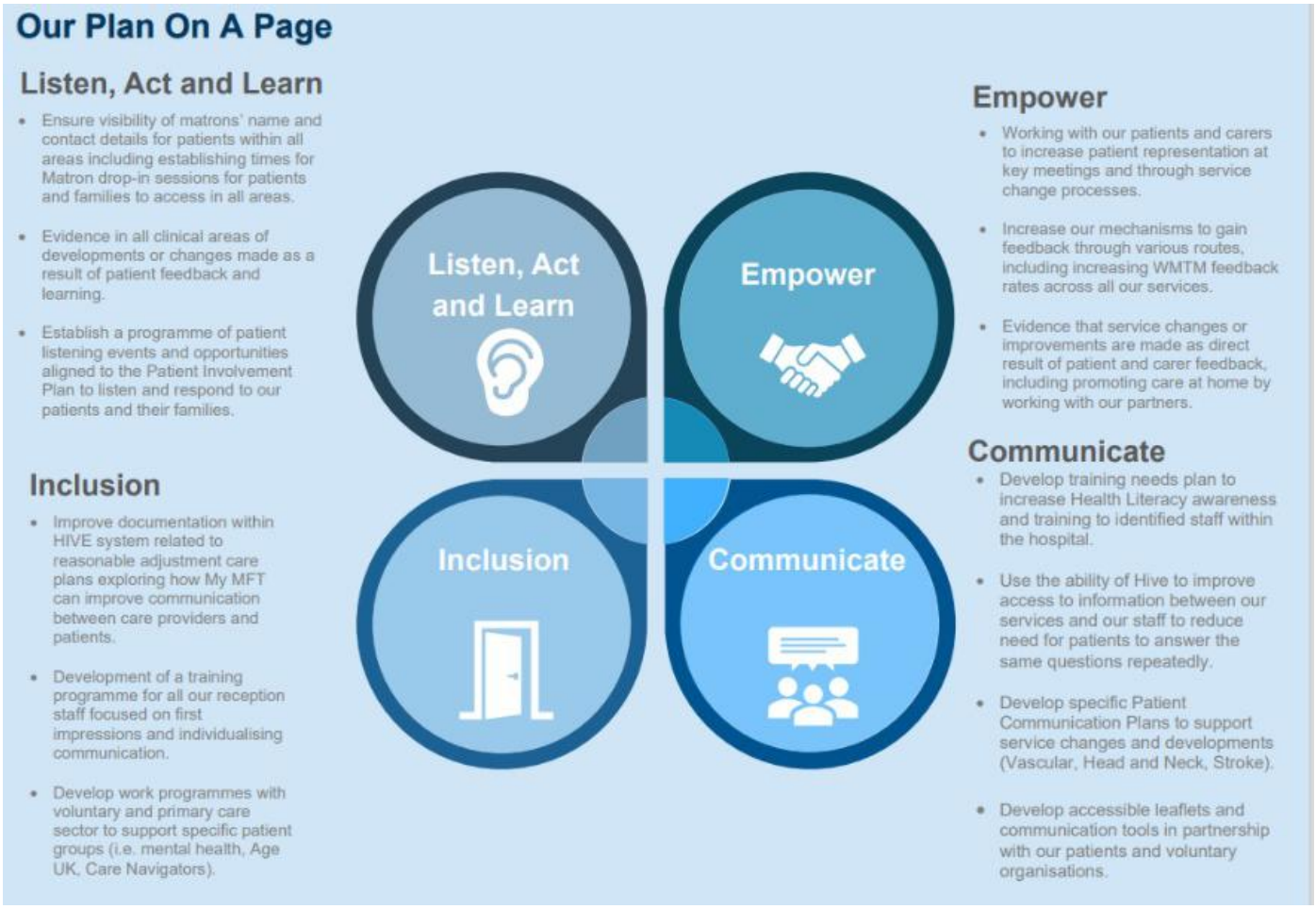
Sources of Insight

In addition, the hospital, in line with the NHS Patient Safety Strategy 2019, established an Insight Cell, which was tasked with using sources of safety data, to inform in a proactive, responsive, and sensitive manner how safe care is in the hospital, sense early signals of safety issues and articulate whether safety is improving over time. Our patient safety 'insight' work aims to improve understanding of safety across the whole system by drawing intelligence from multiple sources of patient safety information, including incidents, complaints, risks, Coroners reports, friends and family testing and trend analysis.

The MRI Transformation Plan supports a programme of continuous improvement that encompasses several the PSIRP priorities and supports a positive compassionate 'Safety Culture through:



We have started work with our patients and their families to enable us to integrate their insight and views into the delivery of our patient safety priorities. Our Patient Involvement Plan is embedded in ensuring that the patient voice is visible in all that we do, especially our approach to and the delivery of safe and effective services. Our Patient Involvement Plan is summarised below and will be key to the delivery of our commitment to Achieving Excellence in Safety.



We have developed patient safety recommendations within our Safety Differently/PSIRF plan, based on the original thematic analysis and our on-going insight which will ensure that our approach is always flexible and dynamic.

Situational Analysis of Patient Safety Activity.

In the last three years, more than 30,087 Patient Safety Incidents have been reported within the Manchester Royal Infirmary, with 481 or 1.59% of these being investigated as Serious Incidents as per the Serious Incident Framework. A large proportion of work undertaken by our Clinical Service Units and Corporate Governance Team is related to what had become a time-consuming process. Safety Differently/ PSIRF gives us the opportunity to keep the learning from previous processes and develop this further to expand our insight and learning opportunities to support safe and effective delivery of care for our patients, alongside compassionate leadership for our staff.

The analysis of the Manchester Royal Infirmary review demonstrates the profile summarised in Table 1 below of patient safety PSRIF related activity broken down into specific themes:

Table 1 - MRI Situational Analysis of Patient Safety Activity

Patient safety Activities	Activity	Definition	Annual Average
National Priotities	Never Event	Patient safty incident which met the criteria for never events framework and reported to STEIS as a SIRI	5
	Incident resulting in death	Serious Incidents requiring investigation which met the standard investigation criteria and resulted in a patient death	17
		Incidents resulting in death which related to a patient with a diagnosed learning disability	
		Mortality reviews including Structured Judgement Reviews	87
Local Patient Safety Activities	Serious Incident Requiring Investigation (SIRI)	Serious Incident Requiring Investigation (SIRI) which met the standard investigation criteria	14 (4 are #NOF)
	Patient Safety Incident Reviews	Includes moderate harm incidents meeting requirements for Standard Duty of Candour, not meeting SIRI criteria	200
		Coroner imitated patient safety investigations	0
		Root Cause Analysis Reviews for level 3 and above incidents: Pressure Ulcers, Falls, Infection control, VTE, Blood transfusion	151
	Patient Safety Incident Validation	Patient safety incidents of low/no harm requireing validation at ward/ department level.	17130
Note: Data from 1st April 2022 - 31st March 2023			

Our patient safety incident response plan: **national requirements**

Patient safety incident type	Required response	Anticipated improvement route
Never Events Criteria	PSII Systems Review	MRI
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	PSII Systems Review MDT	MRI
Deaths of person with learning disability	Structured Judgement review – Refer to Learning Disability (LeDer) Review Programme	LeDer programme
Deaths of a patient detained under the Mental Health Act and care delivery problems have been identified	MDT PS11 Systems review	MRI/ GMMH
Child Death	Refer to child death process- High Impact Learning Assessment (HILA) and PSII if required	MRI/RMCH
Safeguarding Domestic homicide Abuse/violence	Refer to local authority.	MRI Safeguarding leads Group Safeguarding panel

Our patient safety incident response plan: **local focus**

Through this review, we have identified the following local events we must investigate through a PSII in addition to the national 'must dos':

Through our analysis of our patient safety insights, based on both thematic analysis and the incident review, we have determined six patient safety priorities we will focus on for the next two years. These patient safety priorities form the foundation for how we will decide to conduct Patient Safety Incident Investigation (PSII) and patient safety reviews.

The patient safety priorities were approved at the Quality and Safety Committee on 8th August 2023 and form part of the MRI Quality and Safety Work Plan. Delivery of these priorities will be monitors through the MRI Governance Processes as a key process within the MRI Quality and Safety Committee meeting structure.

	MRI Patient Safety Priorities MRI Priority	Required response	Rationale	Anticipated improvement route
1	Falls	SWARM HILA	Falls were the highest patient safety incident identified at the MRI Work has commenced on an improvement program based on learning opportunities identified	Falls Academy
2	Nutrition and Hydration	HILA	Nutrition and Hydration is a risk identified on the MRI Risk register and is a theme through SIRI panel and incident reporting	Nutrition and Hydration Academy MRI Fundamentals of care
3	Infection Prevention	HILA AAR PS11 Systems Review	Infection Prevention is identified as a risk on the MRI Risk register. Identified as a priority via reported incidents and complaints	Infection Prevention Academy MRI Fundamentals of care
4	Procedural Safety	PS11 Systems Review Walk Through	The introduction of the HIVE (electronic patient record) system in September 2022, introduced a number of changes in the way procedural safety is carried out and recorded As the system becomes business as usual it has been identified as a priority to audit	Audit outcome and learning
5	Patient Journey	PS11 Systems Review AAR	Patient journey is identified on the MRI Risk register for Urgent and Planned care Improvement program commenced	Transformation program
6	Medicines Safety	HILA PS11 Systems review Walk Through	Medicines safety is a risk identified on the MRI risk register. Incidents and complaints indicate that medication and medicines errors are a patient safety concern	Medications Safety Academy MRI Fundamentals of care

Appendix 1

PSIRF Terms and abbreviations

PSIRF - Patient Safety Incident Response Framework
National investigation framework to which all Trusts must implement by Autumn 2023.
promotes a range of systems-based approaches for learning from patient safety incidents rather than traditional methods that look to identify a single cause

PSIRP - Patient Safety Incident Response Plan
The plan which sets out the key patient safety priorities for each organisation based on insights gathered from a range of sources

DOC - Duty of Candour
health and care professionals must: tell the person (or, where appropriate, their advocate, carer or family) when something has gone wrong. apologise to the person (or, where appropriate, their advocate, carer or family) offer an appropriate remedy or support to put matters right (if possible)

HILA - High Impact Learning Assessment
Completed following a high scoring patient safety incident to identify areas of learning leading to improvement

PSII- Patient Safety incident investigation
An in depth review of a single patient safety incident to understand what happened and how

SWARM
swarm-based huddles are used to rapidly identify learning from patient safety incidents. Immediately after an incident, staff. 'swarm' to the site to quickly analyse what happened and how it happened and decide. what needs to be done to reduce risk.

AAR - After Action Review
A structured facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from what was expected and the learning to assist

MDT - Multidisciplinary team
Review led by team made up of professionals from multiple disciplines to aid a rounded discussion

WALK THROUGH
Tool used to look at the steps in the process which may have led to an incident or event to identify where there may be a gap/omission/ or weakness in process

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Local Care Organisation

Patient Safety Incident Response Plan

2022-2025

Safety Differently

Manchester Trafford

Effective date: September 2023
Estimated refresh date: September 2024

	Name	Title	Signature	Date
Author	Caroline Greenhalgh	Associate Director of Quality Governance		4th August 2023
Reviewer	Quality and Safety Committee (Quality Priorities)			19th July 2023
Authoriser	Sohail Munshi	Chief Medical Officer		8th August 2023

Contents

Introduction

This patient safety incident response plan sets out how Manchester and Trafford Local Care Organisations intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Our Services

Around 5,000 staff make up Manchester and Trafford's adult and children's NHS community teams and adult social care teams. They include district and community nurses, social workers, health visitors, therapists, care staff, support staff and many other health and care professionals. Our staff serve a population of over 820,000 people across Manchester and Trafford.

Our services support the very youngest, with services such as the Vulnerable Baby Prevent & Protect Service and Health Visiting Teams; to those nearing the end of their life with our Macmillan teams.

We have prevention teams and rehabilitation teams. We have also established innovative new ways of working to support the most complex cases, with our Active Case Management Service and Trafford Rapid Response Urgent Care Therapy Team.

Many of our services prevent people from being admitted to hospital and/or enable them to be safely discharged from hospital, including our Home Intravenous (IV) team, Hospital at Home pilot and Manchester Community Response Teams.

We take a neighbourhood approach to care as we understand that people require care as close to home as possible. We know that local areas have different requirements. This neighbourhood approach is based on dividing Manchester into twelve neighbourhoods and Trafford into four, each containing 30-50,000 people. This enables us to tailor care to local needs. We also provide a range of specialist services across the four wider localities (North, Central and South Manchester and Trafford) and city-wide to support people in the community.

Defining our patient safety incident profile

The plan has been developed in partnership with colleagues across Manchester and Trafford through engagement through existing structures and alignment with operating plans across Manchester and Trafford. A range of insight has been used to inform the patient safety profile.

Figure 1: Insight sources

Manchester and Trafford Local Care Organisations provide community health services including:

- District Nursing
- Health Visiting
- School Nursing
- Manchester Crisis Response
- Trafford Crisis Response
- Podiatry
- Musculo skeletal Services (MSK)
- Community Neurological Rehabilitation
- Community Stroke therapy
- Pulmonary Rehabilitation
- Nutrition and Dietetics
- Children's Community Nursing including complex and palliative care
- Children and Young People's Occupational Therapy
- Children and Young People's Physiotherapy
- Community Paediatrics
- Community Dental Services
- Intermediate Care
- Bladder and Bowel Services
- AAA (Abdominal Aneurysm) Screening
- Falls Service
- Palliative Care and End of Life Service
- Manchester Care Management
- Treatment Room
- Childrens Orthoptic Service
- Childrens Asthma Service
- Community Learning Disability Service
- Sickle Cell and Thalassemia Services
- Audiology
- Medicines Optimisation Service
- Speech and Language Service
- Tissue Viability
- Specialist Weight Management Services
- Combined ADHD Services
- Phlebotomy Service

This list is not exhaustive. For a complete list of services Manchester and Trafford Local Care Organisations provide please follow the link to the websites:

https://www.manchesterlco.org/

https://traffordlco.org/

LCO services carry out an average of 115,349 care contacts every month. The LCO has reported 6398 incidents (June 2021 – May 2023), of these less than 0.1% are moderate or serious harm incidents or incidents resulting in death. Falls and pressure damage make up 100% of the serious incidents reported. The LCO received 41 formal complaints in 2022 – 2023.

A long list of priorities was derived from the sources of insights outlined in figure one. These were further refined to understand where the biggest impact can be made for those priorities that are within the gift of the LCO. For example, discharge as a whole is not included as a LCO only priority as this requires a system response to improvement. The priorities agreed at Quality and Safety Committee in July 2023 are set out below:

1. *We will provide harm free care by ensuring safe and effective assessment of risk and management of pressure damage within our services.*
2. *We will provide harm free care by ensuring safe and effective assessment of risk and management of falls care within our services.*
3. *We will provide safe and effective management of medication for our patients by increasing the number of error free prescribing interactions*
4. *We will provide safe and effective management of medication for our patients by increasing the number of error free administration interactions.*
5. *We will ensure that medication is stored and destroyed safely*

Defining our patient safety improvement profile

Figure 2 shows the large scale change programmes the LCO is leading. Long term conditions, the resilient discharge programme and the children's transformation programme are system level programmes that the LCO are leading on behalf of the system.

The community health transformation programme is a LCO wide programme to review the current commissioned service to ensure equitable services are provided.

The pressure damage reduction programme has delivered improvements in the management of pressure damage to patients being cared for at home and within our bed based care. This programme will continue throughout this year alongside the wound care improvement programme. The medication management improvement programme consists of smaller discreet programmes of work to look at different elements of the medication management processes. The falls improvement programme forms part of a large MFT wide programme.

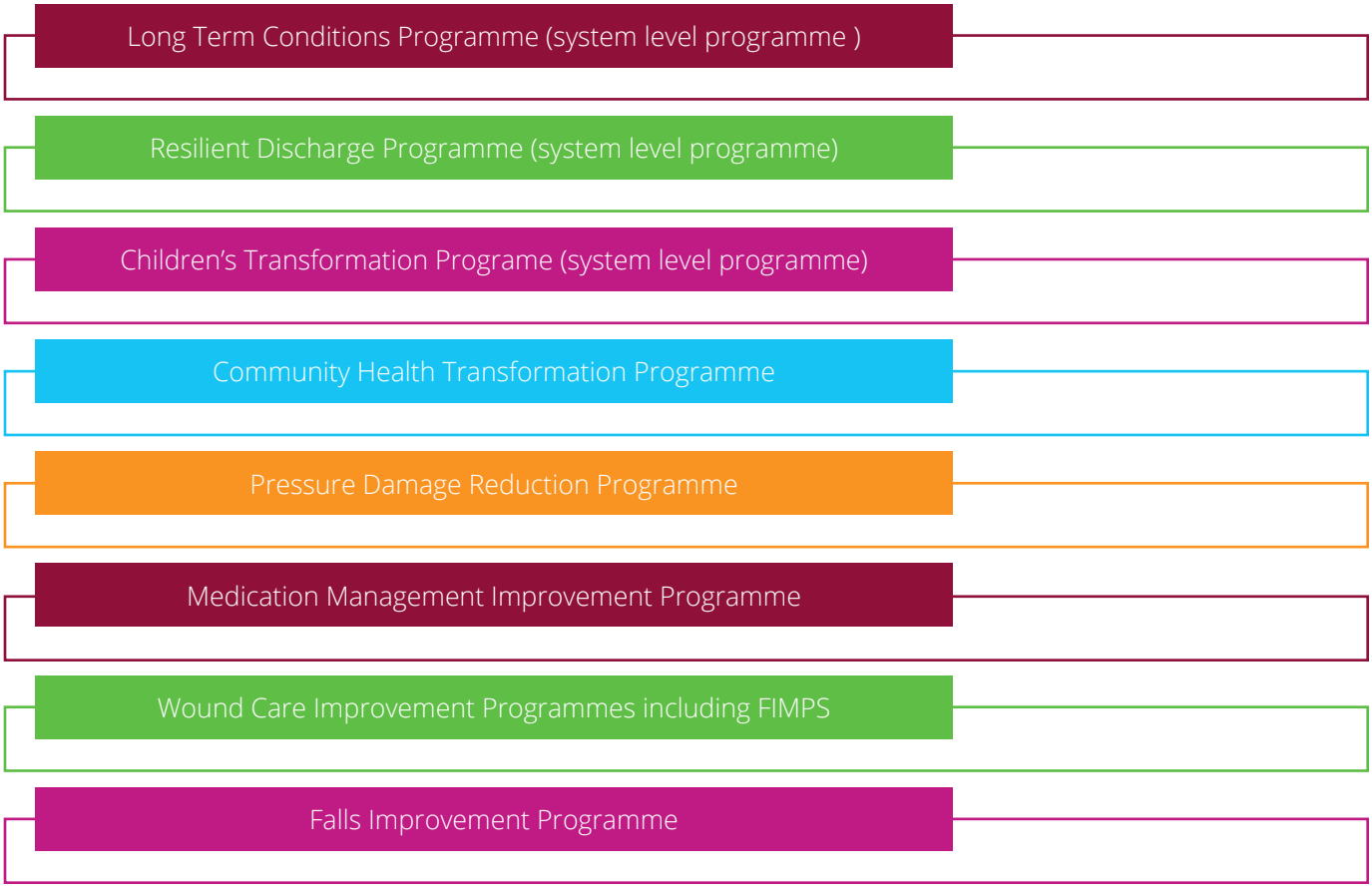

Figure 2

Our patient safety incident response plan: **national requirements**

Patient safety incident type	Required response	Anticipated improvement route
Never Events Criteria	PSII	Existing improvement work-streams that are specific to the never event through the Group and local structures
Death thought more likely than not due to problems in care (in-cident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	Structured Judgement Review/PSII	Learning from Deaths Group. Align improvement actions to specific improvement work-streams
Deaths of person with learning disability	Referred to LeDeR	LeDeR committee
Safeguarding incidents	Refer to Local Authority Safeguarding Lead for appropriate response on a case by case basis	Safeguarding Partnership
Incidents in NHS screening programmes	Refer to local quality assurance service for consideration of appropriate learning response	Existing speciality improvement workstreams

Our patient safety incident response plan: **local focus**

Through our analysis of our patient safety insights, based on both the original thematic analysis and the updated incident review, we have determined the patient safety priorities we will focus on for the next year. These patient safety priorities form the foundation for how we will decide to conduct Patient Safety Incident Investigation (PSII) and patient safety reviews. The patient safety priorities were agreed at the Quality and Safety Committee in July 2023.

Patient safety incident type or issue	Planned response	Anticipated improvement route
Pressure damage	Thematic review/PSII	Pressure damage improvement workstream led by Head of Nursing (Adults) and Lead Nurse – IPC and Tissue Viability
Medication administration	Thematic review/PSII	Medicines Management Group
Medication prescribing	Thematic review/PSII	Medicines Management Group
Medication storage and destruction	Thematic review/PSII	Medicines Management Group
Falls	SWARM	Falls Improvement Group

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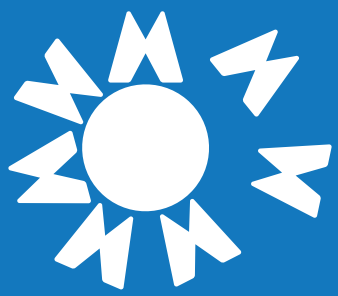
Patient Safety Incident Response Plan

2022-2025

Safety Differently



Report of:	Sue Langley - Director of Nursing and Health Professionals, CSS Sarah O'Shea - Medical Director, CSS
Paper prepared by:	Donna Egan - Quality and Safety Lead, CSS
Date of paper:	29/11/22, updated April 2023, updated July 2023.
Subject:	CSS/MCS Patient Safety Incident Response Plan (PSIRP) 2022-2023
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support ✓ • Resolution • Approval ✓
Consideration of Risk against Key Priorities	Indicate which by ✓ • Clinical Outcomes ✓ • Safety ✓ • Patient Experience ✓ • Staff Engagement ✓ • Operational Efficiency Measures
Recommendations	To note the contents of this paper and approve the recommended safety priorities for 2023/24 ahead of formal sign off at the CSS Quality and Safety Committee Meeting in March 2023.

Clinical and Scientific Services Patient Safety Incident Framework Plan 2022-23

1 Overview

1.1 The National Patient Safety Incident Response Framework (PSIRF) published by NHS England/Improvement, focuses on developing the capability and capacity of healthcare organisations to respond to and learn from patient safety incidents, and patient safety in general, in a different way to approaches that have been used historically.

1.2 The National Patient Safety Framework, which was launched in September 2022, sets out the requirement for all healthcare organisations to develop their own Patient Safety Incident Response Plan (PSIRP) and develop localised plans for improving safety cultures across their organisation.

1.3 Due to the size and structure of Manchester Foundation Trust (MFT), it has been agreed that there will be a Group level PSIRP which will outline the priorities of the Trust as a whole, and each Hospital/Managed Clinical Service (MCS) will hold its own localised PSIRP, that is aligned to localised patient safety priorities.

2 CSS Patient Safety Priorities

2.1 MFT's Clinical Scientific Services (CSS) is a Managed Clinical Service with 6 Divisions, Anaesthesia, Critical Care and Perioperative Medicine, Allied Health Professionals (AHP), Imaging, Laboratory Medicine, Infection Prevention and Control/ Tissue Viability and Pharmacy, providing specialist services across all MFT Managed Clinical Services, Hospitals and Local Community Organisations in multiple specialities.

The following services are managed by CSS:

- Adult Anaesthesia for all specialities including the Pain Team (MRI, Wythenshawe, Trafford, UDHM, St Marys, NMGH) [1]
- Adult Critical Care Units and Outreach Teams (MRI, Wythenshawe, NMGH, Trafford)
- Resuscitation & Simulation Training Team
- Acute Care Team
- AHPs (all sites [2])
- Adult AHP Community Services (MLCO) [3]
- Adult Bereavement Services (all sites)
- Infection Control and Tissue Viability including all medical and nursing staff (all sites)
- Laboratory Medicine/Pathology (all sites)
- Medical Examiner Department
- Mortuary and body store (all sites)
- Medical Engineering and Maintenance (MEAM) all sites and community
- Pharmacy including Adult and Paediatric Services (all sites and community delivery service)
- Imaging (all sites) including Nuclear Medicine and Neurophysiology including Adult and Paediatric Services (all sites)

[1]Some support to paediatric anaesthesia at NMGH- under review
[2]Small specialist AHP teams at WYT and RMCH are out with CSS. ~ 1wte
[3]Some AHP services also site within the LCO

Each Division has identified Quality and Safety Leads as noted in Table 1:

Division	Quality and Safety Leads
Imaging	Andrea Brammer Ananth Ganapathy (Clinical Lead)
Pharmacy	Paul Griffiths - ORC Laura Costello -WTWA
DLM/Pathology	Andrew Sayce Fay Parkin Leena Joseph (Clinical lead)
Allied Health Professionals (AHP)	Samantha Breen Sarah Houghton Sue McCormick
Anaesthesia, Critical Care and Perioperative Medicine	Paul Lancaster (Anaesthesia Clinical Lead ORC) Nick Wisely (Anaesthesia Clinical Lead WTWA). Will Scott (Lead Nurse WTWA and NMGH Sherly Udeshi (Lead Nurse ORC) Richard Templeton (Clinical Lead CTCCU/CICU) Shoneen Abbas/ James Hanison (Clinical Lead ICU ORC) Tracy Duncan (Clinical Lead ICU NMGH)
IPC/TV	Michelle Worsley (Assistant Chief Nurse IPC) Rajesh Rajendran (Clinical Lead)

There are departmental leads identified to support the Divisional Quality and Safety Leads in all areas.

3 Focus and Vision

3.1 Our vision for Clinical and Scientific Services as set out in the CSS Quality and Safety Strategy 2023-2026 is to improve patient safety. This vision also mirrors that of the Trust to ensure continuous improvement in patient safety.

One of our key areas of focus for CSS is to ensure our integrated services support the MFT Group- Hospitals/MCS/Local Care Organisation (LCO) by improving quality and safety throughout our Managed Clinical Service.

Our ambition set out in the CSS Quality and Safety Strategy aligns with the Trust vision to be nationally and internationally recognised as a leading health care provider as well as to optimise the future health and wellbeing of our patients. We will support the Trust Patient Safety Plan 2023/24 by providing the assurance that we are delivering the vision and priorities set out.

This will be provided through the MCS meeting governance structure and our Patient Safety Plan 2023/24 which will include:

- The co-ordination of the effective implementation of the PSIRF
- The implementation of the Patient and Public Involvement in Patient Safety Framework and the National Standards for Patient Safety Investigations
- The achievement of the objectives set in the Group Quality and Safety Strategy
- An effective response to the findings of external reviews
- An effective response to the opportunities for improvement

The MCS monitor and manage performance through a range of key metrics:

- MCS quality and safety dashboard – to be developed
- CSS KPI and Performance Scorecard Reviews e.g., infection prevention KPI
- MCS accountability and oversight framework (AOF)
- IQP data underpinned by quality audit data and patient experience data, including complaints
- Accreditation – national and internal
- National Benchmarking against recommended peers (e.g., Shelford, ICNARC)
- Peer reviews
- Mortality reviews
- Workforce metrics e.g., Pulse Check and National Staff Survey
- National bodies feedback e.g., CQC report, MHRA, KPMG
- Harm Free Care e.g., falls, pressure ulcer and medication safety

3.2 We continue to develop opportunities to lead on research and drive service transformation to sustain continuous service improvement informed by our patients, stakeholders and workforce. CSS realises the benefits of the Single Hospital Service by promoting internal benchmarking and encouraging shared learning to ensure all our patients get the best quality of care experience. The MCS will contribute from all relevant professions to the cross cutting clinical standards groups, which will underpin this vision driving high standards across sites and services.

3.3 CSS demonstrate commitment to high standards through achieving accreditations from external bodies such as ACSA[4], CQC[5], MHRA[6] and QSI[7]. Each area has achieved the required accreditation standards, Critical Care was rated outstanding by the CQC in 2019.

Our values and behaviours and a safety culture will ensure quality and safety are everybody's business, to deliver the best patient outcomes and experience every time. Our work is underpinned by our commitment that 'Together Care Matters' and this is underpinned by our values and behaviours framework which sets out four values:

This framework creates a compassionate inclusive approach to achieving a culture that enables excellence and optimises the quality of care we deliver. Success is measured against the Accountability Oversight Framework (AOF) domains and used in conjunction with the CSS Quality and Safety Strategy 23-25 to ultimately ensure:

1. Our care is safe: we continuously, systematically, and consistently prioritise patient safety in everything we do.

2. Our care is effective: our patients are provided with the best possible clinical outcome based on their individual circumstances and vulnerabilities and ensuring we learn when care is not of the standard we would expect.

3. We are caring; respect, dignity, kindness and compassion and the protection of vulnerable service users are at the core of our service provision.

4. Our care is responsive: our services are quick and convenient to use and responsive to individual needs. We will ensure the patient / family voice is heard and they are involved is supporting patient safety utilising feedback from different sources including CSS Patient safety specialists.

5. We are well led: this strategy is underpinned by high quality leadership with clear focus on staff support and wellbeing.

6. We make our data count and measure for improvement and demonstrate a culture of continuous improvement and learning.

7. We are confident that our care is of high quality, and we understand, contextualise, and manage risk consistently and provide assurance.

[4]Anaesthesia Clinical Services Accreditation
[5]Care Quality Commission
[6]Medicines and Healthcare products Regulatory Agency
[7]Quality Standard for Imaging Accreditation

3.4 Clinical and Scientific Patient Safety Plan

The CSS Patient Safety Plan has been developed to support the Group Patient Safety Plan to move towards the National Patient Safety Framework and the priorities for 2023/24 are summarised by the following key action points:

1. Improving Patient Safety by improving the safety of the care we provide to our patients and improving the experience for patients, their families, and carers wherever a patient safety incident or the need for a PSII[8] is identified.

2. This will be achieved by focusing on aligning with the National and MFT Group workstreams to implement the Patient Safety Incident Response Framework based on 4 pillars which include the implementation of Safety 2 methodology, applying the learning from excellence, what went well, implementation of focused safety huddles and training in areas such as human factors which will feed into how and when risks are identified.

3. Improving Staff Engagement and Reporting Culture by improving the use of valuable healthcare resources and improving the working environment for staff in relation to their experiences of patient safety incidents and investigations.

4. This will be achieved by focusing on learning from best practice, celebrating excellence and supporting through the investigation process providing a real time response to incidents focussing on processes rather than individuals.

5. Patient safety incidents and hospital level risks for CSS/MCS have been profiled using organisational data from recent patient safety incident reports, complaints, freedom to speak up reports, patient safety incident investigations, (PSIIs), mortality reviews, case reviews, systems investigations, staff survey results, claims, staff suspensions and risk assessments.

6. The national PSIRP template requires CSS/MCS to use localised safety profiles to develop up to ten key priorities in relation to patient safety. The purpose of this exercise is to move from a reactive approach to patient safety, which risks themes and trends being missed, to a proactive approach that delivers focused learning in areas in which incident reporting is higher than expected levels to drive improvement.

[8]Patient Safety Incident Investigation
[9]When work went well

3.5 Patient Safety Priorities

During the period 01/04/2020-31/03/2022 just over 11,000 incidents were reported within CSS services. In total during this period there have been 18 serious incidents reported to the Strategic Executive Information System (StEIS)[10]. The Highest 6 reported incident categories were Clinical Assessment, Pressure Ulcers, Medication, Infrastructure (inc. Staffing), Access, Admission, Transfer and Discharge and Patient Care. Medication, Infrastructure (inc. Staffing), and Access, Admission, Transfer and Discharge all exhibited increases following the covid recovery with upper confidence special cause variations present in Feb / March 2022.

As shown below in table 3, the CSS/MCS safety profile has identified 8 incident categories which require an increased focus in relation to patient safety and application of improvement methodology. The 8 priority categories have been determined through a review of CSS/MCS incident numbers between 2021-2022, using statistical process control charts (SPC)[11]. SPC analysis allows for a greater understanding of themes by using the mean ratio of incident reporting within each category. The mean ratio is then used as a marker to determine if there is an increasing or reducing risk in these areas.

Due to variables in data which can be caused for a number of reasons, such as seasonal peaks in activity, an accepted upper and lower control level is applied, which if breached, have undergone further scrutiny to understand the reason behind the special cause variation (SCV). An example of this was around pressure ulcer SCV. This was investigated and found to be due to the acuity of the COVID positive patients within the critical care environment during the peak of COVID 19. Another example was an increase in SCV in Access, Admission, Transfer, Discharge incidents related to patient flow and capacity vs demand for CSS services. As a result of having this oversight, quality improvement projects are targeted to improve these pathways and risks to patient safety are identified early.

It should be noted, that of the 8 categories identified, all are areas which have been previously highlighted across several CSS/MCS forums, the previous PSIRP and many already align to improvement work taking place across CSS/MCS. This is a positive reflection of CSS/MCS level of insight into its patient safety priorities and provides assurance that the MCS is already working towards delivering focused and proactive learning. Risks and challenges have been articulated and targeted improvement workstreams are in place.

[10]NHS England system used to report and monitor serious incident investigations
[11]Statistical process analysis- a tool widely used in the NHS to understand whether change results in improvement.

Table 3 CSS Patient Safety Priorities 2022/23

	Incident type	Speciality
1	Access, Admission, Transfer, Discharge - including delayed scan, discharge planning intrahospital/ external transfer	ACCP, AHP, Imaging, Pharmacy
2	Checklists/ LOCSIP	ACCP, Imaging
3	Infection/ Sepsis - Acquisitions	ACCP, DLM, IPC, Pharmacy
4	Pressure Ulcers	ACCP, DLM, TVN
5	Medication Errors - Administration, Storage and Dispensing	Pharmacy, ACCP
6	Missed/ Delayed Diagnosis/ Treatment or Procedure Delay/ Delay in Recognising Complication – Including Imaging Delayed Diagnosis	Imaging, DLM, ACCP, AHP
7	Communication Failure	CSS-wide
8	Treatment/ Procedure Delay/ Failure - Including Nutrition and Hydration and Blood Transfusion.	Imaging/ DLM/ ACCP/ AHP

The recommended areas of focus as set out in table 3, will direct the CSS/MCS patient safety priorities from Spring 2022 into 2023 and will lead to several initiatives being implemented across a number of areas. These will include.

- The development of a CSS/MCS Safety Oversight System (SOS) – meetings commenced August 2022 with CSS Governance Team and divisional governance leads. Initially to discuss groupwide priorities highlighted through the Group SOS that impact on CSS services.

- Development of training on new methodology - ongoing workstream through presentation of methodology to Divisions and CSS Governance Team support to undertake investigations. Learning through doing/ in action approach has been taken by the CSS Governance Team due to the delay in the national offer. The AQUA[12] human factors training availability has been shared with teams and the e-learning for health programme to support PSIRF nationally is now on the learning hub for staff to access (level 1 and 2 only- awaiting levels 3-5). Current pressures due to rollout of HIVE electronic patient record (EPR) are impacting training but it is expected this will start to increase once this is embedded.
- Increased incident surveillance and use of SPC charts in those areas identified as a patient safety priority. Alignment of incidents, complaints, claim, and litigation themes being undertaken which continues to align with the priorities as set out in table 3. This is fed into the monthly CSS Quality and Safety Committee and quarterly Risk and Audit Committees to bring these themes together in a meaningful way to start improvement conversations and socialise teams to PSIRF methodology.
- A focus on integrated and shared learning. Safety II increased focus to support learning from what went well. Feedback of shared learning being undertaken through Quality and Safety committees locally, at MCS and Group level. Renewed focus on audit compliance and assurance requirements and linking in to PSIRP categories and early identification of risk.
- Focused learning reviews and improved cross site and MDT engagement in response to incidents which sit within the 8 categories identified for an increased safety focus. Increasing number of incidents and learning opportunities investigated using the High Impact Learning Assessment (HILA) approach since the implementation of the methodology in April 2021. Learning is identified much earlier in the process and actions put in place to mitigate which is shared. There is also increased focus on support for staff, just culture and safety culture. Being open and transparent with patients/ family including ensuring patient/ family involvement in development of terms of reference for investigations and good quality duty of candour discussions is also a focus.
- The use of quality improvement methodology to develop specific patient safety projects which are targeted in the 8 areas identified. Where themes have been identified from multiple incidents CSS have worked with Group and other sites /MCS but also within Divisions to extract quality learning and improvement.
- Enhanced monitoring and provision of assurance of the impact of interventions to ensure that they remain in place and are effective. Work is in place to continue in this area to provide tangible evidence of improvement and provide assurance for all investigations, not just higher impact or Never Events and we will regulate our Key Performance Indicators (KPI's) against CQC standards going forwards. There has been an increased focus on inquest assurance with reports being provided ahead of inquest that bring together the assurance related to associated incidents, complaints and identify risks and mitigation.

3.6 Challenges

There have been numerous challenges to the implementation of the PSIRP within CSS over the past 12 months. MFT commenced rollout of the Patient Safety Incident Response Framework in April 2021 and CSS developed a PSIRF plan.

In that time the number of investigations has increased rather than decreased as teams identify high impact learning related to incidents or outstanding practice. The impact of COVID, competing priorities on staff time such as the roll out of HIVE EPR and the delayed training offer has made it difficult for teams to sustain the number of investigations currently being undertaken and provide assurance on feedback and shared learning with the resources available.

[12]Advancing Quality Alliance

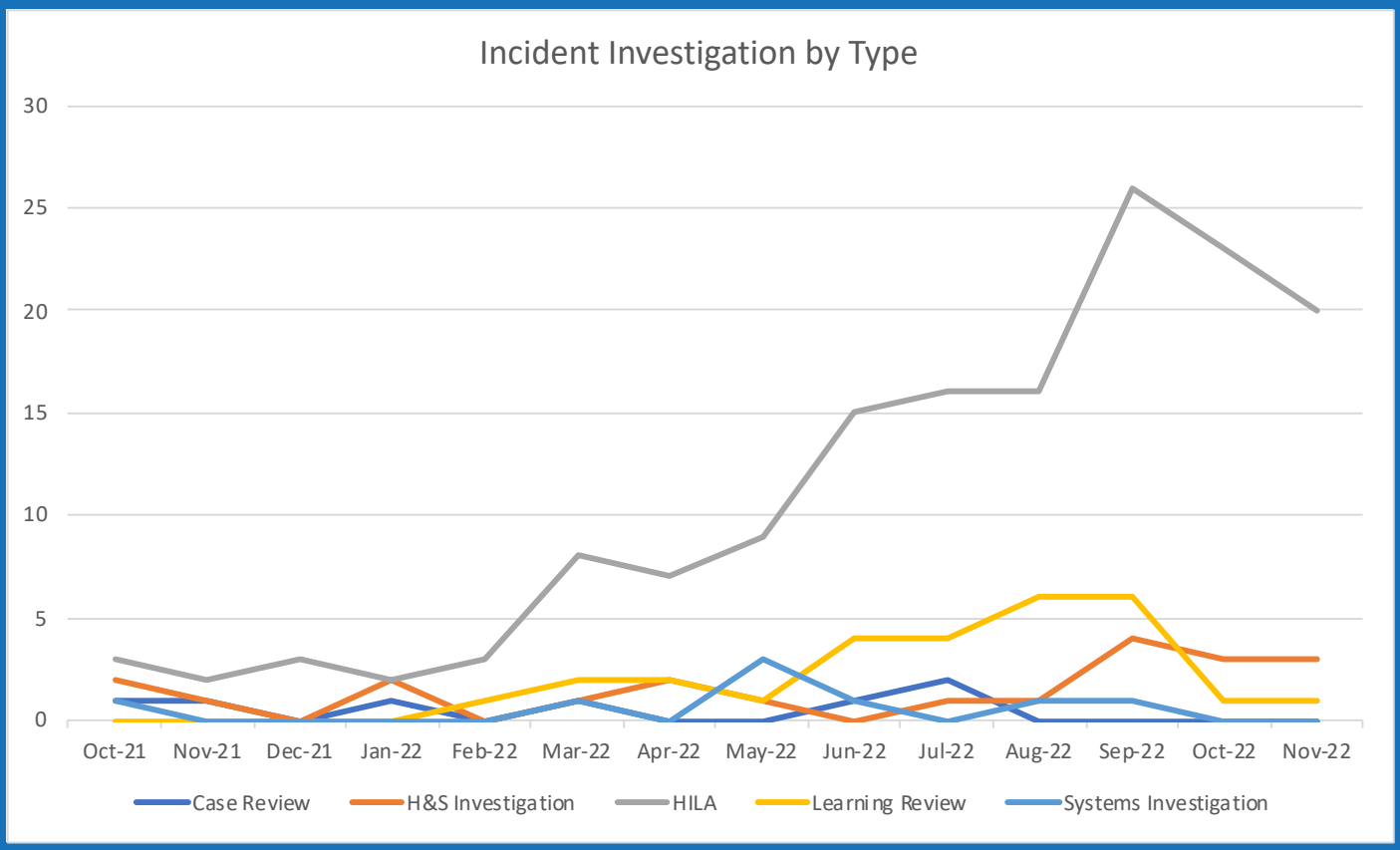
As we move towards increasing Safety II focus this in the short term will become increasingly difficult to maintain. Longer term as improvement projects are instigated the aim is that Safety I (harm) type investigations should become less frequent.

In addition to categories/ priorities outlined in the PSIRP (table 3) for CSS, any Safety I (actual harm /near miss) or Safety II (when things go well or are outstanding) incidents where learning is identified or mandated due to statutory requirements such as RIDDOR, SHOT, HTA, PHE or IRMER reporting requirements has meant that CSS has seen a marked increase in investigations, although teams have highlighted that the HILA approach is a better method from the perspective of time required and extracting learning to improve safety.

4 Situational analysis – CSS

4.1 Results of a review of activity and resources has been undertaken to look at the numbers of investigations undertaken since April 2021, to assist in estimating the resources required to undertake future investigation using the new methodology focusing on high impact learning rather than causation (root cause).

CSS Incident Profile - Numbers of Incidents Investigations and Type. The data below demonstrates that using the new methodology of also looking at Safety II, i.e., Near misses or no harm incidents, where lessons can be learnt, or good practice can be shared. It is noted that there has been an increase in investigations for 2022 from previous data used to estimate resource requirements.



Each type of investigation has a different resource requirement in terms of time, numbers of staff involved from both clinical teams and CSS Governance and which grade staff are required to complete the investigation. As demonstrated in Chart 4 this requirement is increasing.

Further work is required to understand training that is available and its implementation including mapping training requirements of staff involved in investigations. This includes use of statistical process control (SPC) methodology and data analysist support requirements.

As part of PSIRF implementation a review of resources utilised is required to be undertaken. The tables below (pages 10-13) give an overview of previous activity and estimated resources used for investigations previously undertaken as requested by Group.

Table 5. Patient safety incident investigation (PSII) activity: Mar 2018 to Mar 2022:

Table 5	2018-19	2019-20		2021-22	2022-23	Ave
Never Events	2	1		3	6	3↑
Serious Incident investigations (ie StEIS[13] reportable)	13	15		15	18	15.3↑
'Coroner-initiated' patient safety investigations	0	1		0	1	0.5↔
'Coroner-requested' signed statements following patient safety incidents	Not recorded	Not recorded		Not recorded	Not recorded	-
Patient/Family/Carer complaint-initiated patient safety investigations	Not recorded	1		0	1	0.5
Other PSIIs[14] (currently classed as ward, department or directorate-level root cause analyses)	4	6		13	32-3 or more harm	13.75↑
Incidents investigated locally but including/requiring a funded independent specialist on the investigation team	0	0		0	0	0
Independent PSIIs sourced and funded directly by the local provider	0	0		0		0
			2021-22	**Total**	**38**	**28***
Incidents referred (to HSIB[15]/Regional independent investigation teams (RIITs)/PHE[16], etc.) for independent PSII	0	0	0	0		0
Independent PSIIs commissioned nationally or regionally on behalf of the local provider	0	0	1	0		1
				Total		1

*Note year on year increase due to increasing CSS footprint.

[13]Strategic Executive Information System
[14]Patient Safety Incident investigations
[15]Health and Safety Investigation Branch
[16]Public Health England

Table 6. Estimate of current Serious Incident (SI) resources: 2021, This is a draft snapshot baseline measure which has been estimated using 2021 investigation types as more representative of future investigation methodology. This will require future work regarding actual requirements regarding time and cost:

Table 6 For SI investigations	Frequency	Grade(s)	Hours/ year	-£/year
Patient safety team hours dedicated to SI-level PSIIs (investigators at approx. 6 hours each investigation)	50	Various band 7 and above	300	-
Risk management team hours dedicated to SI-level PSIIs (governance teams – 3 hours initial review and subsequent reviews, QA 1 hour,)	50	7 8	300	-
Complaints team resources dedicated to SI-level PSIIs	0	0	0	0
Patient Advice and Liaison Service (PALS) team resources dedicated to SI-level PSIIs	0	0	0	0
Duty of Candour/'being open' resource (if not included above) dedicated to SI-level PSIIs	59	8	50	-
SI-related PSII panels (governance lead) approx. 2 per week	26 per quarter	8	17	-
SI-level PSII leads (at panel)	26 per quarter	8	17	-
SI-related PSII team members/assistants	26 per quarter	7	17	-
SI-related PSII subject matter experts (at panel)	13 per quarter	Various 8 - consultant	8.5	-
Staff involvement in SI-level PSIIs- (statements, information gathering etc. 1 hour)	50	Various	100	-
Resources offering support of staff involved in SIs and throughout any subsequent SI-level investigation (2 hours)	50	Various 7- consultant	100	-
Resources offering SI-level PSII investigator support throughout an investigation	50	Various 8- consultant	50	-
SI-related PSII reviewers	n/a included above			-
Board/executive team sign-off of SI-level investigations	50	MD/ DON	50	-
Solution/improvement identification, design and development costs (action planning) – resulting from SI-level investigations (if not included above)	Currently not monitored	n/a	n/a	n/a
Solution/improvement implementation costs – resulting from SI-related investigations	Currently not monitored	n/a	n/a	n/a
Solution/improvement monitoring/review – resulting from SI-level investigations (if not included above)	n/a	n/a	n/a	n/a
Staff RCA[17]/PSII training time (SI level) (Basic HF and investigation training 2 consultants and 2 Nurse or AHP per division- year 1) 5x5=25 staff	3 days training per individual for leads	Cons Nurse or AHP Governance leads	550	-
PSII trainer time/training fees (for SI-level courses)	unknown	unknown	unknown	-

[17]Root Cause analysis

Table 7. Estimate of current non-SI resources: 2021, This is a draft snapshot, baseline measure which has been estimated using 2021 investigation types as more representative of future investigation methodology. This will require future work regarding actual requirements regarding time and cost:

Table 7 For non-SI investigations	Frequency	Grade(s)	Hours/year	-£/year
Patient safety team hours dedicated to ward/department-level non-SI-related PSIIs (divisional teams-at least 1 hour per day)	Daily monitoring	Band 6-8 to Consultant	varies	-
Risk management team hours dedicated to non-SI PSIIs (CSS Governance Team 1.5 hours a day- band 7 1 hour a day band 8)	Daily monitoring	7 8		-
Complaints team resources dedicated to non-SI PSIIs	0	0	0	0
PALS team resources dedicated to non-SI PSIIs	0	0	0	0
Duty of Candour/'being open' resource (if not included above) dedicated to non-SI PSIIs- some DLM incidents require DOC regardless of harm	32+ regulatory	Various 8 - Consultant	60	
Non SI-level PSII panels	0	0	0	0
Non SI-level PSII leads (3 hours each)	32	Various 8 - consultant	96	-
Non-SI-level PSII team members/ assistants	unknown	unknown	unknown	-
Non-SI-level PSII subject matter experts	unknown	unknown	unknown	-
Staff involvement in non-SI PSIIs	32	Various 8 - consultant	64	-
Resources that support staff involved in non-SI level incidents and throughout any subsequent investigation	32	Various 8- consultant	64	-
Resources that support non-SI PSII investigator throughout an investigation	32	Various 8 - consultant	32	-
Non-SI PSII reviewers	Included above	Included above	Included above	Included above
Board/executive team sign-off of non-SI investigations (45 mins average)	32	Medical Director/ DON	32	-
Solution/improvement identification, design and development costs (action planning) – resulting from non-SI investigations (if not included above)	Not measured	N/A	N/A	N/A
Solution/improvement implementation costs – resulting from non-SI investigations	Not measured	N/A	N/A	N/A
Staff training time for non-SI PSIIs	As for SI investigations			
Non-SI-level PSII trainer time/training fees	unknown	unknown	unknown	Unknown

5 CSS Data on Themes and work being undertaken

Current themes identified across the Group include transfer, delays in radiology reporting, inter hospital management of patients (including major trauma pathway and inter-specialty management), care for patients with a learning disability, NG[18] tube patients: delay in feeding, PCI[19] pathway (external), Femoral lines, use of checklists and second checker. Active surveillance is underway regarding each of these areas.

For CSS there are several areas where special cause variation is demonstrated and should be the focus of investigations moving forwards. See Appendix 1, for detail of incident themes from SPC charts and Ulysses data for further information.

The number of incidents that fall within the category of access, admission, transfer and discharge demonstrates special cause variation and is an area being explored regarding the cause of this variation, identify themes and any improvement work to be undertaken and this should be a focus for CSS investigations. See Table 1 for Divisions where these are applicable.

Within CSS there have been 7 never events since April 2021 which have been investigated with high impact learning identified and are in relation to safety culture and use of checklists. HIVE now has checklists within the system, and this should support an improvement in compliance. Also highlighted through a systems investigation into inadvertent use of an air flowmeter rather than oxygen was the enduring assurance related to patient safety alerts. Work is ongoing with the Human Factors Academy to utilise a safety culture tool to drive improvement, and this is a focus for CSS investigations as part of the PSIRP.

There was a special cause variation for medication incidents and work is ongoing to identify themes that have been discussed at the Group Safety huddle and panels to target improvement work and provide assurance. HIVE implementation has also impacted on this.

Special cause variation has also been noted for:

- Transfer/ discharge within Critical Care and is driven by patient flow and capacity vs demand issues. Patient flow is impacting on the ability for Critical Care to discharge patients within a timely manner and is leading to an increase in mixed sex breeches. Monthly KPI meetings are now established on the ORC, Wythenshawe and NMGH sites with work ongoing on the NMGH site to engage the hospital site teams and improve the reporting and escalation process on that site, in addition an updated escalation policy is in development.
- Treatment delay in Laboratory Medicine and Imaging further impacted since implementation of HIVE. Turnaround times (TATs) delayed due to capacity vs demand. A risk is now on the risk register regarding staffing MFT/001253 and MFT/006222, actions are in place to mitigate and escalated to GROC.
- There is a backlog of reporting radiology images, which is multifactorial. There is a nationally recognised lack of radiologists which results in a backlog of reporting, which is normally mitigated with a mixture of extra contractual lists and outsourcing to external reporting companies. The backlog appears to have significantly increased in examinations from September to October 2022.

[18]Nasogastric
[19]Percutaneous coronary intervention

The reason for the disparity is due to:

- Staffing – Multiple radiologist vacancies across the Trust and nationally.
- Technical IT problems resulting in the inability to outsource examinations. 'Cube' – funding has been approved – no date for installation.
- North Manchester Disaggregation – on 8th September 2022, MFT acquired a reporting backlog from Northern Care Alliance and no additional staff allocated with the acquisition of NMGH service.
- Demand vs capacity – increasing annual demand for radiology services in line with the national picture.
- HIVE deployment and rollout.
- Risk has been assessed at 16 and currently with SLT for review.

CSS SPC chart and complaint themes review, highlights the above areas that will require local focus for investigation, in addition to Group and National priorities as well as statutory requirements to investigate incidents in areas such as HTA[20], SHOT[21], IRMER[22], RIDDOR[23] and PHE[24].

7 Plan to roll out PSIRF

7.1 The CSS plan for the implementation of PSIRF started to roll out in April 2021 with engagement of the Divisional teams as well as the Executive Team. Each Division is still required to develop its own implementation plan and identified lead(s). To achieve readiness to be compliant with the PSIRF in CSS by September 2023 the principle of 4 pillars will be applied:

- Stakeholder mapping
- Discovery- identifying areas of focus regarding risk
- Training
- Implementation

In readiness for full implementation of PSIRF CSS will:

1. Identify areas for investigation including Safety I and Safety II investigation as outlined in Table 3. This has been underway since April 2021. Work is still required to move from investigation to improvement work around all themes which has been hampered by training issues, regulatory requirement for investigation and safety I incidents and capacity due to HIVE EPR rollout.

2. Implementation of Safety II methodology and increased scrutiny of excellence reports (new format to be confirmed) - applying the learning from what went well. Increased scrutiny of excellence within CSS since February 2022 but sharing of learning from group at CSS Quality and Safety Committee since April 2021. CSS Safety Oversight Huddle commenced in August 2022 and plan to share output from CSS specific Excellence Reporting to be implemented. Currently sharing good and outstanding practice which is raised at Group Huddle that is applicable within CSS to share learning.

[20]Human Tissue Authority
[21]Serious Hazards of Transfusion
[22]Ionising Radiation Medical Exposure Regulations 2017
[23]Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013
[24]Public Health England

3 Training – including Human Factors, simulation, patient safety specialists and making data count. See point 4.6 bespoke CSS sessions undertaken and Group Presentations at CSS Quality and Safety Committee. Patient Safety Specialists identified across each Division and CSS attendance at Group meetings to facilitate change. Training has been hampered by the delay in the national training provision being rolled out which has impacted on ability to roll out all aspects of the plan as detailed in point 8 below. Also provision of good quality patient, family feedback and duty of candour, ensuring staff have the skills and confidence to ensure investigations are inclusive and focus on what is required.

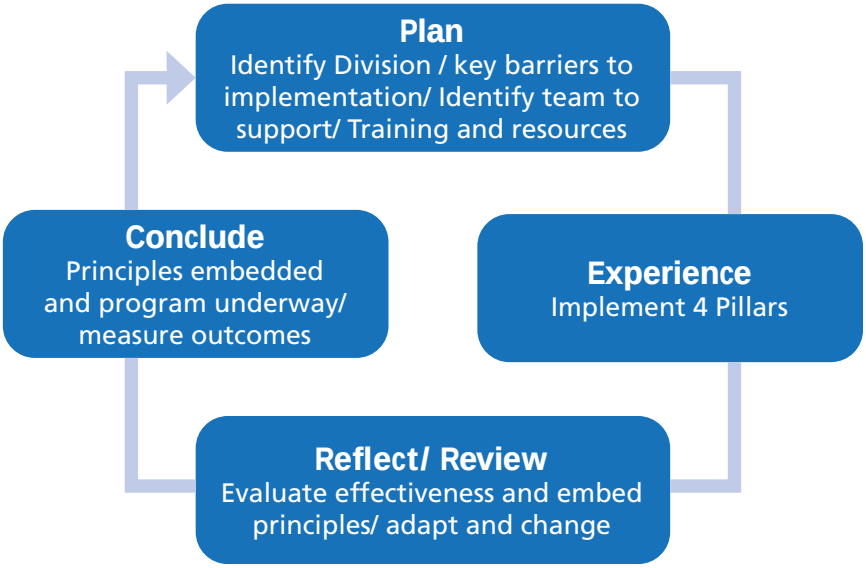
4 Implementation of Safety Huddles weekly, CSS wide initially using the safety oversight dashboard as a template and exploring the use of this template at divisional level. Due to capacity and COVID 19 pandemic and HIVE rollout this has been delayed but commenced in August 2022. Work is underway to identify specific key areas within the CSS Safety Oversight System (SOS) to mirror the Group work undertaken in this area and how to collate data whilst awaiting the Group electronic solution and data analyst support.

The implementation of the points above will support the following aims:

- Learning from best practice and sharing information.
- Providing a real time or rapid response to learning when things go wrong.
- Seeing a real difference - improvement in data, patient and staff experience, knowledgeable workforce, increased sharing of good practice.
- Increased oversight of safety issues that will be fed into local meetings and to staff on the frontline to ensure there is a real impact.
- Improving our safety culture - using culture tools and audit to demonstrate improvements.

The plan will also involve monitoring of data monthly for any outlying information that requires further investigation.

Chart 10. The Implementation Cycle



8 The Detail of the Plan

8.1 Implementation of Safety I and Safety II methodology

The CSS Governance Team have been working with divisional teams on completion of HILA and different types of investigations utilising the human factors methodology. This has moved the focus away from causation/ Root Cause Analysis to sharing of high impact learning, this is to support progressing the changing approach to patient safety.

To prepare staff for the implementation, presentations were undertaken by the Senior Group Quality and Safety Team at the CSS Quality and Safety Committee, to introduce the PSIRF and related methodology. Local sessions via teams have been undertaken to further enhance this work by the CSS Governance Team. The challenge is to now support divisional teams to communicate this message widely so that staff have the knowledge and psychological safety to report incidents and participate in investigations and know how to access support if they are involved in an incident.

8.2 Resources and Training requirement

The PSIRP for CSS has been shared at CSS Quality and Safety Committee and with CSS Patient Safety Experts to socialise staff to the methodology ahead of the launch in September 2022. This included information on the Trust plan for future investigations including Safety II work, training and resource requirements such as:

- SPC data analysis - resources will be required to implement this across all services within CSS, to make it relevant and make the real-time data count. CSS wide data will need to be scrutinised, and a dashboard developed with data analyst input (See Group Safety Oversight System- SOS) this should then move to local divisional data/ divisional dashboards to allow real time identification of statistical variation, identifying emerging negative trends and impact of improvements.
- Human Factors Methodology – to undertake human factors scoping exercise of Human Factors Academy (HFA) Members and Patient Safety Specialists in the first instance and identify training requirements. Resource requirements to provide training will require review.
- Patient Safety Specialists and Governance Leads require training in the principles of investigation using new methodology - HILA[25]/Case review/ Systems review etc., not only for patient harm but where things went well, this is an additional resource requirement.
- Training of teams in tools developed by the HFA - such as safe culture tool, simulation, project 2V[26] and debrief.
- Divisions should develop individualised training packages specific to their requirements.
- Applying the learning from what went well.
- Implement a plan to investigate and share good practice across the MCS and Trust where applicable, utilising SPC and other tools to measure for improvements and merge with current Quality Improvement methodology.

[25]High Impact Learning Assessment
[26]Second Victim

8.3 Implementation of Safety Huddles

Development of huddles, weekly CSS huddles set up (see Group SOS) plan to review regarding frequency and requirement for divisional huddles to share the information from Group Safety Huddle with teams and provide Group with oversight of any emerging issues, outstanding practice or risks within the MCS.

9 Conclusions and Recommendations

In conclusion, for CSS to comply with the Group and National requirements to fully implement PSIRF and improve patient safety, there is an increased requirement for monitoring, data analysis, oversight, sharing of high impact learning, training in the various methodologies that will be utilised and with that the resources to implement the plan. This will lead to benefits in timely identification of high impact learning to improve services across the MCS which can be shared across the Trust to promote shared learning. The introduction of PSIRF will promote benefits for patients and staff.

For patients and families, this process will enhance their experience and standards of care delivered and lead to a reduction of adverse incidents due to staff acquiring increased knowledge and skills. This will be achieved from sharing good practice rather than focusing only on when things go wrong. There will be a greater understanding of the factors that impact or influence the work they undertake every day and the potential impact, both positive and negative. This approach will help to engage and support staff and patients in the investigation process, in a less punitive or negative way and promote improved multidisciplinary team working across the Trust and facilitate patient or family involvement in the process.

The contents of this paper should be noted for approval regarding the recommended safety priorities for CSS in 2023/24.

SAFETY DIFFERENTLY
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NHS
Manchester University
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St Mary's Hospital

Patient Safety Incident Response Plan

2022-2025

Safety Differently

Effective date: August 2023
Estimated refresh date: August 2024

	Name	Title	Signature	Date
Author	Jen Sager	Assistant Director Quality and Safety SM MCS		
Reviewer	Sarah Vause	Medical Director		
Authoriser	Alison Haughton	Chief Executive Officer		

Contents

Introduction

Patient safety events are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare.

This patient safety incident response plan (PSIRP) sets out how Saint Mary's Managed Clinical Service which is part of Manchester University NHS Foundation Trust (MFT) intends to respond and seek to learn from patient safety incidents reported by staff and patients, their families, and carers as part of our work to continually improve the quality and safety of the care we provide.

Manchester University NHS Foundation Trust is an NHS Acute Foundation Trust which operates 10 hospitals throughout Greater Manchester. It is the largest NHS trust in the United Kingdom. The Trust was formed on 1st October 2017 following the merger of Central Manchester University Hospitals NHS Foundation Trust (CMFT) and University Hospital of South Manchester NHS Foundation Trust (UHSM), and more recently the acquisition of North Manchester Hospital.

Due to the size and structure of MFT, it has been agreed that there will be a MFT Group level PSIRP which will outline the priorities of the Trust as a whole, and each Hospital/Managed Clinical Service (MCS) will hold its own localised PSIRP, that is aligned to localised patient safety priorities.

Saint Mary's Managed Clinical Service is a centre of excellence for the provision of healthcare for women, children and families. Our four Divisions and one Directorate offer integrated secondary and tertiary services with strong research and innovation programmes.

Components of the Managed Clinical Service include:

- Maternity services
- Newborn services
- Gynaecology
- Genomic Medicine
- Sexual Assault Referral Centre

This plan will enable us to focus our patient safety improvement work in light of our local patient safety incident investigations (PSIIs) by:

- reviewing patient safety events in a holistic way focussing on learning, using data constructively and ensuring patients are at the centre of our safety improvement work
- integrating information from multiple sources and using a systems approach to identify interconnected causal factors and systems issues
- Focusing on addressing these causal factors and the use of improvement science to prevent or continuously and measurably reduce repeat patient safety risks and incidents
- transferring the emphasis from the quantity to the quality of PSIIs such that it increases our stakeholders' (notably patients, families, carers, and staff) confidence in the improvement of patient safety through learning from incidents
- demonstrating the efficacy of this approach by improving safety across our MCS

The patient safety incident response plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Scope

A PSIRP is a requirement of each provider or group/network of providers delivering NHS-funded care.

This document should be read alongside the introductory Patient Safety Incident Response Framework (PSIRF) 2022, which sets out the requirement for this plan to be developed.

The aim of this approach is to continually improve. As such this document will be reviewed every 12 – 18 months to ensure that the site plan remains appropriate to our changing patient safety profile.

There are many ways to respond to an incident. **This document covers responses conducted solely for the purpose of system learning and improvement.** There is no remit to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement

Responses covered in this plan include:

- Patient Safety Incident Investigations (PSIIs)
- Patient Safety Reviews (PSRs)

Other types of response exist to deal with specific issues or concerns. Examples of such responses include complaints management, claims handling, human resources investigations into employment concerns, professional standards investigations, coroners inquests or criminal investigations. The principle aims of each of these responses differ from the aims of a patient safety response and are outside the scope of this plan.

To be effective in meeting their specific intended purposes, responses that are not conducted for patient safety learning and improvement are separate entities and will be appropriately referred as follows:

- human resource (employee relations) teams for professional
- conduct/competence issues and if appropriate, for referral to professional regulators
- legal teams for clinical negligence claim
- medical examiners and if appropriate local coroners for issues related to the cause of a death
- the police for concerns about criminal activity

SM MCS Strategic Objectives

The MFT Group Quality and Safety Strategy sets the direction for the delivery of quality services within the Trust for the next three years. It supports and builds upon the Trust's proven delivery of high-quality services, whilst supporting its ambition for a continuous improvement of services and sustainable growth.

The Group Quality and Safety Strategy sets out an approach which aims to put quality right at the heart of everything we do. It ensures that quality services are delivered in the Trust in response to the specific requirements of our patients, carers, our staff, the public, our commissioners and regulators. Core to this Strategy is the Trust's values and related behaviours. This Quality Strategy describes a consistent and integrated approach to providing quality services across the Trust.

The Group policy has identified seven quality and safety aims to support the delivery of this strategy.

These aims are:

- **Our care is safe:** we continuously, systematically and consistently prioritise patient safety in everything we do
- **Our care is effective:** our patients are provided with the best possible clinical outcome based on their individual circumstances and demonstrate a culture of continuous improvement and learning
- **We are caring:** Respect, dignity, kindness and compassion are at the core of our service provision
- **Our care is responsive:** our services are quick and convenient to use and responsive to individual needs
- **We are well led:** this strategy is underpinned by high quality leadership
- We make our data count and measure for improvement
- We are confident that our care is of high quality and we understand, contextualise and manage risk consistently

Our patient safety incident response plan (PSIRP) sets out how Saint Mary's Managed Clinical Service (MCS) will seek to learn from patient safety events reported by staff and patients, their families and carers as part of our work to continually improve the quality and safety of the care we provide.

Our PSIRP will assist us to make more effective use of current resources by transferring the emphasis from the quantity of investigations to a higher quality, more proportionate response to patient safety incidents. The aim is to:

- make PSIIs more rigorous and, with this, identify causal factors and system-based improvements
- engage patients, families, carers, and staff in PSII and other responses to incidents, for better understanding of the issues and causal factors
- develop and implement improvements more effectively

We will also continue to foster a climate that supports a 'just culture' and an effective learning response to patient safety incidents.

Addressing Health Inequalities

When people already negatively affected by unfavourable social determinants of health seek care, healthcare itself may exacerbate health inequalities rather than mitigate them. One way in which this occurs is when patients experience disproportionate levels of harm from the healthcare they receive.

For example, a 2022 review in the UK found that ethnic minority women's experiences of poor communication and discrimination during interactions with healthcare staff may explain some of the stark inequalities observed in maternal health outcomes. Healthcare may therefore be less safe for some patients than others.

Evidence is growing that patient safety incidents are experienced unequally. Inpatient safety data from the US indicate that adjusted rates of perioperative pulmonary embolism and sepsis among black patients are 28% and 24% higher, respectively, compared with white patients admitted to the same hospital. These data add to evidence from a range of high-income settings that patients from ethnic minority communities are at increased risk of hospital acquired infections, adverse drug events, and pressure ulcers.

Socioeconomic disadvantage has been associated with higher rates of death from avoidable causes such as delayed healthcare interventions, as well as delays in promptness of resuscitation after in-hospital cardiac arrest. In addition, patients with learning disabilities have been shown to experience harmful delays in the timely diagnosis of sepsis. Such failures in patient safety lead to higher levels of harm for these patients.

People from marginalised ethnic backgrounds are more likely to be harmed by healthcare because of interpersonal and structural factors that shape their care experiences. These factors include ineffective communication during clinical care, implicit biases among healthcare providers, and medical educational and clinical treatment approaches designed around white patient populations as the norm.

Ineffective communication between clinicians and patients can cause harm to any patient. However, those with poor proficiency in the dominant language of the healthcare system, including migrants, are at heightened risk of harm because of medication errors and misunderstanding verbal advice.
Risk of harm from healthcare is experienced unequally and compounds existing vulnerabilities to poor health outcomes, ultimately exacerbating health inequalities.

SM MCS has a key role to play in tackling health inequalities in partnership with our local partner agencies and services. SM MCS has developed a draft health equality action plan to address some of the most urgent issues. However, most of the fundamental factors driving inequalities in health are beyond the responsibility of the health care system, for example education; economic and community development in our most deprived neighbourhoods; employment levels; pay and conditions; and availability of quality of housing.

Through our implementation of PSIRP, we will seek to utilise data and learning from investigations to identify actual and potential health inequalities and make recommendations to support tackling these. We are already actively considering language barriers and social deprivation in our incident reviews.

Our engagement with patients, families and carers following a patient safety investigation must also recognise diverse needs and ensure inclusivity for all. Any potential inclusivity or diversity issues must always be identified through the investigation process and engagement with patients and families, for example, during the duty of candour / being open process.

Our Services

SM MCS has four clinical divisions **and one directorate** providing a wide range of services.

Division of Genomic Medicine

Childhood metabolic paediatric disorders
Lysosomal Storage Disorders
General Adult Genetic Clinics
General Paediatric Clinics
General Cancer Genetic Clinics
Genetic Counsellor Clinics
Outreach Clinics
NW Genomic Laboratory Hub
The Division offers the following specialist clinics:
Adult endocrine
Heart conditions
Cleft lip and palate
Deafness
Genetic dermatology
Inherited neurological problems
Rare forms of interited cancer (inc. NF1, NF2)
Rare childhood developmental disorders Kidney
Eye conditions

Division of Gynaecology

Benign Gynaecology including: Menstrual disorders, hysteroscopy, colposcopyand vulval disorders
Paediatric and Adolescent Gynaecology
Reproductive Medicine including IVF, endometriosis and menopause
Urogynaecology
MESH complication service

Division of Maternity Services

Antenatal Assessment Units
Diabetic pregnancy service
Fetal cardiology Fetal Medicine
Joint obstetric cardiology clinic
Joint obstetric haematology
Joint obstetric neurology
Joint obstetric / HIV clinic
Lupus in Pregnancy (LIPS) clinic
Manchester Antenatal Vascular Service (MAViS)
Specialist midwifery service for asylum seekers and refugees
Obstetric ultrasound service
Young parents' specialist service
Manchester placenta clinic
Obstetric anaesthetic clinic
Perinatal mental health clinic
Obstetric cardiac clinic
Renal hypertension antenatal
Preterm labour clinic
Physiotherapy
Rainbow clinic
Raised BMI clinic

Division of Newborn Services

Neonatal intensive care
High dependency and special care
Complex respiratory diseases
Complex renal conditions
Complex cardiac conditions
Complex neurological conditions
Babies who require surgical care
Complex genetic and metabolic disorders

Sexual Assault Referral Centre

24 hour forensic medical examinations for all ages and genders
STI/pregnancy advice for adults
HIV/Hepatitis B Prophylaxis
Specialist Child Clinics
Specific STI Clinics for Children
Child medical examinations-FGM
Crisis work support (including 24 hour helpline ISVA)
Counselling including pre-trial therapy, group intervention and psycho-education courses
SAFEPlace Merseyside

Defining our patient safety incident profile

Over the past 2 years, SM MCS as part of MFT has focused on improving our response to and learning from patient safety incidents. We have already initiated a number of important safety processes to facilitate this such as the establishment of the SM MCS Serious Incident panel and our SM MCS Patient Safety Response Group which was established to focus on sharing learning from patient safety events. Essential to this has been fostering a patient safety culture in which people feel safe to report incidents, share experiences and be actively involved in the development of safety actions.

Our patients are key partners in our safety responses and our staff involve patients to ensure that where possible their experience is heard, and they have the opportunity to contribute their questions about a safety event and contribute to safety action planning.

It is important to recognise that there are good reasons to carry out an investigation. Sharing findings, speaking with those involved, validating the decisions made in caring for patients and facilitating psychological closure for those involved are all core objectives of an investigation. The challenge for us is to develop an approach to investigations that facilitates thematic insights to inform ongoing improvement. Our approach must acknowledge the importance of organisational culture and what it feels like to be involved in a patient safety incident.

Patient safety incidents and Hospital level risks for SM MCS have been profiled using organisational data including:

- Incident Reports: Two years of data has been reviewed and review of any special cause variation considered and triangulated with other data sources.
- Complaints and compliment's themes were reviewed
- Risk Register: a review of the risk register was undertaken
- National & Clinical Audit outcomes and recommendations were reviewed, and the themes triangulated with other data
- CQC reports and those of recent maternity service inspections were reviewed

Incident Profile

Patient safety events are reported via the Trust Ulysses system and each event is reviewed by a manager within our MCS. Events that have potentially caused serious harm or had the potential to do so if corrective action had not been taken are reviewed in detail and discussed by a multi-disciplinary team at our SM MCS serious incident panel. Whilst each incident is reviewed individually every month the totality of our incident data is reviewed to ascertain if there are any trends and identify areas that may benefit from further safety improvement work. Analysis of these profiles has been a major contributor to our priorities within this plan.

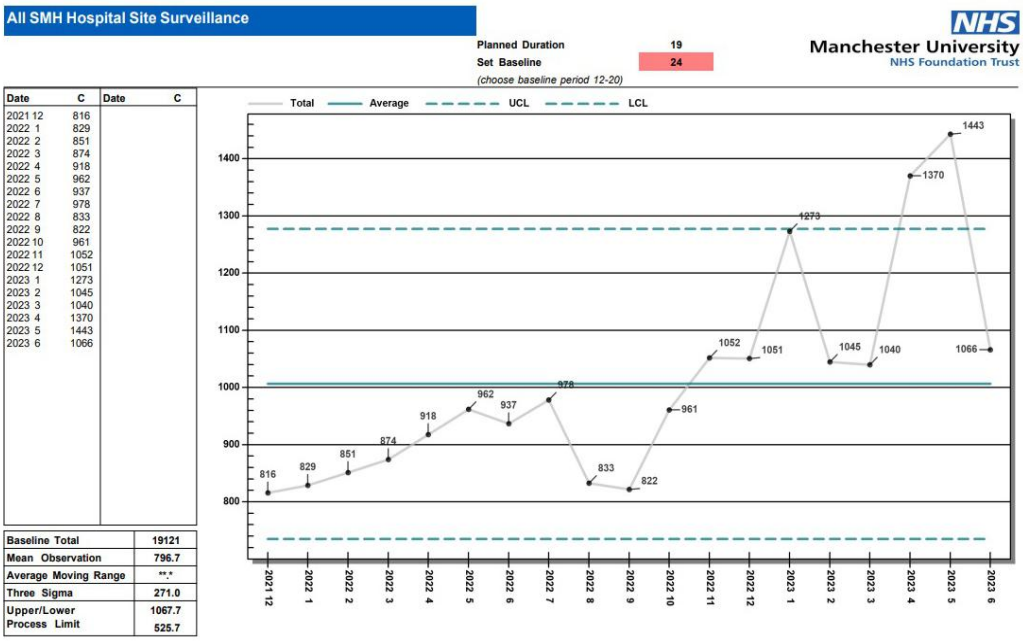

Figure 1: Graph illustrating the total number of potential patient safety events reported across SM MCS in the period December 2021 – June 2023

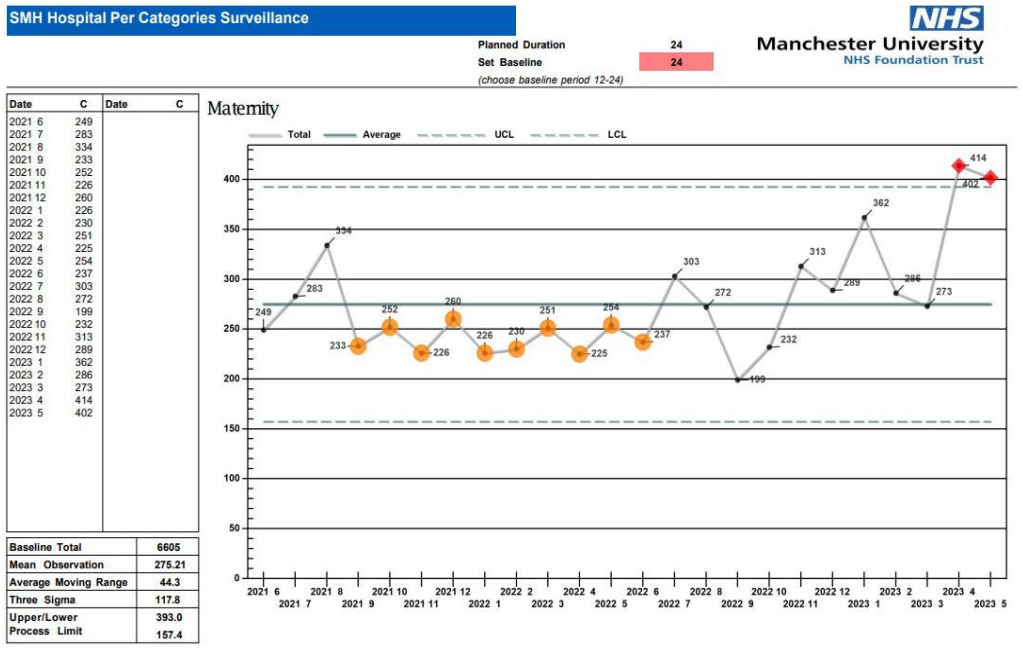

Figure 2: Graph illustrating the total number of potential patient safety events reported within maternity services in the period June 2021 – June 2023

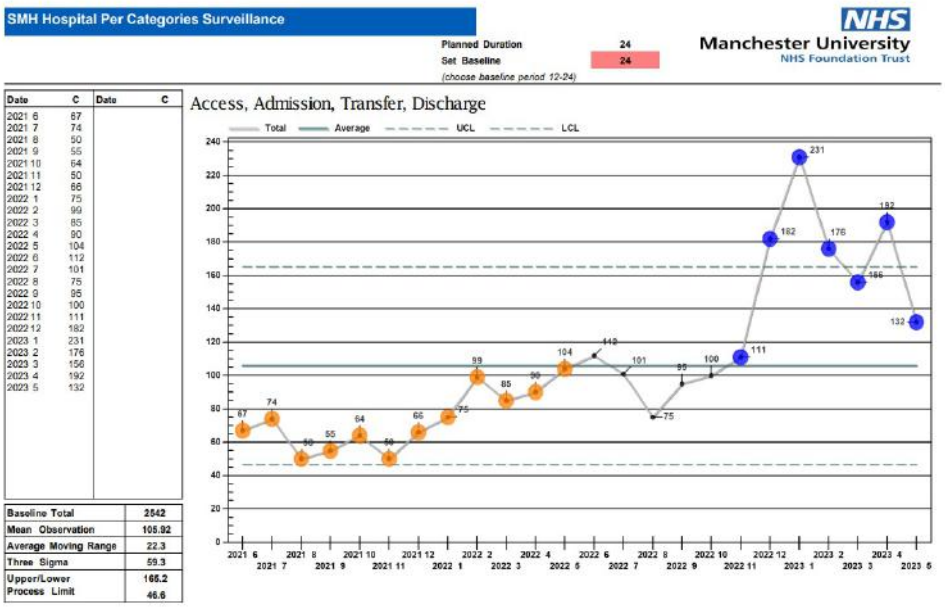

Figure 3: Graph illustrating the number of potential patient safety events related to access, admission, transfer ad discharge reported across SM MCS in the period June 2021 – June 2023

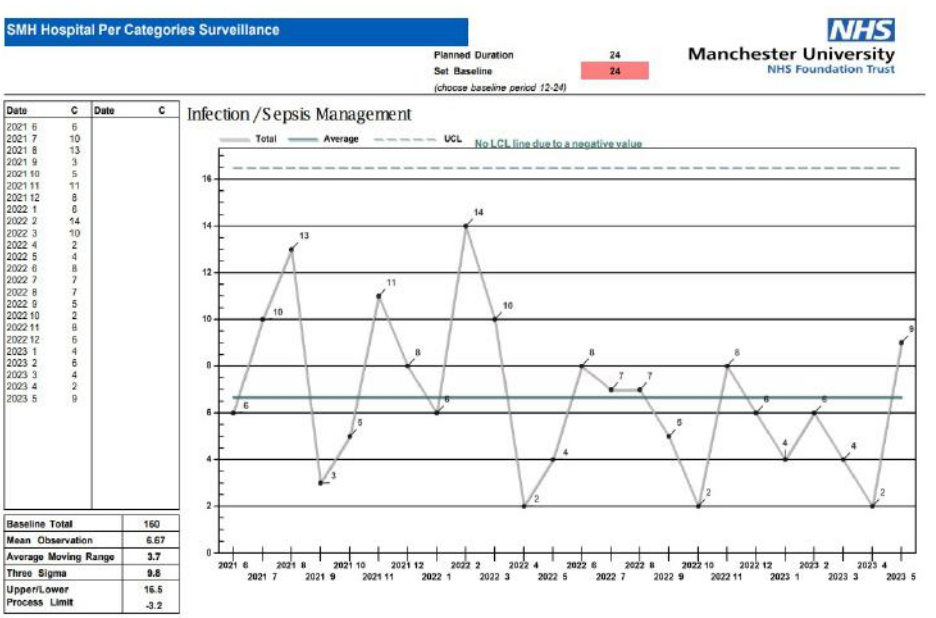

Figure 4: Graph illustrating the number of potential patient safety events related to infection and sepsis management reported across SM MCS in the period June 2021 – June 2023

Our patient safety priorities are

- Safe and timely management of patients accessing SM MCS for assessment and treatment
- Working towards closing the gap in health inequalities by working with patients and staff to develop services that effectively provide care to patients across all sites and from all backgrounds and ethnicities
- Safe and effective care of women attending maternity triage across the MCS
- Safe, effective and responsive management of infection
- Safe and effective escalation of the deteriorating patient

These key priorities are discussed, and assurance given of progress through the following groups and committees:

- SM MCS Quality & Patient Safety Committee
- Divisional Quality and Safety Committee meetings
- SM MCS Patient Safety Summit
- SM MCS Patient Safety Response Group

Developing our patient safety improvement program

SM MCS has developed a comprehensive quality and safety strategy and each division/directorate has it's own action plan. Although the strategy covers a 3 year period the action plans are dynamic to enable them to be responsive to changing priorities within the service. Our clinical governance framework enables a robust assurance process, providing assurance that improvements are being made, embedded and sustained.

SM MCS works collaboratively with patient representatives such as our maternity voices partners, charities such as the neonatal charity Spoons, our colleagues from across MFT and the Local Care Organisation (LCO), as well as external stakeholders to improve safety.

Our patient safety incident response plan: **national requirements**

Patient Safety incidents that 'must' be investigated under PSIRF are detailed below in table 1.

Patient safety incident type	Required response	Anticipated improvement route
Never Events	PSII	Create local organisational actions and feed these into the SM MCS and MFT quality improvement strategies. Review previous safety improvement work that was undertaken following previous Never Events and ensure safety actions are embedded and sustained.
Learning from Deaths: death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	PSII	Improve the processes for interlinking learning from national review processes such as PMRT and MBBRACE to maximise safety improvement both within SM MCS and working with MFT colleagues.
Deaths of Persons with learning disabilities	PSII	Ensure that the learning disability champions within SM MCS are involved should their be a death of a person with a learning disability within our service.
Safeguarding Incidents	PSII	Create local organisational actions and feed these into the SM MCS and MFT quality improvement strategies
Incidents in NHS Screening Programmes	PSII	Ensure learning from all NHS screening program related patient safety events is shared at the SM MCS PSRG meeting for shared learning as well as with regional screening teams.

Our patient safety incident response plan: **local focus**

The SM MCS safety profile has identified five incident categories which require an increased focus in relation to patient safety. Table 2, details the locally identified areas of focus and improvement.

Several system-based learning response methods are available to respond to a patient safety incident or cluster of incidents. These will be applied where contributory factors are not well understood, and further local improvement work is required to enable the greatest potential for new learning and improvement.

Table 2

	Patient safety incident type	Speciality	Planned/Suggested Response(s)	Anticipated improvement route
1	Medication Safety	All	HILA MDT SWARM PSII Observation Walkthrough	SM MCS Harm Free Care committee Trust Medicines Safety Committee
2	Access, Admission, Transfer, Discharge	Maternity Services	HILA MDT SWARM PSII Observation Walkthrough	Maternity Triage Safety improvement workstream in progress SM MCS Quality and Safety Committee
3	Patient Care, Monitoring, Review: • Delay/Failure in assessing patient • Delay/Failure to monitor Ensuring safe and effective follow up of care	All	HILA MDT PSII SWARM	Locally identified workstreams or QIP appropriate to theme and improvement identified SM MCS Quality and Safety Committee
4	Infection / Sepsis Management	All	Outbreak review Thematic Review	SM MCS Harm Free Care committee Outbreak meetings
5	Positive Patient Identification	All	HILA MDT Walkthrough	Locally identified workstreams or QIP SM MCS Quality and Safety Committe

Where a PSII is required (as defined in this Plan for both local and national priorities), the investigation / review will start as soon as possible after the patient safety incident is identified. PSII will usually be completed within one to three months of their start date, but not exceeding six months. Any PSII anticipated to require an extended timeframe should be agreed with the patient/family/carer.

Incidents that meet the statutory duty of candor thresholds

There is no legal duty to investigate a patient safety incident. Once an incident that meets the Statutory Duty of Candour threshold has been identified, the legal duty, as described in Regulation 20 says we must:

- Tell the person/people involved (including family where appropriate) that the safety incident has taken place.
- Apologise. For example, "we are very sorry that this happened"
- Provide a true account of what happened, explaining whatever you know at that point.
- Explain what else you are going to do to understand the events. For example, review the facts and develop a brief timeline of events.
- Follow up by providing this information, and the apology, in writing, and providing an update. For example, talking them through the timeline.
- Keep a secure written record of all meetings and communications.

A review of compliance with Regulation 20: The Statutory 'Duty of Candour' under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 presented to Group Quality and Safety Committee in June 2021 highlighted that there are gaps in assurance regarding the approach to, and the quality of, Duty of Candour disclosures across the Trust. A Review of Saint Mary's MCS compliance with Regulation 20: The Statutory 'Duty of Candour' under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in January 2023 has confirmed that there remain gaps in assurance.

A process is now in place to review our local compliance data with Duty of Candour statutory requirements. Monthly reminders have been instituted. Training is being organised at group level for staff who undertake Duty of Candour.

Resource Analysis

The current incident management structure relies on clinicians, undertaking reviews in their allotted governance role time allocations. The SM MCS Governance Team do not have any line management responsibilities with regards investigators and are supported by the medical director, director of nursing and midwifery and the clinical heads of division to assist investigators to prioritise their time for investigations. Investigation reports have SM MCS senior leadership team level approval prior to submission to the group governance team or external agencies.

In order to effectively deliver the requirements of the patient safety incident investigation standards and the PSIRF, consideration of the required resources and training is required.

Learning response leads, those leading engagement and involvement and those in PSIRF oversight roles require specific knowledge and experience. Learning responses are not led by staff who were involved in the patient safety incident itself or by those who directly manage those staff and it is recommended that learning responses are led by staff at Band 8a and above.

Therefore, job planning and time is required to enable identified staff to complete the required PSIIs.

Table 3 below outlines the proactive response planning and overview of estimated resource allocation for patient safety incidents that fall outside national priorities

Table 3

Response Type	Category	Total number of responses	Hours
PSII (formally referred to as Serious Investigation Reports)	Locally defined PSIIs	Approx 20 per year	***Minimum 60 hours per investigation for:*** • 1 lead investigator • 1 support investigator ***Up to 30 hours per investigation for:*** • subject matter expertise • family liaison ***Plus Up to 30 hours per investigation for:*** • investigation oversight and support administration support • interview and statement time of staff involved in the incident • SLT approval and sign off
	Unanticipated Incidents identified as requiring PSII	5	As above
PSRs (often referred to as Practice Reviews)	All types including learning from work went well (safety II)	500	Approximately 15 hours per response review (MDT Approach)

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North Manchester General Hospital

Patient Safety Incident Response Plan

2022-2025

Safety Differently

North Manchester General Hospital

Safety Priorities

- Medication safety
- Staffing
- Communication
- Pressure Ulcers
- Infection/sepsis management
- Management of the deteriorating patient
- Ensuring safe and effective follow up of care
- Safe and effective use of the Respect process
- Nutrition and Hydration
- Safeguarding
- End of Life/Palliative Care

Effective date: July 2023
Estimated refresh date: July 2024

	Name	Title	Signature	Date
Author	Alison Talbot	Assistant Director of Governance and Patient Experience		
Reviewer	Cheryl Casey	Director of Nursing		
	Professor Matthew Makin	Medical Director		
Authoriser	Ian Lurcock	Chief Executive		

Contents

Introduction

North Manchester General Hospital (NMGH) which is part of Manchester Foundation Trust (MFT) are delighted to share our first published Patient Safety Incident Response Plan (PSIRP). The PSIRP sets out how NMGH intends to respond to patient safety incidents over the next 12 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Our executive team are committed to ensuring that our PSIRP puts the patients and staff at the heart of the plans. Below is an update from NMGH executive team highlighting explaining why these key changes are so important.

The Patient Safety Incident Response Plan (PSIRP) changes the way the NHS respond and review patient safety incidents and focusses on improving our learning responses when patient safety incidents occur. At NMGH we are committed to ensuring we create a culture of passionate and supportive engagement to patients and staff, and we welcome those new changes. I am very proud to be sharing our plans with you.

Mr Ian Lurcock, Chief Executive

The PSIRP plans outlines the importance of collaborative working across learning events to ensure proportionate and quality learning outcomes, which is line with our strategic aim across NMGH. This is a welcomed shift in focus from doing many reviews to doing it well. Safety differently will empower all nurses, doctors, junior doctors, allied health professionals, patients and carers to feel supported.

Mrs Cheryl Casey, Director of Nursing

PSIRP advocates a compassionate response to patient safety incidents and creates a shared vision for working together to get it right. We are delighted to move into "Safety Differently" and fully support and endorse this exciting change.

Professor Matthew Makin, Medical Director

Our services

NMGH is located in Crumpsall which is 3.5 miles north of Manchester City Centre and is part of the wider family of MFT (since 2020). The hospital has a full accident and emergency department (A&E), which includes a separate paediatric A&E unit. We also offer a full range of general and acute surgical services and is the base for the region's specialist infection disease unit. We deliver approximately 26 different clinical services and serve Crumpsall, Moston, Blackley, Cheetham Hill, Collyhurst, Broughton, Prestwich and across the inner city. Our services support approximately 280,000 people from a wide range of backgrounds.

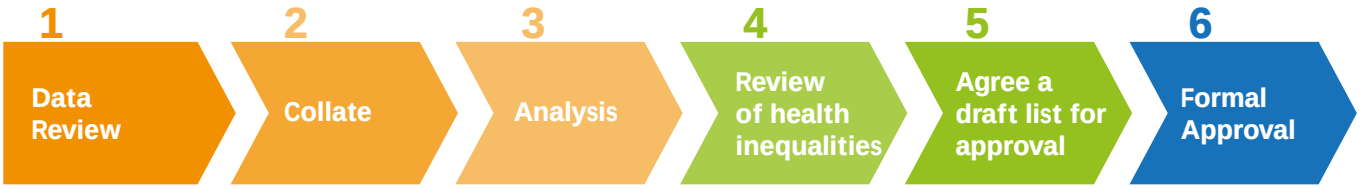
Our services range from A&E, children's services and the care of the elderly and we are very proud to be the specialist centre for infectious diseases (ID).
As part of MFT wider vision for single hospital services we have recently become the single hospital for ID. This is an exciting development which will support with making a different to the health outcomes, wellness, and quality of life for our diverse communities.

Further development is on the horizon as we plan a new hospital and wider health and care campus being built as part of 'once-in-a-generation' plans to transform both the hospital and the North Manchester area, creating new jobs, promoting healthy lifestyles, developing skills for the benefit of the local neighbourhood and beyond.

Defining our patient safety incident profile

Over several months in spring 2022, we started to review our patient safety profile and an in-depth review was undertaken of all our data, including incidents, complaints, inquests, SJRS and any additional intelligence. The review considered any inequalities within health care for the community we service. Following this review, the main patient safety risks were highlighted to the senior leadership team and discussed in various committees.

The process taken is defined below: (Figure 1)



1. Data Review

Our data review took place in spring of 2022 and underwent six stages. It is also worthwhile highlighting in 2021, North Manchester was part of Northern Care Alliance (NCA) and were working on different systems. Following disaggregation North became part of the "MFT family" and the data reviewed considered disaggregation and the complexity that came with the merge. We reviewed data from 1st April 2022 to 1st April 2023 for our thematic analysis. As part of that review, we determined that:

2. Collate

The data was collated and presented to the team at North Manchester.

3 Analysis

A thematical review was undertaken to understand the themes and a triangulation of all data was completed.

4. Review of inequalities

A review of patients within protected characteristics was undertaken against the community that we serve. Age, gender and ethnicity (if available) was also considered as part of the review.

5. Agree draft list for approval

A long list was determined for review and consideration within various committees, using staff feedback to ensure the focus was applied to the appropriate common themes.

6 Agreed list

The list was formally agreed and shared with staff.

Defining our patient safety improvement profile

Our profile was determined via a number of profiles including:

- Trust Wide Quality Improvement Projects (QIP)
- Safety improvement programmes already in place
- Operational Work
- National Projects
- Audits

Our patient safety incident response plan: **national requirements**

Patient safety incident type	Required response	Anticipated improvement route
Never Events Criteria	PSII Systems Review	NMGH
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	PSII Systems Review	NMGH
Deaths of person with learning disability	Structured Judgement review – Refer to Learning Disability (LeDer) Review Programme	LeDer programme
Deaths of a patient detained under the Mental Health Act and care delivery problems have been identified	MDT	NMGH/GMMH
Child Death	Refer to child death process- High Impact Learning Assessment (HILA) and PSII if required	NMGH /Child Death Panel

Safeguarding • Domestic homicide • Looked after children • Babies • Abuse/violence	Reported to named safeguarding lead/ Refer to local authority.	Safeguarding leads NMGH/ Local safeguarding boards
Deaths in custody police custody, in prison, where health care is delivered by the NHS	NMGH will fully support and link in with any investigation that is needed which has been a referral via the Independent Office for Police Conduct (IOPC) or prison service.	IOPC
Maternity and neonatal incidents	Health and Safety Investigation Branch (HSIB)	HSIB
Learning from deaths – Structured Judgement Reviews (SJRS) which found death more than likely than not related to problems with the care	PSII	Learning from Deaths CMOG.

Our patient safety incident response plan: **local focus**

Patient safety incident type or issue	Planned response
Medication safety	HILA/ Thematical Review
Communication	HILA/Thematical Review
Staffing	HILA/ SWARM/ Thematical Review
Pressure Ulcers	Thematical review /After Action Review
Infection/sepsis management	PSII
Management of the deteriorating patient	PSII /MDT
Ensuring safe and effective follow up of care	SWARM
Safe and effective use of the Respect process	HILA/ Thematical Review
Nutrition and Hydration	PSII /MDT
Safeguarding	HILA/ SWARM/ Thematical Review
End of Life/Palliative Care incident	HILA/ SWARM/ Thematical Review

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WTWA

Patient Safety Incident Response Plan

2022-2025

Safety Differently

Our family of hospitals caring for you

Effective date: August 2023
Estimated refresh date: August 2024

	Name	Title	Signature	Date
Author	Rebecca Golden	Assistant Director Quality Governance Risk & Patient Safety WTWA		
Reviewer				
Authoriser				

Contents

Introduction

This patient safety incident response plan (PSIRP) sets out how Wythenshawe, Trafford, Withington and Altrincham (WTWA) Hospitals which is part of Manchester University NHS Foundation Trust (MFT) intends to respond and seek to learn from patient safety incidents reported by staff and patients, their families, and carers as part of our work to continually improve the quality and safety of the care we provide.

Manchester University NHS Foundation Trust is an NHS Acute Foundation Trust which operates 10 hospitals throughout Greater Manchester. It is the largest NHS trust in the United Kingdom. The Trust was formed on 1st October 2017 following the merger of Central Manchester University Hospitals NHS Foundation Trust (CMFT) and University Hospital of South Manchester NHS Foundation Trust (UHSM), and more recently the acquisition of North Manchester Hospital.

Due to the size and structure of MFT, it has been agreed that there will be a MFT Group level PSIRP which will outline the priorities of the Trust as a whole, and each Hospital/Managed Clinical Service (MCS) will hold its own localised PSIRP, that is aligned to localised patient safety priorities.

WTWA provides district hospital services to our local community as well as a number of tertiary services. WTWA also manages a number of single hospital services within MFT including, cardiac, trauma and orthopaedics, breast and urology.

This plan will help us measurably improve the efficacy of our local patient safety incident investigations (PSIIs) by:

A. *refocusing PSII towards a systems approach and the rigorous identification of interconnected causal factors and systems issues*

B. *focusing on addressing these causal factors and the use of improvement science to prevent or continuously and measurably reduce repeat patient safety risks and*

C. *incidentstransferring the emphasis from the quantity to the quality of PSIIs such that it increases our stakeholders' (notably patients, families, carers, and staff) confidence in the improvement of patient safety through learning from incidents*

D. *demonstrating the added value from the above approach.*

The patient safety incident response plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Scope

A PSIRP is a requirement of each provider or group/network of providers delivering NHS-funded care.

This document should be read alongside the introductory Patient Safety Incident Response Framework (PSIRF) 2022, which sets out the requirement for this plan to be developed.

The aim of this approach is to continually improve. As such this document will be reviewed every 12 – 18 months to ensure that the site plan remains appropriate to our changing patient safety profile.

There are many ways to respond to an incident. **This document covers responses conducted solely for the purpose of system learning and improvement.**

Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare.

There is no remit to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement

Responses covered in this Plan include:

- Patient Safety Incident Investigations (PSIIs)
- Patient Safety Reviews (PSRs)

Other types of response exist to deal with specific issues or concerns. Examples of such responses include complaints management, claims handling, human resources investigations into employment concerns, professional standards investigations, coroners inquests or criminal investigations. The principle aims of each of these responses differ from the aims of a patient safety response and are outside the scope of this plan.

To be effective in meeting their specific intended purposes, responses that are not conducted for patient safety learning and improvement are separate entities and will be appropriately referred as follows:

- human resource (employee relations) teams for professional
- conduct/competence issues and if appropriate, for referral to professional regulators
- legal teams for clinical negligence claim
- medical examiners and if appropriate local coroners for issues related to the cause of a death
- the police for concerns about criminal activity

WTWA Strategic objectives

Act on feedback from patients, families, carers, and staff about the current problems with patient safety incident response and PSIIs in the NHS.

Develop a climate that supports a 'just culture' and an effective learning response to patient safety incidents.

Make more effective use of current resources by transferring the emphasis from the quantity of investigations to a higher quality, more proportionate response to patient safety incidents. The aim is to:

- make PSIIs more rigorous and, with this, identify causal factors and system-based improvements
- engage patients, families, carers, and staff in PSII and other responses to incidents, for better understanding of the issues and causal factors
- develop and implement improvements more effectively
- explore means of effective and sustainable spread of improvements which have proved demonstrably effective locally.

Addressing health inequalities

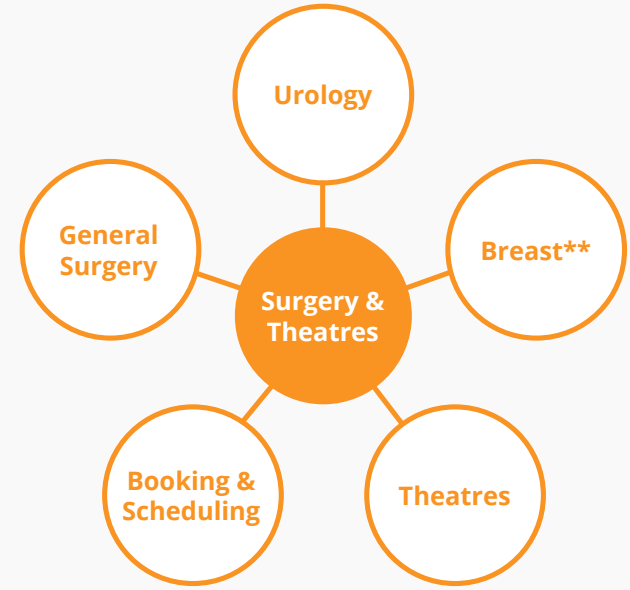
As a provider of a number of single hospital services across MFT, WTWA has a key role to play in tackling health inequalities in partnership with our local partner agencies and services. However, most of the fundamental factors driving inequalities in health are beyond the responsibility of the health care system, for example education; economic and community development in our most deprived neighbourhoods; employment levels; pay and conditions; and availability of quality of housing.

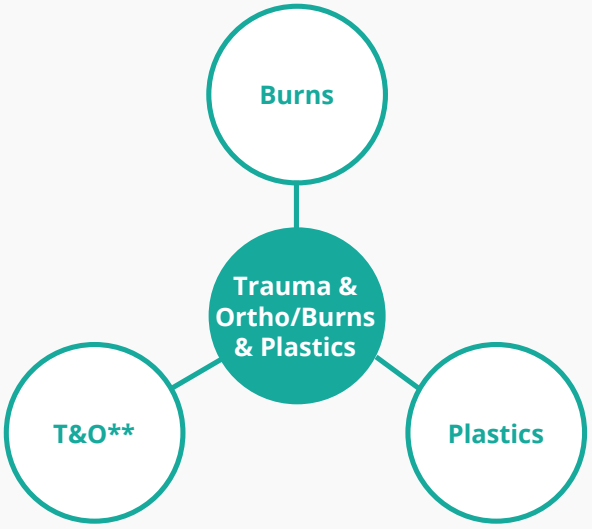
Through our implementation of PSIRP, we will seek to utilise data and learning from investigations to identify actual and potential health inequalities and make recommendations to support tackling these.

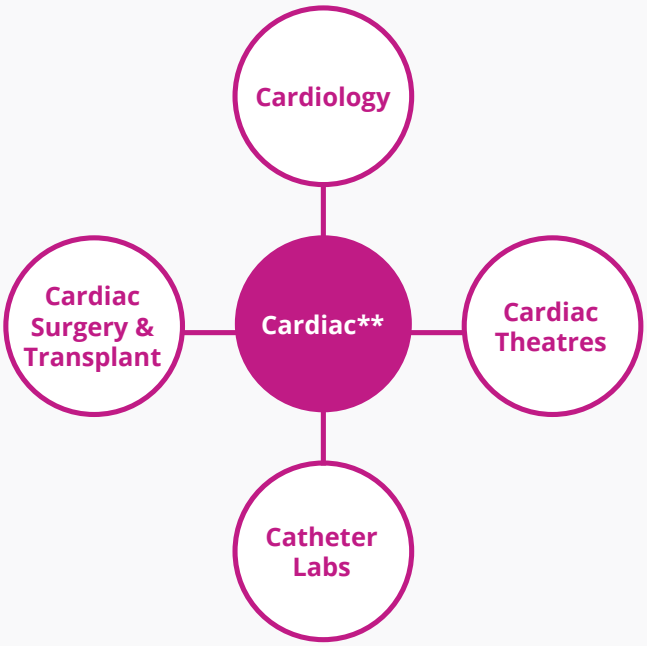
Our engagement with patients, families and carers following a patient safety investigation must also recognise diverse needs and ensure inclusivity for all. Any potential inclusivity or diversity issues must always be identified through the investigation process and engagement with patients and families, for example, during the duty of candour / being open process.

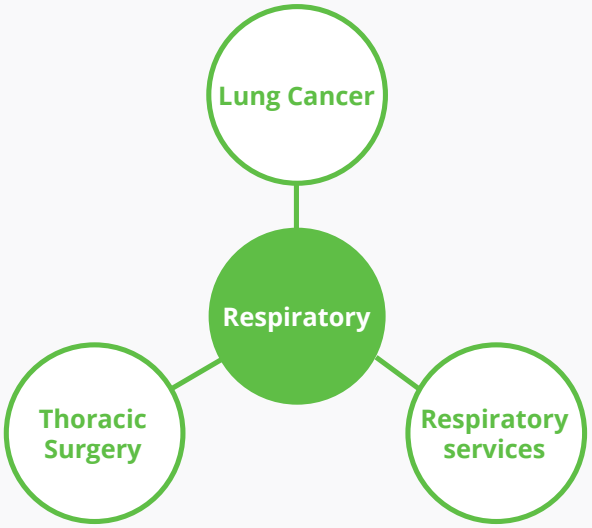
Our Services

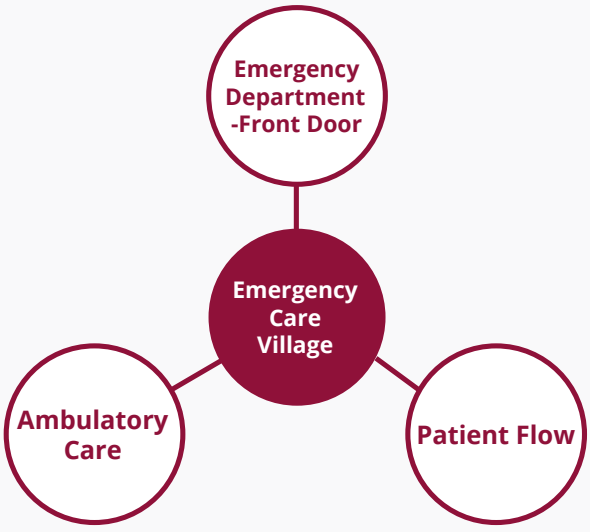
WTWA has six clinical divisions providing a wide range of services.

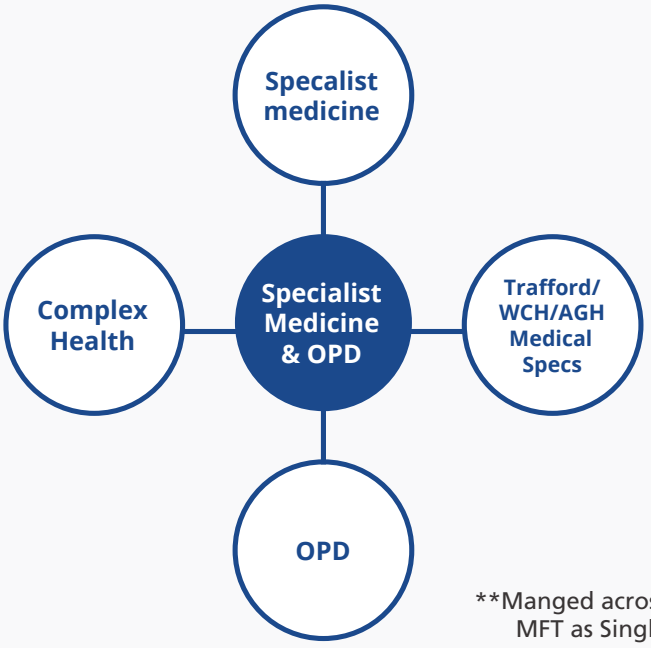












**Manged across MFT as Single Hospital Service

Through the Managed Clinical Service model, there a number of services hosted across WTWA managed as part of Managed Clinical Services (MCS):

Paediatric Services Managed by RMCH	**Obstetrics, Gynaecology & Neonates** Managed by Saint Mary's	**CTCCU, AICU, Radiology, AHP & Labs** Managed by Clinical & Scientific Services	**Eye & Dental Outpatient Services** Managed by Manchester Royal Eye Hospital & University Dental Hospital	**SHS: ENT/Max Fax, Renal Dialysis (@ AGH) Gastro / Endoscopy** Managed by Manchester Royal Infirmary

With the introduction of elective surgical hubs nationally to support access and timeliness of elective surgical procedures, the Trafford site is home to the Trafford Elective Hub (TEH), the focus is on those high volume, low complexity procedures in various specialities. Therefore, surgeons from across MFT will utilise the TEH to drive improvements in waiting time, with protected capacity for elective surgical pathways.

Defining our patient safety incident profile

Over the past 2 years, WTWA as part of MFT has focused on improving our approach to patient safety incidents, with many great examples of learning and involvement.

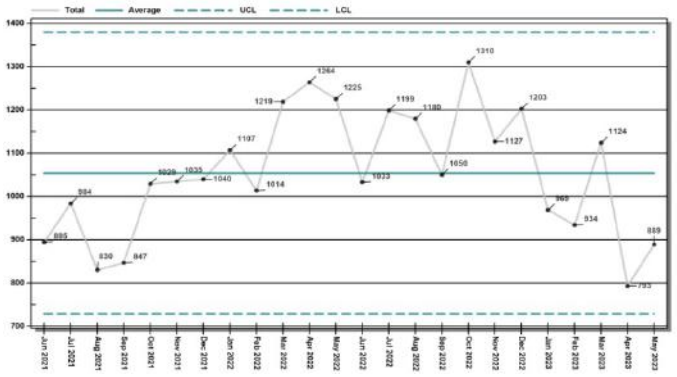
Essential to this has been fostering a patient safety culture in which people feel safe to talk. Having conversations with people relating to a patient safety incident can be difficult and we will continue to explore how we can equip and support our colleagues to best hear the voice of those involved. This has included the use of High Impact Learning Assessments (HILA) as well as a move towards system based reviews rather than root cause analysis.

It is important to recognise that there are good reasons to carry out an investigation. Sharing findings, speaking with those involved, validating the decisions made in caring for patients and facilitating psychological closure for those involved are all core objectives of an investigation. The challenge for us is to develop an approach to investigations that facilitates thematic insights to inform ongoing improvement. Our approach must acknowledge the importance of organisational culture and what it feels like to be involved in a patient safety incident.

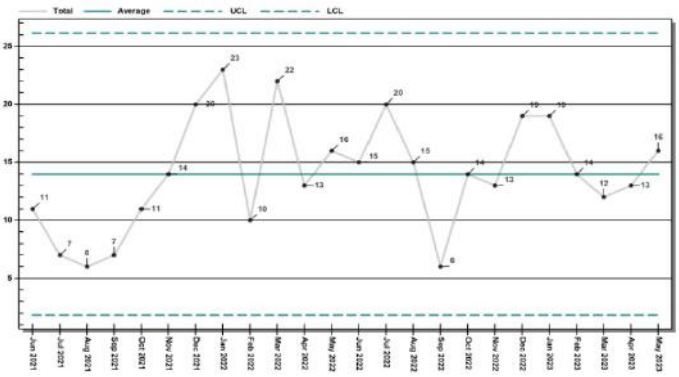
Patient safety incidents and Hospital level risks for WTWA have been profiled using organisational data including:

- Incident Reports: Two years of data has been reviewed and review of any special cause variation considered and triangulated with other data sources.
- The WTWA Risk Register was reviewed, with a focus on risks related to patient safety and this was triangulated with incidents and complaint themes

- Complaints and compliment's themes were reviewed.
- Friends and Family Test (FFT), What Matters To Me (WMTM) and Quality Care Round (QCR) data reviewed and triangulated with other data sources.
- Coroners' findings including prevention of future death notifications.
- National & Clinical Audit outcomes and recommendations were reviewed, and the themes triangulated with other data



WTWA All incidents June 2021- May 2023



WTWA Notifiable incidents June 2021- May 2023

Defining our patient safety improvement profile

WTWA has a comprehensive programme of patient safety improvement, as well as an active Quality Improvement programme. The clinical governance framework enables a robust assurance process, providing assurance that improvements are being made, embedded and sustained.

WTWA works collaboratively with our colleagues from across MFT and the Local Care Organisation (LCO), as well as external stakeholders to improve safety.

The Quality improvement priorities for WTWA

- The Deteriorating Patient
- Safer Surgery and Interventional Procedures
- Dementia
- Falls prevention
- Tissue Viability
- Infection Prevention and Control
- Medication Safety
- Mental Health & Safeguarding
- Access, Admission and Discharge
- End of Life
- Nutrition and Hydration

These key priorities are discussed, and assurance given of progress through the following groups and committees:

- Quality & Patient Safety Committee
- WTWA Safeguarding Committee
- WTWA Infection Prevention and Control
- WTWA Falls Operational Group
- Falls collaborative
- WTWA Medicines Management Committee
- Trust Medicines Safety Committee
- Theatre Safety Committee
- Meeting
- Nutrition steering Committee WTWA
- WTWA Patient Experience Delivery Group
- WTWA Clinical Effectiveness Committee

Our patient safety incident response plan: **national requirements**

Patient Safety incidents that 'must' be investigated under PSIRF are detailed below in table 1.

Patient safety incident type	Required response	Anticipated improvement route
Never Events	PSII	Create local organisational actions and feed these into the WTWA and MFT quality improvement strategies
Learning from Deaths: death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	PSII	Create local organisational actions and feed these into the WTWA and MFT quality improvement strategies
Deaths of Persons with learning disabilities	PSII	Create local organisational actions and feed these into the WTWA and MFT quality improvement strategies
Safeguarding Incidents	PSII	Create local organisational actions and feed these into the WTWA and MFT quality improvement strategies
Incidents in NHS Screening Programmes	PSII	Create local organisational actions and feed these into the WTWA and MFT quality improvement strategies

Table 1

Our patient safety incident response plan: **local focus**

The WTWA safety profile has identified ten incident categories which require an increased focus in relation to patient safety. Table 2, details the locally identified areas of focus and improvement.

Several system-based learning response methods are available to respond to a patient safety incident or cluster of incidents. These will be applied where contributory factors are not well understood, and further local improvement work is required to enable the greatest potential for new learning and improvement.

	Patient safety incident type	Speciality	Planned/Suggested Response(s)	Anticipated improvement route
1	Slips, Trips and Falls	All	HILA SWARM Thematic Review	WTWA Falls Operational Group / Falls collaborative Quality & Patient Safety Committee
2	Medication Safety	All	HILA MDT SWARM PSII Observation Walkthrough	WTWA Medicines Management Committee / Trust Medicines Safety Committee
3	Access, Admission, Transfer, Discharge • Including impact of SHS transition	All	HILA MDT SWARM PSII Observation Walkthrough	Locally identified workstreams or QIP appropriate to theme and improvement identified / Quality & Patient Safety Committee / Safeguarding Committee
4	Disruptive, aggressive behavior • Impact of mental health patient delays	All	HILA SWARM MDT	WTWA Safeguarding Committee WTWA Risk Committee Quality & Patient Safety Committee
5	Patient Treatment / Procedure /Surgery • Delay / Failure - Treatment / Procedure	All	HILA MDT PSII SWARM Walkthrough	Theatre Safety Committee Meeting
6	Patient Care, Monitoring, Review: • Delay/Failure in assessing patient • Delay/Failure to monitor • Ensuring safe and effective follow up of care	All	HILA MDT PSII SWARM	Locally identified workstreams or QIP appropriate to theme and improvement identified / Quality & Patient Safety Committee

7	Pressure ulcers	All	Thematic Review	Locally identified workstreams or QIP appropriate to theme and improvement identified / WTWA Safeguarding Committee
8	Infection / Sepsis Management	All	Outbreak review Thematic Review	WTWA Infection Prevention & Control Committee meeting
9	Consent	All	HILA MDT	Theatre Safety Committee Meeting
10	Nutrition and Hydration	All	HILA Thematic Review MDT SWARM	Locally identified workstreams or QIP appropriate to theme and improvement identified

Table 2

Where a PSII is required (as defined in this Plan for both local and national priorities), the investigation / review will start as soon as possible after the patient safety incident is identified. PSII will usually be completed within one to three months of their start date, but not exceeding six months. Any PSII anticipated to require an extended timeframe should be agreed with the patient/ family/carer.

Incidents that meet the Statutory Duty of Candour thresholds

There is no legal duty to investigate a patient safety incident. Once an incident that meets the Statutory Duty of Candour threshold has been identified, the legal duty, as described in Regulation 20 says we must:

1. Tell the person/people involved (including family where appropriate) that the safety incident has taken place.

2. Apologise. For example, “we are very sorry that this happened”

3. Provide a true account of what happened, explaining whatever you know at that point.

4. Explain what else you are going to do to understand the events. For example, review the facts and develop a brief timeline of events.

5. Follow up by providing this information, and the apology, in writing, and providing an update. For example, talking them through the timeline.

6. Keep a secure written record of all meetings and communications.

Resource analysis

The current incident management structure relies heavily on senior clinicians, undertaking reviews in their allotted management time. The WTWA Risk & Governance Team do not have any line management responsibilities with regards investigators and thus limited influence over how investigators prioritise their time for investigations. Investigation reports have WTWA executive level sign off.

In order to effectively deliver the requirements of the patient safety incident investigation standards and the PSIRF, consideration of the required resources and training is required.

Learning response leads, those leading engagement and involvement and those in PSIRF oversight roles require specific knowledge and experience. Learning responses are not led by staff who were involved in the patient safety incident itself or by those who directly manage those staff and it is recommended that learning responses are led by staff at Band 8a and above.

Therefore, job planning and time is required to enable identified staff to complete the required PSIIs. Table 3 below outlines the proactive response planning and overview of estimated resource allocation for patient safety incidents that fall outside national priorities.

Response Type	Category	Total number of responses	Hours
PSII	Locally defined PSIIs	15	**Minimum 60 hours per investigation for:** • 1 lead investigator • 1 support investigator **Up to 30 hours per investigation for:** • subject matter expertise • family liaison **Plus Up to 30 hours per investigation for:** • investigation oversight and support • administration support • interview and statement time of staff involved in the incident • SLT approval and sign off
	Unanticipated Incidents identified as requiring PSII	5	As above
PSRs	All types including learning from work went well (safety II)	1000	Approximately 20 hours per response review

Table 3

SAFETY DIFFERENTLY
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NHS
Manchester University
NHS Foundation Trust

Royal Manchester Children's Hospital

Patient Safety Incident Response Plan

2022-2025

Safety Differently

Effective date: June 2023
Estimated refresh date: June 2024

	Name	Title	Signature	Date
Author	Mrs Tracy Cryer	Assistant Director of Quality Governance and Patient Experience, RMCH.		July 2023
Reviewer	Rachael Barber Julia Birchall-Searle	Medical Director, RMCH Director of Nursing and Health Professionals		July 2023
Authoriser	RMCH Senior Leadership Team			August 2023

Contents

Introduction

This patient safety incident response plan (PSIRP) sets out how Royal Manchester Children's Hospital (RMCH) intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

There are a number of ways in which an incident can be responded to, however, for the purpose of this document, responses to patient safety incidents, will be focused on learning systems and improvement workstreams.

Patient safety incidents can be defined as an unintended or unexpected outcome for a patient, which is thought to have been contributed to by the health care system. Management of such patient safety incidents should not seek to apportion blame or determine causation but should focus on learning and improvement.

Not all patient safety incidents will be appropriately managed through the learning and improvement system and may require alternative methods of investigation, such as coronial reviews, professional standards and criminal routes. These types of reviews are not within the scope of this Patient Safety Incident Response plan.

Our Services

The Royal Manchester Children's Hospital (RMCH) is one of ten Hospitals that sits within the Manchester University Foundation Trust organisational structure.

RMCH is one of the largest and busiest Children' Hospital in Europe, delivering emergency, tertiary and specialist level care across a multi-site inpatient bed base.

RMCH also delivers several outreaching services, hosting the Northwest Transport Service (NWTS) and locality CAMHS services across North Manchester, Trafford and Central sites.

A number of networked services are hosted by RMCH. These networked services are delivered across a range of specialities, including Cancer services, Paediatric Surgery, Paediatric Critical Care, NORCESS, and Cleft, Lip and Palate.

RMCH services are offered across a number of key sites:

- Oxford Road Campus – tertiary services, paediatric critical care and CAMHS (inpatients).
- Wythenshawe – General Paediatrics (including HDU), Theatres, Day case and Outpatients.
- North Manchester – General Paediatrics (including HDU) and Outpatients.
- Trafford – dental surgery hub and Outpatients.
- CAMHS community services.

Defining our patient safety incident profile

There have been a range of initiatives and structures introduced at Trust level to support the development and implementation of the patient safety profiles across all Hospital sites. These initiatives include an increased focus on insight, oversight, involvement, improvement, and assurance, the utilisation of SPC charts as a means to identify variations and trends within data sets and the introduction of new ways of delivering proactive safety systems, utilising improvement methodology.

Within Royal Manchester Children's Hospital, patient safety incidents and Hospital level risks have been profiled by triangulating organisational data from recent patient safety incident reports, complaints, freedom to speak up reports, patient safety incident investigations, (PSIIs), mortality reviews, case note reviews, staff survey results, claims, staff suspensions and risk assessments.

The purpose of this exercise is to move from a reactive approach to patient safety, which risks themes and trends being missed, to a proactive approach that delivers focused learning in areas in which incident reporting is higher than expected levels.

As shown below in table 1, the RMCH safety profile has identified ten incident categories which require an increased focus in relation to patient safety. These ten categories have been consistently under review during the last twelve months. Utilising SPC analysis allows for a greater understanding of themes by using the mean ratio of incident reporting within each category. The mean ratio is then used as a marker to determine if there is an increasing or reducing risk in these areas.

Due to variables in the data which can be caused for a number of reasons, such as seasonal peaks in activity, an accepted upper and lower control level is applied, which if breached, would require further investigation, under a special cause variation.

Of the ten areas identified, all are areas which have been previously highlighted across a number of RMCH forums and many already align to improvement work taking place across RMCH. This is a positive reflection of RMCH level of insight into its patient safety priorities and provides assurance that the Hospital is already working towards delivering focused and proactive learning.

Table 1: RMCH Safety Profile Priorities

Top Five Priority Categories Identified:

	Incident Type	Speciality
1	Medication error	RMCH-wide
2	Patient Care, Monitoring and Review	RMCH-wide
3	Access, Admission, Transfer, Discharge	RMCH-wide
4	Infrastructure – Staffing, Facilities, Utilities	RMCH-wide
5	Communication Failure	RMCH-wide

Further Learning Categories; Integrated Learning From Priority Categories

	Incident Type	Speciality
7	Treatment / Procedure Delay / Failure	RMCH-wide
8	Clinical Assessment – Test Results/Reports	RMCH-wide
9	Documentation	RMCH-wide
10	Disruptive, Aggressive Behavior	RMCH-wide

Defining our patient safety improvement profile

Utilising the themes and trends identified within the RMCH Patient Safety profile, a number of safety improvement initiatives have been identified and commenced as outlined in Table 2, below.

Alongside the development of a safety oversight system within RMCH, which will allow for ongoing review and consideration of the RMCH risk and improvement profile, a proactive safety approach to the areas identified within the profile below, by undertaking focused work at both Hospital and local ward and department level.

Improvement profiles will be flexible and will be updated according to intelligence gained via the RMCH safety oversight system and learning gained from high impact learning reviews and PSII reviews.

Table 2: RMCH Improvement workstreams/ priorities.

Priority Category	Improvement Objective/ Commitment
Priority Category 1: Medication	We will implement the RMCH MCS Medicines Safety Strategy that is multi-disciplinary and is aligned to current safety monitoring structures.
	We will review the second checking of medicines process in place across RMCH to ensure it is effective and being used consistently across all areas.
	We will undertake a review of medicines storage across all areas of RMCH to ensure that medicine cupboards meet regulatory requirements and are fit for purpose.
	We will grow and develop the RMCH Medicines Safety Group, which will have appropriate representation from across all professions.
	We will review of the way in which medicine related incidents are investigated and ensure learning from what goes well, is incorporated into the learning culture of RMCH MCS.
Priority category 2: Patient Care, Monitoring, Review	RMCH will be a key stakeholder and pilot area for the launch of the national NPEWS tool.
	We will lead on Group wide Sepsis improvement workstreams, to ensure that Paediatric Sepsis pathways are effective across all Paediatric areas within the Trust (including NMGH and WTWA ED)
	We will develop a mandated centralised EWS/ Watcher's system.
	We will review the existing ESCALATE escalation pathway, to support appropriate and consistent escalation and response to parental and staff concerns.
	We will launch the Lead Consultant policy across RMCH.
	We will ensure robust oversight and monitoring of HIVE data, to ensure every patient has a provider care team and lead consultant allocated to them on admission to Hospital.
	We will develop of a robust monitoring system for NPEWS triggers and response via the RMCH Accountability Oversight Framework (AOF).
	We will launch our localised parental concerns process 'Speak to Sister, Chat to Charge Nurse' including the utilisation of the incident management process, as opposed to complaints process, for concerns raised by families about clinical incidents.
	We will optimise the data available from the parental concerns element of the NPEWS national tool.

Priority Category	Improvement Objective/ Commitment
Priority category 3: Access, Admission, Transfer, Discharge.	We will optimise the way in which HIVE supports patient access to services, including the promotion of proxy access to the MYMFT app.
	We will develop a safety oversight system across RMCH, to prevent patients becoming lost to follow up.
	We will ensure robust monitoring of the RMCH Transfer policy through clinical audit activity, to ensure that the policy is fit for purpose and that it promotes safety for all intra and inter Hospital transfers.
	We will review the RMCH Discharge policy to ensure it is fit for purpose and that it promotes safety.
	We will ensure that RMCH has robust transition plans in place across all of its relevant speciality teams, to ensure that all relevant patients are transitioned into adult services within a timely and effective manner.
	We will continue to implement innovative operational initiatives, such as the launch of virtual wards and a virtual discharge lounge, which will promote effective pathways for patients that are not only safe but reduce long waits and improve patient and families' experiences of RMCH services.
Priority category 4: Infrastructure – Staffing, Facilities, Utilities.	We will continue to develop our Hospital 24 rota's and undertake a comprehensive review of junior doctor rotas, workload, skill mix, and alternative roles being undertaken across RMCH for both in and out of hours.
Priority category 5: Communication Failure.	We will launch our parental concerns process, Speak to Sister, Chat to Charge Nurse across RMCH.
	We will utilise the incident reporting system to manage parental concerns, supporting Group wide work to establish a mechanism that allows families to report incidents/ concerns directly.
	We will further develop and enhance the RMCH Significant Event Team Support System (SETS), to ensure that all staff across RMCH are supported when there has been a significant patient safety event.
	We will review communication training and models in use across RMCH to enhance communication between teams.
	We will launch the Civility saves lives programme across RMCH.
	We will develop an RMCH patient and family's involvement and engagement strategy.
Priority category 6: Medical Device Failure.	We will demonstrate robust monitoring of medical device training compliance across RMCH.
	We will ensure all device related incidents are appropriately recorded via the yellow card system.
	We will ensure health and safety incidents are robustly reviewed and that learning is shared across RMCH.
Priority category 7: Treatment / Procedure Delay / Failure.	We will optimise the Theatre improvement programme, including a review of theatre utilisation.
	We will ensure our waiting list monitoring process is robust and that it ensures that patients are appropriately prioritised according to their clinical urgency.
	We will further develop and monitor our harm review process for long waiters.
Priority category 8: Clinical Assessment – Test Results/Reports.	We will review the processes for notification of critical results to ward medical and nursing staff to ensure thresholds are correct and that appropriate staff are being notified via suitable communication methods
	We will review HIVE results acknowledgement data by ward and specialty and develop actions and a trajectory for improved results acknowledgement performance

Priority Category	Improvement Objective/ Commitment
Priority category 9: Documentation.	We will ensure that documentation on patients records, meets the required standards, through an annual clinical audit.
	We will ensure the safe and effective storage of section paperwork and Deprivation of Liberty orders, within the HIVE system, through biannual audit cycles.
	We will ensure that safeguarding practices via HIVE are safe and effective and ensure that there is a clear line of sight for staff of any patients and families under a safeguarding plan.
Priority category 10: Disruptive, Aggressive Behavior.	We will develop our staff knowledge and confidence in relation to legal frameworks and processes for children and young people in crisis.
	We will review our environmental risks associated with the care of complex patient groups within an acute setting.
	We will scope training opportunities for our staff relating to communication with patients, families, and each other.
	We will review and develop our 'Managing and Maintaining Relationships with Families' guidance, to ensure that our families and our staff are supported to work collaboratively from admission.
	We will continue to develop the newly established RMCH mental health delivery group.
Overarching/ All Priority Categories	We will strengthen our processes of and accessibility of all policies and guidelines across RMCH/MCS.
	We will develop a safety oversight system within RMCH that will ensure timely escalation and response to emerging risks and issues.
	We will develop a Hospital Quality and Safety Strategy/Plan, to ensure that the Hospital's vision and safety objectives are clearly captured and articulated to staff and families.
	We will ensure that our localised improving quality work-streams are aligned to the RMCH MCS audit strategy and held and/ or monitored centrally.
	We will develop an RMCH Quality and Safety communication strategy. To ensure effective shared learning is achieved and that there is engagement of all staff in Safety processes, from Board to ward.
	We will review the just culture system across RMCH, ensuring this is understood and applied consistently, to ensure that all staff are supported through all significant events.
	We will continuously review our staff education and training availability and format.

Our patient safety incident response plan: **national requirements**

Patient safety incident type	Required response	Anticipated improvement route
Eg incidents meeting the Never Events criteria	PSII	Create local organisational actions and feed these into the quality improvement strategy
Eg death thought more likely than not due to problems in care (in-cident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs)	PSII	Create local organisational actions and feed these into the quality improvement strategy
Eg incident meeting Each Baby Counts criteria	Referred to Healthcare Safety Investigation Branch for independent patient safety incident investigation	Respond to recommendations as required and feed actions into the quality improvement strategy

Our patient safety incident response plan: **local focus**

Patient safety incident type or issue	Planned response	Anticipated improvement route
Never Events	PSII	Create local safety actions and feed these into both localised and Group wide oversight/ improvement workstreams.
Incidents where death has occurred, and potential contributory factors have been identified	PSII	Create local safety actions and feed these into both localised and Group wide oversight/ improvement workstreams.
Incidents where death has occurred, and potential contributory factors have been identified	CDRM/ Mortality Review	Learning shared via quality and patient safety structures.
Incidents raised by patients and families	HILA/PSII	Inform ongoing improvement efforts
Incidents within the patient safety profile	HILA/PSII/ alignment to improvement workstreams	SEIPS review/Inform ongoing improvement efforts

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NHS
Manchester University
NHS Foundation Trust

MREH & UDHM

Patient Safety Incident Response Plan

2022-2025

Safety Differently

Effective date: August 2023
Estimated refresh date: August 2024

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Authoriser				

Contents

Introduction

The patient safety incident response plan (PSIRP) July 2023 sets out how MREH and UDHM will seek to learn from patient safety incidents reported by staff and patients, their families, and carers as part of our work to continually improve the quality and safety of the care we provide.

Due to the size and structure of MFT, there is a Group level PSIRP which outlines the priorities of the organisation, supported by localised PSIRP's for each Hospital/MCS.

MREH and UDHM are part of Manchester University NHS Foundation Trust which is an NHS Acute Foundation Trust which operates 10 hospitals throughout Greater Manchester. It is the largest NHS trust in the United Kingdom. The Trust was formed on 1st October 2017 following the merger of Central Manchester University Hospitals NHS Foundation Trust (CMFT) and University Hospital of South Manchester NHS Foundation Trust (UHSM), and more recently the acquisition of North Manchester Hospital (NMGH).

MREH and UDHM provide ophthalmic and dental services to the local population of Manchester but are also tertiary centres providing specialist care and services across the UK.

This plan will help us measurably improve the efficacy of our local patient safety incident investigations (PSIIs) by:

A. *refocusing PSII towards a systems approach and the rigorous identification of interconnected causal factors and systems issues*

B. *focusing on addressing these causal factors and the use of improvement science to prevent or continuously and measurably reduce repeat patient safety risks and incidents*

C. *transferring the emphasis from the quantity to the quality of PSIIs such that it increases our stakeholders' (notably patients, families, carers and staff) confidence in the improvement of patient safety through learning from incidents*

D. *demonstrating the added value from the above approach..*

The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Scope

A PSIRP is a requirement of each provider or group/network of providers delivering NHS-funded care.

The PSIRP document should be read alongside the introductory Patient Safety Incident Response Framework (PSIRF) 2022, which sets out the requirement for this plan to be developed.

The aim of this approach is to continually improve. As such this document will be reviewed every 12 – 18 months to ensure that the site plan remains appropriate to the Hospitals changing patient safety profile.

There are many ways to respond to an incident. **This PSIRP covers responses conducted solely for the purpose of system learning and improvement.**

Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patient's receiving healthcare.

There is no remit to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement.

Responses covered in the plan include Patient Safety Incident Investigations, High Impact learning Assessments (HILA) and Patient Safety Reviews (PSRs).

Other systems are in place to manage specific issues or concerns. These include complaints management, legal claims, human resources investigations, professional standards investigations and rarely for MREH and UDHM coroners' inquests or criminal investigations. The principle aims of each of these responses differ from the aims of a patient safety response and are outside the scope of this plan. Where a response is required that is not conducted for patient safety, learning and improvement then the response will be appropriately referred to the relevant department.

MREH & UDHM Strategic objectives

- Improve the safety of the care we provide to our patients and their families and improve our patients', their families', and carers' experience of it.
- Further develop systems of care to improve quality and efficiency.
- Respond quickly to incidents to ensure immediate safety actions are taken where needed.
- Improve the experience for patients, their families and carer's wherever a patient safety incident or the need for a PSII is identified.
- Involve patients and their carers in line with the Framework for Involving patients in Patient Safety (NHS June 2021)
- Improve the working environment for staff in relation to their experiences of patient safety incidents and investigations.
- Improve methods of communication to all staff in relation to reported incidents, investigations, and risk management.
- Work with regulators and external organisations to ensure care is timely, safe and exceeds expected standards.

Addressing health inequalities

As a provider of healthcare across Greater Manchester MFT has a role to play in tackling health inequalities in partnership with our local partner agencies and services. However, most of the fundamental factors driving inequalities in health are beyond the responsibility of the health care system, for example education; economic and community development in our most deprived neighbourhoods; employment levels; pay and conditions; and availability of quality of housing. Through the implementation of PSIRP, MREH and UDHM will seek to utilise data and learning from investigations to identify actual and potential health inequalities and make recommendations to support tackling these.

Our engagement with patients, families and carers following a patient safety investigation must also recognise diverse needs and ensure inclusivity for all. Any potential inclusivity or diversity issues must always be identified through the investigation process and engagement with patients and families, for example, during the duty of candour / being open process.

Both MREH and UDHM have identified a large proportion of health inequalities within their services including elderly patients, young patients who may not realise long term health implications of their conditions and those patients with learning disabilities and autism.

Our Services - MREH

MREH provides ophthalmic services both on the Oxford Road Campus (ORC) and at satellite areas based at Altrincham General Hospital (AGH) , Withington Cataract Centre (WCC), Trafford Hospital and within specialist community sites at Wythenshawe shopping centre and Cheetham Hill shopping centre.

Oxford Road Campus

- Theatres
- Genetics
- Macular Treatment
- Daycase & Pre -
- Specialist Services
- Emergency Eye Dept
- Inpatients
- Orthoptics
- Optometry

Community Hospitals

- AGH
  - Virtual Clinics
  - Outpatients

Paediatric Ophthalmology and Retinopathy of Prematurity

- St Marys
- NMGH
- Stepping Hill
- Wythenshawe

Outreach

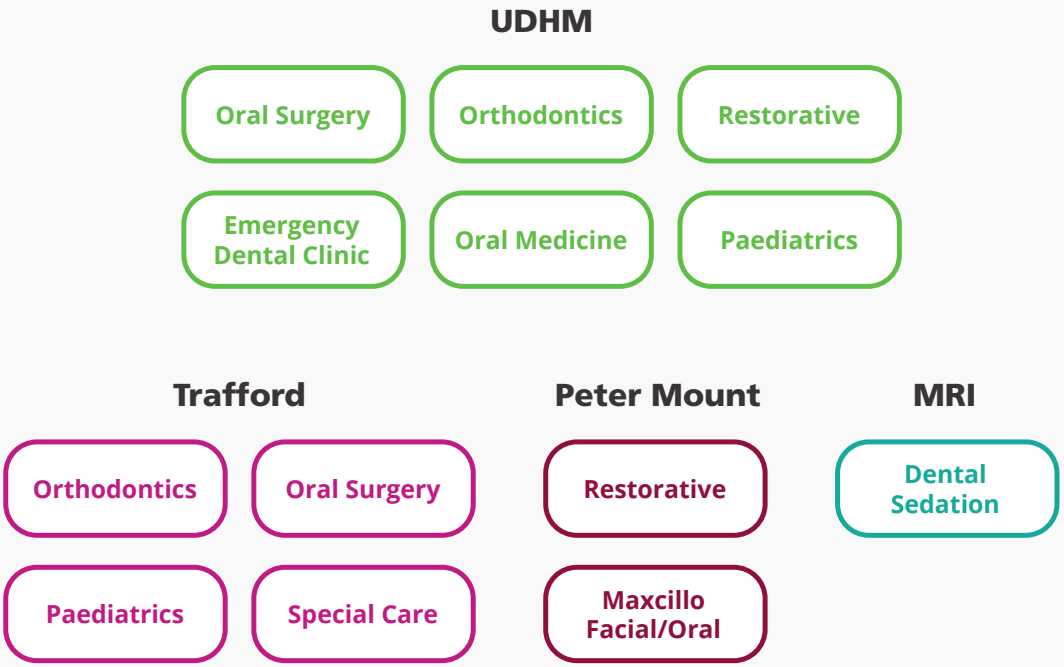
- Christies Hospital
- Salford Hospital
- Wythenshawe Community

Satellite Units & Virtual Clinics

- St Marys
  - St Marys
- NMGH
  - Wythenshawe
- Stepping Hill
  - Stepping Hill

Our Services - UDHM

UDHM provides dental services on the Oxford Road Site and at Trafford



Defining our patient safety incident profile

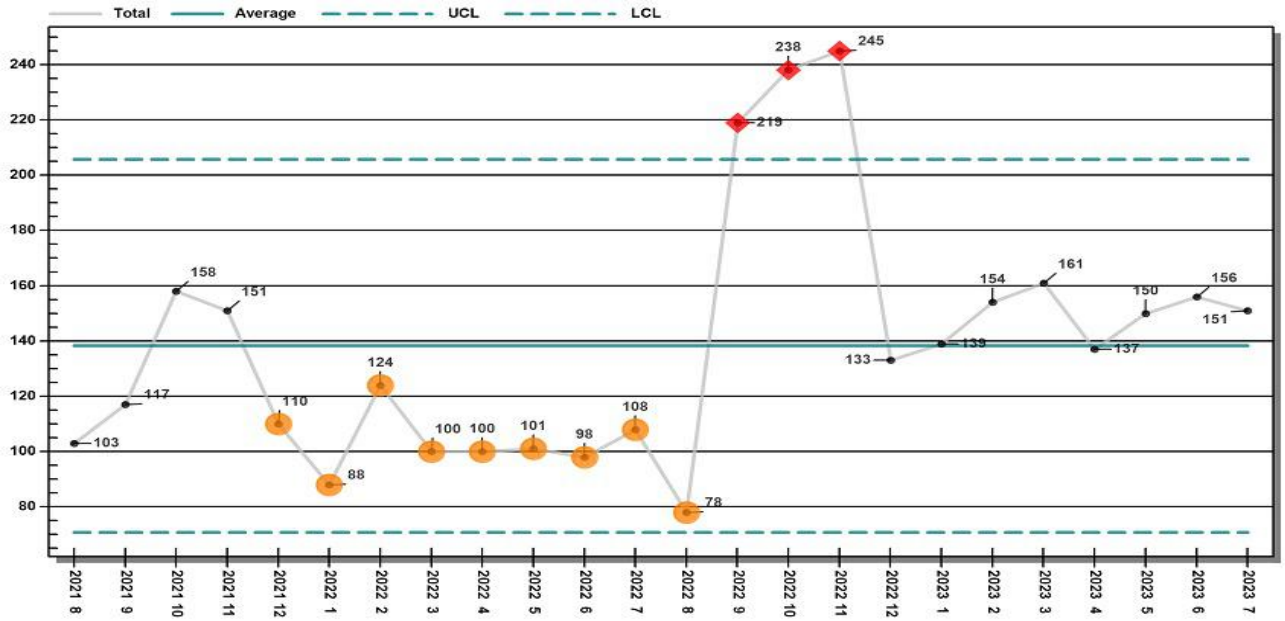
MREH and UDHM have and are focused on improving our approach to patient safety incidents, with many great examples of learning and involvement.

Essential to this has been the ongoing development of a patient safety culture in which people feel safe to talk. Having conversations with people relating to a patient safety incident can be difficult and MREH and UDHM will continue to explore how we can equip and support our colleagues to best hear the voice of those involved. This has included the use of High Impact Learning Assessments (HILA) as well as a move towards system-based reviews rather than root cause analysis.

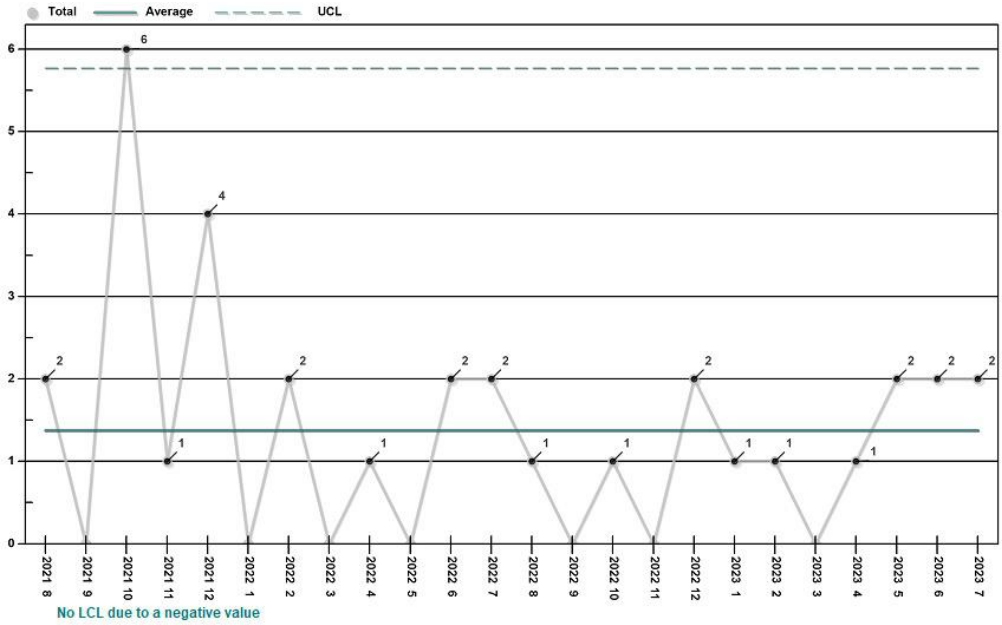
It is important to recognise that there are good reasons to carry out an investigation. Sharing findings, speaking with those involved, validating the decisions made in caring for patients and facilitating psychological closure for those involved are all core objectives of an investigation. The challenge for us is to develop an approach to investigations that facilitates thematic insights to inform ongoing improvement. Our approach must acknowledge the importance

Patient safety incidents and Hospital level risks for MREH and UDHM have been profiled using organisational data including:

- Incident reports
- Complaints, PALS and compliments
- Excellent reports and "shout outs"
- Legal claims
- Audit where there is a patient safety focus. NB UDHM do not participate in National Clinical audits and MREH supply data for complication and visual outcomes of cataract surgery to the national Ophthalmic Database
- Review of the MREH and UDHM risk registers to ensure that the risk registers include patient safety risks that reflect the reported incidents, audit action plans and themes from complaints.
- Quality Care Round (QCR), What Matters To Me (WMTM) and Friends and Family Test (FFT) data is reviewed as a part of the Quality meeting



All incidents for MREH and UDHM



Notifiable incidents for MREH and UDHM

Defining our patient safety improvement profile

Our incident profile between August 2021 and July 2023 our risk profile and our patient experience metrics has enabled MREH and UDHM to identify a list of priorities with the aim to improve the safety of our patients and their families across our hospital sites and in the community.

MREH Table 1

	Incident type	Specialty
1	Capacity across all specialties	ALL
2	Access, admission, transfer and discharge	ALL
3	Clinical assessment, diagnosis and tests	ALL
4	Patient treatment/procedure /surgery	ALL
5	Patient care monitoring and review	ALL
6	Medication	ALL
7	Falls, slips and trips	ALL
8	Infection/ sepsis management	ALL
9	Communication and consent	ALL
10	Medical devices	ALL

UDHM Table 1

	Incident type	Specialty
1	Capacity within services	ALL
2	Communication and consent	ALL
3	Access, admission, transfer and discharge	ALL
4	Medical device and equipment	ALL
5	Patient treatment/procedure and surgery	ALL
6	Infrastructure – staffing, facilities, utilities	ALL
7	Patient care, monitoring, review	ALL
8	Health and safety/general accident	ALL
9	Documentation and information governance	ALL
10	Falls. Slips and trips.	ALL

The key priorities for MREH and UDHM are:

- Maximise capacity both surgical and outpatients to ensure patients are treated and reviewed in the recommended time frames.
- Develop new ways of working which operate safely and within MFT and national guidelines in order to increase capacity.
- Focus relentlessly on improving access, safety, clinical activity and outcomes.
- Improve continuously the experience of patients, carers and families.
- Implement the People Plan to support staff and developing their skills to ensure that safe and effective care is provided.
- Improve communication with all staff across MREH and UDHM in relation to incident and investigation feedback and risk management.

The key priorities are discussed through the following Committees:

- Quality and Safety Committee (MREH & UHDM)
- Safety Committee (MREH & UDHM)
- Hospital Management Board (MREH & UDHM)
- Joint Quality Board
- Joint Safeguarding Committee
- Joint Infection Control meeting
- MREH Pharmacy Sub Committee
- MFT Medicines Safety Committee
- Risk Management Committee (MREH & UDHM)

Our patient safety incident response plan: **national requirements**

Patient Safety incidents that 'must' be investigated under PSIRF are detailed below in table 1.

Patient safety incident type	Required response	Anticipated improvement route
Eg incidents meeting the Never Events criteria	PSII	Create local organisational actions and feed these into the MREH & UDHM quality improvement strategy
Eg death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	PSII	Create local organisational actions and feed these into the MREH and UDHM quality improvement strategy
Safeguarding Incidents	PSII	Respond to recommendations as required and feed actions into the MREH & UDHM quality improvement strategy

Our patient safety incident response plan: **local focus** MREH

Patient safety incident type	Required response	Anticipated improvement route
Capacity across all specialties	HILA, Swarm, PSII, MDT	Quality and Safety Committee Risk Committee
Access, admission, transfer, and discharge	HILA, Swarm, MDT PSII Observation Walkthrough	Locally identified work streams, Quality and Safety Committee
Clinical assessment, diagnosis, and tests	HILA MDT PSII Walkthrough	Locally identified work streams, Quality and Safety Committee, Risk Committee
Patient treatment/procedure/ surgery	HILA MDT PSII Swarm Walkthrough	Theatre Improvement Board Safety Committee
Patient care monitoring and review	HILA MDT PSII Swarm Walkthrough Observation	Quality and Safety Committee Safety Committee
Medication	HILA Swarm MDT, PSII Walkthrough Observation	Pharmacy Sub Committee – MREH MFT Medicines safety Committee
Falls, slips and trips	HILA PSII	Quality and Safety Committee Joint Quality Committee
Infection/sepsis management	HILA PSII	Joint infection Control Committee MFT Infection control committee
Communication and consent	HILA MDT	Theatre Improvement Board
Medical devices	HILA Observation Walkthrough PSII	Safety Committee MFT Medical Device Management group

Our patient safety incident response plan: **local focus**
UDHM

Patient safety incident type	Required response	Anticipated improvement route
Capacity within services	HILA, Swarm, PSII, MDT	Quality and Safety Committee Risk Committee
Communication and consent	HILA MDT	Quality and safety Committee
Access, admission, transfer and discharge	HILA, Swarm, MDT PSII Observation Walkthrough	Locally identified work streams, Quality and Safety Committee
Medical device and equipment	HILA Observation Walkthrough PSII	Safety Committee MFT Medical Device Management group
Patient treatment/procedure and surgery	HILA MDT PSII Swarm Walkthrough	Safety Committee
Infrastructure – staffing, facilities, utilities	MDT Walkthrough HILA	Quality and Safety Committee Local workstreams
Patient care, monitoring, review	HILA MDT PSII Swarm Walkthrough Observation	Quality and Safety Committee Safety Committee
Health and safety/general accident	HILA MDT PSII Swarm Walkthrough Observation	Local health and safety Committee MFT Health, Safety and well-being Committee
Documentation and informa-tion governance	HILA Swarm MDT	Safety Committee Risk Committee
Falls, slips and trips	HILA PSII	Quality and Safety Committee Joint Quality Committee

Where a PSII is required (as defined in this Plan for both local and national priorities), the investigation / review will start as soon as possible after the patient safety incident is identified. PSII will usually be completed within one to three months of their start date, but not exceeding six months. Any PSII anticipated to require an extended timeframe should be agreed with the patient/family/carer.

Incidents that meet the Statutory Duty of Candour thresholds

There is no legal duty to investigate a patient safety incident. Once an incident that meets the Statutory Duty of Candour threshold has been identified, the legal duty, as described in Regulation 20 says we must:

1. Tell the person/people involved (including family where appropriate) that the safety incident has taken place.

2. Apologise. For example, “we are very sorry that this happened”.

3. Provide a true account of what happened, explaining whatever you know at that point.

4. Explain what else you are going to do to understand the events. For example, review the facts and develop a brief timeline of events.

5. Follow up by providing this information, and the apology, in writing, and providing an update. For example, talking them through the timeline.

6. Keep a secure written record of all meetings and communications.

Resource analysis

The current incident management structure relies heavily on the Clinical Effectiveness team with limited support from senior clinicians and departmental managers undertaking reviews in their allotted management time. The MREH & UDHM Clinical Effectiveness team do not have any line management responsibilities with regards investigators apart from the team itself and thus limited influence over how investigators prioritise their time for investigations. Investigation reports have MREH and UDHM senior leadership team sign off.

In order to effectively deliver the requirements of the patient safety incident investigation standards and the PSIRF, consideration of the required resources and training is required.

It is recommended that learning responses are led by staff at band 8A and above who have had no involvement in the incident itself or by those who directly manage those staff involved.

Therefore, MREH and UDHM need to complete a resource analysis looking at job planning and training needs of those identified staff to complete PSIIs in the required time frame

Agenda Item 11.7

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Joint Group Medical Director
Paper prepared by:	Dr Tanya Claridge, Acting Group Director of Clinical Governance
Date of paper:	September 2023
Subject:	Focus on Never Events
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support ✓ • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Patient safety and clinical quality
Recommendations:	The Board of Directors is asked to: • note the content of the report • acknowledge the progress being made in relation to the transformative approach to understanding patient safety across the Trust • note the alignment of the work of the Trust with strategic risk exposure described in the Board Assurance Framework and Integrated Performance Report
Contact:	Name: Dr Tanya Claridge, Acting Group Director of Clinical Governance Tel: 0161 276 8764

1. Introduction

The Trust recognised that in pursuit of achieving its strategic aim, *to focus relentlessly on improving access, safety, clinical quality and outcomes*, a range of enablers and controls need to be in place to effectively manage and mitigate the risk associated with a failure to understand the way that our staff and our patients interact with systems and processes of care effectively to optimise care delivery 'human/system interaction'.

Without these enablers and controls, and their effective application, the Trust was clear that patient safety incidents and never events will continue to occur leading to potential serious physical or psychological harm for patients and their families, the teams caring for the patient, and that this will have a significant impact on stakeholder confidence in the Trust.

The Trust escalated a risk relating to the failure to effectively understand human/system interaction for oversight and scrutiny at the Group Risk Oversight Committee in 2021, with a range of actions completed to mitigate the risk, including those related to the implementation of the Patient Safety Incident Response Framework.

The Quality Performance and Scrutiny Committee considered a paper at its meeting in June 2023, which provided evidence of how the learning from Never Events, near miss never events and the safety oversight system in general has been used to support, direct and strengthen the approach to mitigating the risk, and demonstrated now how there is a consistent approach to applying systems thinking and human factors methods to patient safety insight, learning and response.

As a result of the deliberations of the Committee, it was agreed that the strategic risk of not 'understanding' the impact of the way staff and patients interact with our systems and processes of care to enable safety could be closed, with all actions completed, and that specific risk mitigated. It was agreed that the risk exposure now related to the potential impact of not optimising that interaction through better system and process design and the direct application of human factors and ergonomic design principles. The Group Risk Oversight Committee will receive the closure report and the revised escalated risk exposure at its meeting in September 2023.

2. Never Events

Never Events are serious incidents considered wholly preventable because there exist strong systemic protective barriers[1]. Their occurrence implies that the relevant barriers were not in place, or they were in place but not adhered to. Understandably, Never Events are used by regulators to help judge the 'safety culture' within a Trust.

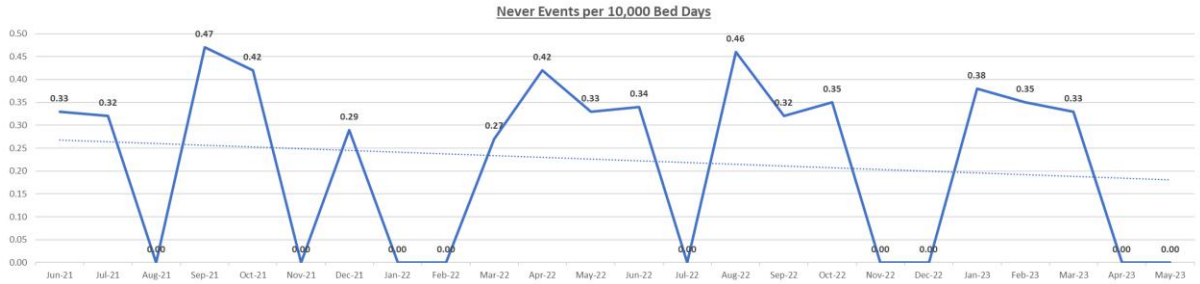
However, it is only their absolute number that is used. MFT has reported 8 Never Events in the last 12 months rolling period, the most recent in July 2023: the more Never Events a Trust has in a year, the more concern there is about the underlying safety culture. The Care Quality Commission is clear in its statement that "[even] a single never event can act as a red flag that an organisation's systems may not be robust"[2]. This was reflected in their 'Insight' publication, where the absolute number is used as an indication of worsening performance. There is some justification to this approach because a Never Event has the potential to cause serious patient harm or death (although fortunately only a small minority do) and might suggest a consistent failure to apply or follow processes and policies. In this way, regulatory oversight might identify the consistently under-performing 'outlier' centres where culture may be problematic, as a focus for intervention.

[1] https://www.england.nhs.uk/patient-safety/revised-never-events-policy-and-framework/

[2] https://www.cqc.org.uk/publications/themed-work/opening-door-change

It is now well established that the number of Never Events occurring in an organisation is related primarily to its size (workload) and, at least for surgical Never Events, does not generally correlate with other measures of performance[3], implying they are random rare events. In other words, the bigger (busier) the Trust, the more Never Events it is likely to have. This is self-evident on first principles. A Never Event is a 'binomial' event; it either occurs or not; and can only occur if preceded by the necessary causative or precursor intervention. A nasogastric tube cannot be misplaced if never sited; a wrong side block cannot happen if there is no anaesthetic injection.

The quantification and analysis of Never Events and their occurrence in relation to the 'measurement of safety culture' is complex. The Trust has previously explored the clear correlation of the 'absolute number' with caseload, developing a 'rate' and comparing that with other acute Trusts (See Graph 1). However, this is further complicated Never events are pooled as a single category and the episodes are all regarded as if equally likely to cause them. Therefore, the manner in which Never Event data are collected and presented does not permit the adjustment of these by the relevant denominator data (i.e.the number of wrong side blocks should be adjusted by only the number of total blocks and not by any other statistic).



Graph 1: never events per 10,000 Bed Days

It is appropriate to adjust never event data for case volume, if not a hospital performing just one procedure per year would be judged on the same basis as one performing several hundred thousand. However, the adjustment for case volume, in its aggregated sense is compromised, as described above, in relation to the Trust's attempts to analyse Never Events as a rate, the denominator needs to be appropriate and also account needs to be taken of the impact of the primary reporting of both Never Events and also of caseload.

The other complicating factor in the use of the presence or absence of Never Events as a determinant of safety culture and the effective optimisation of human/system interaction, is safety science in its purest sense; the absence of harm does not mean that care systems are safe.

The National Patient Safety Strategy (2019) is clear that the NHS should be applying the principles of safety II and 'safety differently' and the focus should be on understanding and optimising the reliability of system and human/system interaction, and ensuring they are effective in enabling safety, rather than preventing harm. 'Systems thinking' is now recommended in healthcare to support quality and safety activities but a shared understanding of this concept and purposeful guidance on its application remain limited. Th Trust is working to implement systems thinking, incorporating a 'Safety-II systems approach' to promote understanding of how safety may be achieved in complex work systems where human adaptation to localised circumstances is often necessary to achieve success.

[3] Moppett IK, Moppett SH. Surgical caseload and the risk of surgical Never Events in England. Anaesthesia 2016; 71: 17–30.

It is anticipated that over the next 12 to 18 months the Trust will have developed a range of reliability measures that will serve as an indicator of patient safety culture and the effective optimisation of human and system interaction, supported by quantitative and qualitative data. This will be presented as a context with data relating to absolute patient safety event data, including Never Events.

3. Never Events: An opportunity for high impact and transferable learning?

Without exception, the systems reviews into the circumstances surrounding individual Never Events reported across the Trust, aligned with the outcome of other relevant patient safety event reviews (including near miss never events and safety II focused reviews has yielded significant high impact and transferable learning. This learning is presented in a culminative way in the Trust's monthly patient safety profile. The learning identified is routinely subject to a consideration in relation to the most effective knowledge transfer mechanism, measures of success for any improvement identified, the focus for further curiosity and an assurance strategy is developed.

The Quality Performance and Scrutiny Committee received a detailed paper describing the learning from the Never events profile, near miss incidents and other sources of patient safety intelligence presented in a 'systems theory' format (See Figure 1), with learning from all reviews presented together, with particular emphasis on where the safety I and safety II learning directly complemented each other.

Figure 1: Systems theory (SEIPS 2.0)

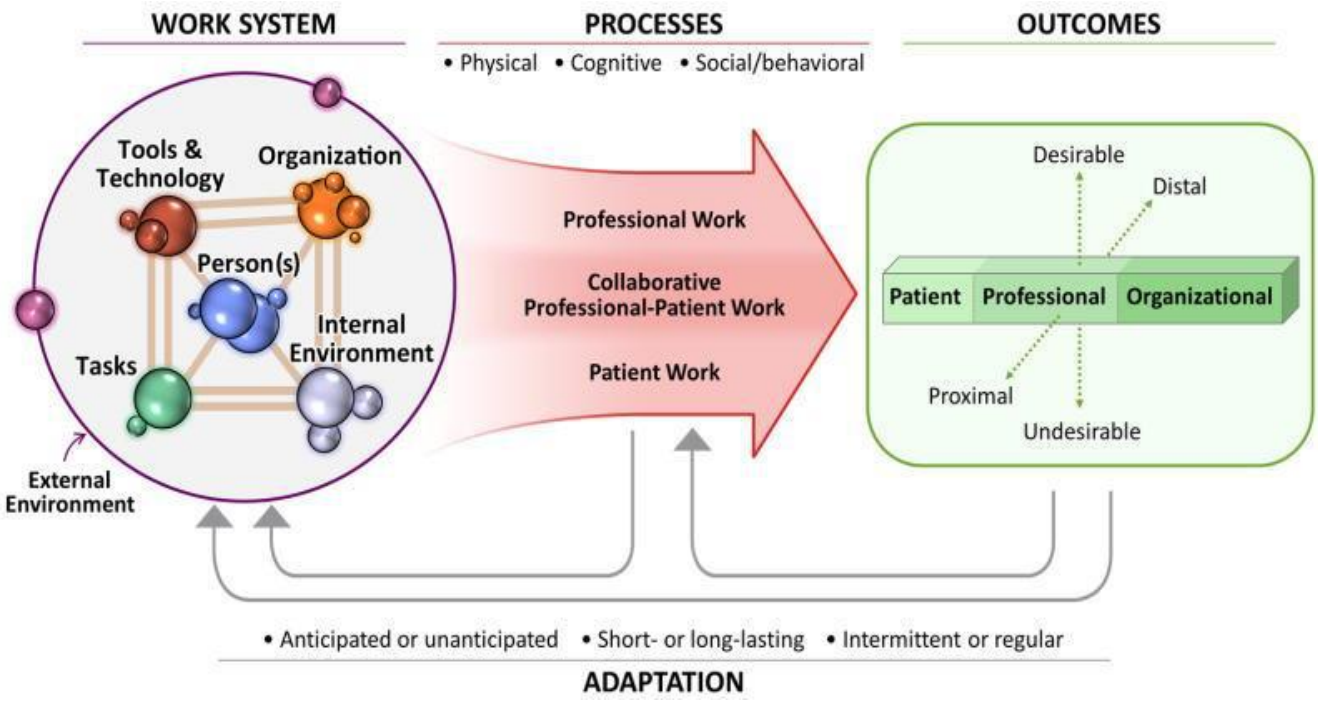


Table 1 provides a summary of the thematic analysis of the high impact learning generated from the Trust's Never Event profile, the work of the safety oversight system, including safety II type analysis.

Table 1: Thematic Analysis of learning

Thematic analysis	We know that risk is increased by:	We know safety is enabled by:
	Psychological stress and distress Sub-optimal arrangements for service transition Lack of harmonisation of procedural documentation Lack of clarity in relation to the role of the second checker Desensitisation to risk Lack of implementation of all available barriers (for instance, controlled procurement) Lack of understanding the importance of a mature patient safety culture Sub-optimal transfer of learning within and between sites/MCS/LCO An inconsistent approach to assurance Procedures and policy not tested in different environments (work as imagined vs work as done) The lack of substantive and consistent leadership Leadership behaviour across the organisation Lack of ergonomic consideration Lack of policy /procedure Lack of organisational understanding of what is an invasive procedure Assumption that lack of harm means processes are safe	Positive communication internally and externally Thinking of the patient throughout the whole care pathway Listening to patients and including them in decisions about their care Consider care pathways and processes through patient perspective Including patients' carers in decisions about their care and treatment Support staff with appropriate training and allowing them the time to attend courses Providing appropriate induction for staff when moving between departments/sites Ensuring staff know how to escalate issues and the processes to follow, internally and externally Understanding the roles and responsibilities of each team member Strong and supportive leadership Experienced staff within teams Consistency in skills and experience within teams Shared focus and goals, Familiar team working, Trust in team members Right climate = right culture Time to think

4. Responding and improving

Following any patient safety incident including Never Event, there is routine consideration of areas of improvement identified by any investigation or learning response. These actions can be local, for instance an ergonomic change to a specific environment, or relevant to the whole Trust. This 'sphere of influence and control' of the areas of improvement is reviewed at a Trust- wide forum (a Serious Incident Requiring Investigation Panel or Improving Reliability Improving Safety Panel) to ensure that the right subject matter expertise and support is available.

The Trust wide actions taken in response to the learning from Never Events, near miss never events and other safety events identified through the safety oversight system aligns to the evolution from "old" thinking about human error to "new" thinking in healthcare-based resilience engineering in which the focus is not just on what went wrong (Safety-I) but better understanding the everyday performance that usually succeeds (Safety-II). Safety-II considers the ability of systems to adapt to variation, disruption, and degradation of expected conditions.

During 2022/23 there has been a noticeable transition in the approach to the review of Never Events, with explicit human factors tools and techniques evident in the reports. The investigations have moved from a focus on incident barrier classification and analysis, to enabling safety through systems thinking. This demonstrates the Trust's recognition that a reactive approach was insufficient, necessitating accident prevention and retrospective management of risk, to a different approach to safety as a dynamic event, situated in a systems with complex interdependencies.

Importantly, the reactive approach of Safety-I is complemented (not replaced) by proactive Safety-II approaches that attempt to develop ways to support things that "go right".

The Human Factors Academy has undertaken a wide range initiatives during 2022/23 in

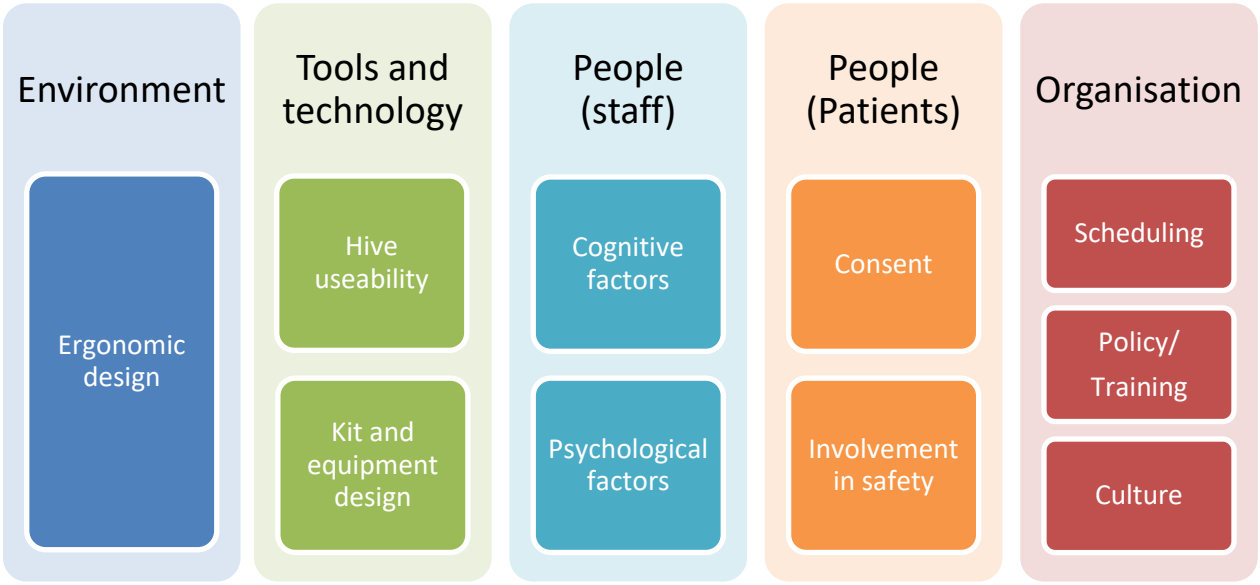
response to learning from the safety oversight system, with particular focus on understanding human and system interaction. These initiatives have included

- A targeted ethnographic study into the cultural workings of a complex acute care delivery area demonstrated how an ethnographic model can support learning about 'work as done' and what we do well. The key identified themes helped provide important clarity and foundation upon which the human factors academy would support 'enabling safety' across the Trust (See Appendix 1 for draft publication paper)
- Project 2v- the development of a hot-debrief tool following an incident
- Human Factors walk rounds - focus on picking errors (completed)
- New document on storage and labelling of IV fluids on wards (to be tested)
- Development QRG with staff through simulation to ensure new policy reflects WAD
- Functional Resonance Analysis Methodology (FRAM) – Controlled drug from arrival to patient processes
- The integration of LocSSIPs into Hive
- FRAM- Swab count
- Ethnographic observations in critical care areas around medicine management critical tasks (partly as result of never event)

In addition, and in response to the learning described in this paper the Human Factors Academy is hosting the Trust-wide Optimising Surgical and Invasive Procedural Safety Group. This group was established in April 2023. It is developing a Trust-wide action plan based on the thematic analysis (table 2), and is aligning the safety improvement plan to key workstreams (Figure 2)

The OSIPS members are working alongside Hive and Informatics colleagues to ensure that all improvement actions are prioritised accordingly and that key measures of success are in place that will be monitored through the Patient Safety Committee, assured through the Quality and Safety Committee and scrutinized through the Quality and Performance Scrutiny Committee with their inclusion within the quality component of the Integrated Performance Report.

Figure 2: safety improvement plan workstreams



5. Conclusion

The Trust has, in pursuit of achieving its strategic aim, to focus relentlessly on improving access, safety, clinical quality and outcomes, put in place a range of enablers and controls to effectively manage and mitigate the risk associated with a failure to understand human-system interactions effectively to optimise care delivery.

With these enablers and controls in place, and a renewed focus on their effective application, the Quality Performance and Scrutiny Committee agreed that the current strategic risk 'the failure to effectively **understand** human/system interaction in relation to patient safety' is closed by September 2023. It is proposed that a new risk 'the failure to effectively **optimise** human system interaction' is assessed by the OSIPS group to replace the current strategic risk and discussed at the September meeting of GROC

This will align to the implementation of the Patient Safety Incident Response Framework (PSIRF) across the Trust, and the completion of all the associated actions and the publication of the Trust-wide Patient Safety Incident Response Plan.

6. Recommendations

The Board of Directors is asked to:

- note the content of the report
- acknowledge the progress being made in relation to the transformative approach to understanding patient safety
- note the alignment of the work of the Trust with strategic risk exposure described in the Board Assurance Framework and Integrated Performance Report

Agenda Item 11.8

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Joint Group Executive Medical Director
Paper prepared by:	Cameron Chandler, Head of Programmes, Joint Group Executive Medical Directors' team
Date of paper:	September 2023
Subject:	Annual report to the Board of Directors: Management of Medical Appraisal and Revalidation
Purpose of Report:	Indicate which by ✓ • Information to note • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	The issues contained in this report have an impact on medical staff engagement, quality improvement and organisational reputation
Recommendations:	The Board of Directors is asked to receive this update as part of the Annual Board Report on the implementation of Medical Revalidation, and approve submission of an Annual Statement of Compliance to the Higher Level Responsible Officer, NHS England (North West)
Contact:	Name: Cameron Chandler, Head of Programmes Tel: 0161 701 0217

1. Executive summary

This report describes the progress of the Trust over the last financial year in the management of medical appraisal and revalidation.

Summary of key points:

- at the end of the last appraisal year (31 March 2023), MFT had 2,414 doctors with a prescribed connection plus an additional 94 dentists
- 94/7% of connected doctors had an appraisal within the year
- appraisers were rated as 'very good' or 'good' by 99% of appraisees who submitted feedback
- appraisal rates for clinical fellows and short term contract holders have increased to comparable levels with other medical staff
- the Trust has been instructed to submit a signed Statement of Compliance to NHS England for 2022/2023

2. Purpose of the paper

The purpose of this report is to:

- summarise the Trust's performance in relation to medical appraisal and revalidation for the period April 2022 to March 2023
- provide assurance to the Board that the Trust is compliant as a designated body for medical revalidation, continues its pursuit of quality improvement, and that the Responsible Officer (RO) is discharging their statutory responsibilities

3. Background

Revalidation was formally launched in the UK in January 2013 and is the process by which all licensed doctors are required to demonstrate, on a regular basis, that they are up to date and fit to practise in their chosen field and able to provide an appropriate standard of care. The process of revalidation seeks to give extra confidence to patients, the public and the profession that the doctor is being regularly checked by both their employer and the General Medical Council (GMC). Licensed doctors must revalidate usually every five years, part of which is the requirement to have an annual appraisal based on the GMC's Good Medical Practice framework[1]. The Trust's appraisal and revalidation process is managed operationally by the team of the Responsible Officer (RO); a role established in statutory legislation[2] and currently undertaken by Miss Onon. The RO's role is supported by Professor Daniel Keenan and Dr Emma Hurley, Group Associate Medical Directors for Appraisal and Revalidation, in addition to the Chief of Staff, Head of Programmes, and the revalidation administration team.

The revalidation process is based on a recommendation from the RO to the GMC, the regulator making the final decision about revalidating a doctor. In order to make this recommendation, the RO must be assured that:

- the doctor has a track record of engagement with annual appraisals consistent with the guidance on strengthened medical appraisal and has been appraised on the full scope of their practice (including in the Independent Sector) at a single appraisal meeting
- any concerns about the doctor raised through the appraisal have been brought to the attention of the relevant medical line manager and successfully addressed

[1] http://www.gmc-uk.org/static/documents/GMP_.pdf

[2] The Medical Profession (Responsible Officers) Regulations 2010, amended 2013

- the doctor has undertaken a multisource feedback evaluation of their work and professional behaviour, including feedback from both colleagues and patients, and that this has been discussed with their appraiser (one formal multisource feedback per five year revalidation cycle)
- there are no outstanding concerns about the doctor's performance or professional conduct known to the Trust

Options available to the RO are to recommend revalidation, defer the recommendation for a period of up to 12 months (either due to insufficient information for a positive recommendation or because the doctor is subject to an ongoing process), or to notify the GMC of the doctor's non-engagement with the process.

4. Designated body

Manchester University NHS Foundation Trust is a designated body, as established in the Responsible Officer regulations; this also determines which doctors should be connected to the Trust for appraisal and revalidation. At 31 March 2023 (the end of the last appraisal year), 2,414 doctors were connected. 1,506 consultants, 137 SAS grade doctors, 765 temporary and short term contract holders (including clinical fellows and bank doctors), and six other doctors (such as clinical trial physicians). There was an increase on the previous year of 197, primarily consisting of clinical fellows.

Doctors who work jointly within the Trust and the University of Manchester in an academic position are required to undergo a joint appraisal under the Follett Principles. These doctors connect to the Trust for revalidation. Additional doctors who work for the Trust, who are not connected for appraisal and revalidation, include GPs (who connect to one of the NHS England local teams), and doctors who undertake work at MFT but also with another NHS organisation, who is their main employer and designated body. Despite not connecting directly with these doctors, the Trust still has an obligation to monitor their fitness to practise and report any concerns to the doctor's RO. Doctors in a training grade are appraised and revalidated separately by Health Education England.

5. Revalidation

For the appraisal year 01 April 2022 – 31 March 2023, 259 doctors were due to be revalidated. Of the doctors due, 207 doctors were recommended for revalidation and a further 19 were deferred and subsequently revalidated; 32 doctors were deferred with a future revalidation date after 31 March. Of the 32 deferrals, 29 were due to insufficient information and three due to involvement in an ongoing process; one doctor from the period is on hold from the revalidation process due to ongoing GMC investigations. There was also one submission of non-engagement which has been followed up by the GMC; the doctor has subsequently engaged and has been successfully revalidated. All of the recommendations regarding revalidation have been approved by the GMC. For the year April 2023 – March 2024, 479 doctors are due for revalidation.

Revalidations by submission approved date (01/04/22 – 31/03/23)

Designated Body	Total submissions	Revalidated	Deferred	Non-engagement	Late submissions
All DBs (England)	39,958	84.3%	15.4%	0.29%	2.7%
All NHS Acute Trusts	11,580	80.7%	19.1%	0.16%	4.7%
MFT	287	82.2%	17.8%	0.00%	0.0%

For those deferred due to lack of sufficient information, the primary reason for this remains to the absence of patient feedback.

Reasons for Deferral	No. of Deferrals
Patient feedback	24
Colleague feedback	16
Appraisal activity	11
Interruption to practice	10
QIA	2
CPD	2
Compliments and complaints	0
Significant events	0

6. Appraisal

All doctors must ensure that they undergo appraisal within each financial year and are responsible for the continuous collection of their portfolio of evidence covering their full scope of practice. For medical staff who are registered with the GMC as well as the General Dental Council, continued engagement with appraisal is necessary over the course of the five year revalidation cycle.

At 31 March 2023, 2,414 connected doctors were due to have an appraisal within year (01 April – 31 March). The appraisal rate for the 2022-2023 appraisal year is as follows (Table 1):

Table 1. Number of medical appraisals at MFT during 2022 – 2023

Group	Connected	(1) Completed appraisal	(2) Approved incomplete or missed appraisal	(3) Unapproved incomplete or missed appraisal
Consultants	1,506	1,447 (96%)	59 (4%)	0 (0%)
SAS	137	132 (96%)	5 (4%)	0 (0%)
Temporary or short term contract holders	765	701 (92%)	63 (8%)	1 (0.1%)
Other	6	6 (100%)	0 (0%)	0 (0%)
Total	**2,414**	**2,286 (95%)**	**127 (5%)**	**0 (0.4%)**

Category definitions (as established by NHS England)[3]

1. *Appraisal held within year*
2. *Appraisal not held or completed within year with approval from the RO (e.g. maternity leave)*
3. *Appraisal not held or completed within year without approval from the RO*

Consultant and SAS appraisal rates have remained consistent, temporary and short-term contract holders saw a significant increase last year and this has been maintained bringing them in line with other medic groups. These have previously been a problematic group for appraisal compliance and these figures represent a positive improvement.

[3] england.nhs.uk/revalidation/qa/

7. Revalidation management system

The SARD appraisal software was launched in April 2019 with all medical appraisal held via this system. The contract was for an initial three years with the option to extend by two further years; this has been extended for this year with a view to utilise the full five year contract. An assessment is currently being undertaken to assess whether to further extend the contract or complete another tender process.

The single software across all sites also has the capability for multisource feedback to be done within the same system. Medical Directors and other clinical managerial staff can view and report on the staff within their hierarchy level and monitor appraisal progress directly.

The system can be developed individually for each user organisation allowing MFT to tailor the system to specific requirements; providing a bespoke appraisal portfolio for each clinician according to their role and specialty, so that only the relevant information is requested to be submitted. Recent additions include sections to reflect on the impact of the pandemic and a section to consider personal and professional wellbeing and reflect on this. Processes have commenced to automatically upload governance information into appraisal portfolios, with incidents of level 3 and higher being imported from the Ulysses risk system.

8. Appraisers

The Trust has a responsibility to support appraisers in the maintenance and development of their skills, to assure the quality of medical appraisals, and to ensure that appropriate resources are available to support this. Those who undertake medical appraisals for the Trust must be adequately trained in this role. Refresher training should be undertaken every one to three years, since September these have been held virtually facilitated by the Group Associate Medical Directors. At 01 August 2023, 638 appraisers are currently in date with training. Of the 28 not currently compliant, 23 are booked onto an upcoming training session. The remaining five have been written to confirm if they wish to book onto a training session or come off the appraiser list if not.

9. Appraisee feedback

Following each completed appraisal, appraisees are asked to submit feedback regarding their appraisal, appraiser, and the overall process. For the last appraisal year, a total of 1,791 feedback responses were received which saw an increase in positive feedback across all metrics. Individual reports for each appraiser are collated and added to their appraisal portfolios for discussion at their own appraisal. Of the responses received:

- 89% rated their appraiser overall as ‘Very Good’ and a further 10% as ‘Good’
- 72% ‘Strongly Agreed’ that their appraisal discussion was important in their professional development and 24% ‘Agreed’
- 67% ‘Strongly Agreed’ that the overall administration of their appraisal had been satisfactory and 31% ‘Agreed’

10. Quality assurance

The need for a robust Quality Assurance (QA) process for appraisal as part of the Medical Revalidation process is self-evident, but also explicitly expected by both NHS England, as the Senior Responsible Owner of the revalidation process, and the GMC. A need for oversight of both appraisers and appraisal outputs is necessary to ensure a consistent,

effective and constructive appraisal system, benefiting both the doctor's development and the Trust assurance processes.

Appraisers are responsible for ensuring the quality of the appraisal outputs for the appraisals they undertake. They must ensure that both the appraisal summary and the Personal Development Plan (PDP) adhere to the required standards. Feedback is requested from doctors following an appraisal; this information is collated and used to assist appraisers with their development and gives an indication of how the process is progressing.

An appraisal quality tool ASPAT (Appraisal Summary and PDP Audit Tool) developed by NHS England has been incorporated within SARD so that randomised samples of appraisal can be audited online to assess the quality of the appraisal process. The process for this is currently being trialled with an audit of representatives' samples of outputs being assessed and the tool being refined.

Appraisal and revalidation are covered by the Trust's Revalidation and Appraisal Policy for Medical and Dental Staff; this was due for renewal in November 2021 and an updated version is currently with the Local Negotiating Committee (LNC) for approval. Compliance and quality assurance are also monitored via the Appraisal and Revalidation Group which meets quarterly with clinical and managerial representatives from each Hospital/MCS, Medical Education, and Workforce, in addition to the Group Revalidation team.

11. Summary and future challenges

Following a return to the appraisal process post-pandemic, consultant and SAS appraisal rates have remained consistent, temporary and short term contract holders have, after a number of years lagging behind, seen a significant increase bringing them in line with other medic groups. Work is being taken in conjunction with Medical Education to closer align the work of Educational Supervisors and the Revalidation team helping with the increase. Moving forward, there is still work required to embed the process of appraiser allocation by hospital sites with appraisals being held in good time.

12. Recommendations

The Board is asked to note the contents of this paper, progress made to date and the challenges to be faced in the coming year. The Board is asked to approve submission of the Annual Statement of Compliance (Appendix 1) with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013), signed on behalf of the designated body by the Group Chief Executive Officer.

APPENDIX 1

NHS England North West
Medical Directorate
Professional Standards Team

2022-2023 Annual Submission to NHS England North West:

Appraisal and Revalidation and Medical Governance

Contents

Introduction:
The Annual Organisational Audit (AOA) has been stood down for the 2022/23 year. A refreshed approach is in development. It still remains a requirement for each Designated Body to provide assurance to their Board about the governance arrangements in place in relation to appraisal, revalidation and managing concerns. In addition, NHS England North West use information previously provided in the AOA to inform a plan for assurance visits to Designated Bodies.

Amendments have been made to Board Report template (Annex D) with the intention of making completion of the submission straightforward whilst retaining the goals of the previous report:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

This template for an Annual Submission to NHS England North West should be used as evidence for the Board (or equivalent management team) of compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) or appended to your own board report where a local template exists.

This completed document is required to be submitted electronically to NHS England North West by **31st October 2023** and should be sent to england.nw.hlro@nhs.net

Section 1: General

2022-2023 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	**Manchester University NHS Foundation Trust**
What type of services does your organisation provide?	

	Name	Contact Information
Responsible Officer	Miss Toli Onon	toli.onon@mft.nhs.uk
Medical Director (Joint)	Miss Toli Onon Prof Jane Eddleston	toli.onon@mft.nhs.uk jane.eddleston@mft.nhs.uk
Medical Appraisal Lead	Prof Danny Keenan Dr Emma Hurley	daniel.keenan@mft.nhs.uk emma.hurley@mft.nhs.uk
Appraisal and Revalidation Manager	Cameron Chandler	cameron.chandler@mft.nhs.uk
Additional Useful Contacts	Andrea Roberts (Revalidation Manager) Yvonne Jenkinson (Revalidation Admin)	andrea.roberts@mft.nhs.uk yvonne.jenkinson@mft.nhs.uk

Service Level Agreement

Do you have a service level agreement for Responsible Officer services?

No

If yes, who is this with?

Organisation: N/A

Section 2a: Appraisal Data

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Total number of doctors with a prescribed connection as at 31 March 2023?	**2,414**
Total number of appraisers as at 31 March 2023?	2,286
Total number of agreed exceptions granted between 1 April 2022 and 31 March 2023?	127
Total number of missed appraisals* between 1 April 2022 and 31 March 2023?	1

*A missed appraisal is an appraisal that is not completed, and no exception has been granted in that appraisal year (1 April 2022-31 March 2023).

Section 2b: Revalidation Data

Timely recommendations are made to the General Medical Council (GMC) about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Total number of recommendations made to the GMC between 1 April 2022 and 31 March 2023?	**290**
Total number of positive recommendations submitted between 1 April 2022 and 31 March 2023?	234
Total number of recommendations for deferral submitted between 1 April 2022 and 31 March 2023?	55
Total number of recommendations for non-engagement submitted between 1 April 2022 and 31 March 2023?	1
Total number of recommendations submitted after due date between 1 April 2022 and 31 March 2023?	0

Section 3: Medical Governance

Concerns data

How many doctors have been through the Maintaining High Professional Standards (MHPS) or equivalent process between 1 April 2022 and 31 March 2023?	**29**
How many doctors have been referred to the GMC between 1 April 2022 and 31 March 2023?	24 (this figure represents doctors discussed with GMC but not necessarily under investigation by the GMC)
How many doctors have been referred to the Practitioner Performance Advice Service (PPA) between 1 April 2022 and 31 March 2023?	11
How many doctors have been excluded from practice between 1 April 2022 and 31 March 2023?	8

Organisational Policies

List your policies to support medical appraisal and revalidation	Implementation date	Review date
Revalidation and Appraisal Policy for Medical and Dental Staff	23/11/2018	23/11/2021

List your policies to support MHPS and managing concerns	Implementation date	Review date
Handling Concerns about Medical Staff (MHPS) Policy	13/02/2019	04/05/2024

Other relevant policies	Implementation date	Review date

How do you socialise your policies?
Appraisals are all located centrally on the trust appraisal hub accessed via the intranet. Updates are communicated by email and appraisal group newsletters. Copies of the relevant policies are also accessible via the appraisal software system.

Section 4: General Information

The board / executive management team can confirm that:

4.1 An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Yes
Action for next year (1 April 2023 – 31 March 2024). None

4.2 The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes
If No, please provide more detail:

4.3 An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained?

Yes
If yes, how is this maintained? RMS system (SARD), ESR, regular auditing reporting
If no, what are you plans to implement a record keeping process? (Action for next year (1 April 2023 – 31 March 2024).

4.4 Do you have a peer review process arranged with another organisation?

If yes, when was the last review? Being planned for 2024 using similar sized organisations. An internal of all appraisal processes (medical and non-medical) was undertaken by KPMG in 2021 which had an outcome of significant assurance with minor improvement opportunities.

4.5 Is there a process in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation?

Yes

4.6 How do you ensure they are supported in their continuing professional development, appraisal, revalidation, and governance?

Appointment of educational supervisors; appointment of a dedicated Associate Director of Medical Education for Locally Employed Doctors and International Medical Graduates. Access to same appraisal system and guidance as consultants; tailored portfolios and guidance on system specific to cohort of doctors.

Section 5: Appraisal Information

5.1 Have you adopted the Appraisal 2022 model?

Yes
If no, what are your plans to implement this? (Action for next year (1 April 2023 – 31 March 2024).

5.2 Do you use MAG 4.2?

No
If yes, what are your plans to replace this? (Action for next year (1 April 2023 – 31 March 2024).

5.3 Please describe any areas of good practice or improvements made in relation to appraisal and revalidation in the last year (1 April 2022 to 31 March 2023).

The appraisal rate for locums and short-term contract holders has had a significant increase bringing the appraisal figures in line with other groups of doctors. To improve the experience of new international doctors and to provide them with adequate information when they join UK clinical practice; an 'Initial ES Checklist for New International Doctors' has been developed and included on the appraisal software

5.4 Have you any plans for any changes/ improvements in the coming year (1 April 2023 to 31 March 2024)?

Extension of the appraisal quality assurance process to include a greater number of appraisal outputs.

5.5 How do you train your appraisers?

Appraiser training sessions are held online and led by one of the Group Associate Medical Directors for Appraisal and Revalidation. Some reading materials are sent out in advance to allow for more discussions time and group work. Refresher training sessions are also held online with appraisers expected to attend once every three years.

5.6 How do you Quality Assure your appraisers?

Modified ASPAT form has been incorporated into appraisal software to audit a representative sample. Appraisee feedback forms completed after each appraisal. Refresher training undertaken every three years by appraisers.

5.7 How are your Quality Assurance findings reported to the board?

Annual reports to HR Scrutiny Committee and Board of Directors

5.8 What was the most common reason for deferral of revalidation?

Insufficient evidence for a recommendation to revalidate – Patient feedback

5.9 How do you manage doctors that are difficult to engage in appraisal and revalidation?

Escalation system set-up including notification to site Medical Directors, Group Associate Medical Directors for Revalidation and the Group Medical Director / Responsible Officer for action as appropriate. These are discussed with the GMC ELA and also raised at the quarterly Medical Professional Matters Oversight Group (MPMOG) which meets with site Medical and HR Directors. Compliance and quality assurance are also monitored via the Appraisal and Revalidation Group which meets quarterly with clinical and managerial representatives from each Hospital / MCS, Medical Education, and Workforce, in addition to the Group revalidation team.

Section 6: Medical Governance

6.1 What systems and processes are in place for monitoring the conduct and performance of all doctors?

Quarterly MPMOG meetings between Group Medical Director / RO, Group Associate Medical Directors (Appraisal and Revalidation, Professional Matters) and site Medical Directors and HR leads to discuss medical professional matters and concerns.

6.2 How is this information collated, analysed and shared with the board? (Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors).

Register of MPMOG data maintained for each meeting. Overview of MHPS cases and numbers provided to Board of Directors and Medical Director Workforce Board.

6.3 How do you ensure that any concerns are managed with compassion?

Right to be accompanied for all clinicians attending formal meetings; signposting of self-help services to employees; ability for clinicians to ask a member of staff to provide pastoral care, mentorship and personal staff who will be support.

All managers and directors who are involved in undertaking investigations or sitting on disciplinary/capability panels or appeals panels shall have undertaken formal equal opportunities training prior to undertaking such duties. Case Managers, Case Investigators and Panel Members should be trained in the operation of the conduct, capability and ill health procedures. Training update in both is required every 3 years.

6.4 How do you Quality Assure your system for responding to concerns?

Each site holds regular MPMOG meetings with Group Medical Director and Associate Medical Directors to ensure consistency across the group. MPMOG overseen by Medical Directors Workforce Board and Workforce and Education Committee, reporting to the Group Management Board.

6.5 How if this Quality Assurance information reported to the board?

MPMOG overseen by Medical Directors Workforce Board and Workforce and Education Committee, reporting to the Group Management Board.

6.6 What is the process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility)?

Transfer of information process within NHS is managed by Revalidation Manager. Sharing of information with two main private providers in locality is managed by RO and Group AMDs for professional matters. Quarterly assurance meetings are held with two main private providers to discuss any issues.

6.7 What safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination?

Work is currently being undertaken to assess the medical workforce in line with the WRES and monitor the protected characteristics of doctors involved in an ongoing process and GMC referrals, and those who have deferral recommendations made to the GMC. This will be further enabled by the roll out of the Empactis case management module.

6.8 Please describe any areas of good practice or improvements made in relation to medical governance in the last year (1 April 2022 to 31 March 2023)?

Programme of MHPS training for case investigators and case managers set up for commencing in April 2023 Learning from an employment tribunal shared across all hospital sites

6.9 Have you any plans for any changes/ improvements in the coming year (1 April 2023 to 31 March 2024)?

Roll out of the Empactis case management module.

Section 7: Employment Checks

What is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties?

Pre-employment checks undertaken as part of the Trac system checklist including DBS, GMC register, visa/work permit, ESR-IAT checks, and screening of qualification certificates, in addition to request and review of previous appraisals on appointment. All overseas doctors undergo an induction appraisal within the first three months which enables learning and development requirements to be assessed.

Do you collate EDI data around recruitment and /or concerns information?

Yes
EDI data gathered for recruitment data but not concerns information. Work is currently being undertaken to assess the medical workforce in line with the WRES and monitor the protected characteristics of doctors involved in an ongoing process and GMC referrals, and those who have deferral recommendations made to the GMC. This will be further enabled by the roll out of the Empactis case management module.

Section 8: Summary of comments and overall conclusion

Please use the table below to detail any additional information that you wish to share.

Section 9: Statement of Compliance:

The Board of Manchester University NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body:

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Manchester University NHS Foundation Trust

Name: Mark Cubbon

Role: Group Chief Executive

Date:

Agenda Item 11.9

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce and Corporate Business
Paper prepared by:	Nick Gomm, Director of Corporate Business and Trust Board Secretary
Date of paper:	September 2023
Subject:	Terms of reference for the Remuneration and Nominations Committee
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:	In the absence of a robust and comprehensive Governance Framework, the opportunities for supporting and enhancing organisational governance by using a body of good practice outcomes and evidence would be compromised.
Recommendations:	The Board of Directors is asked to approve the terms of reference for the Remuneration and Nominations Scrutiny Committee.
Contact:	Name: Nick Gomm, Director of Corporate Business and Trust Board Secretary Tel: 0161 276 4841

1. Introduction

1.1 MFT currently has a Remuneration Committee which meets, as required, to approve matters regarding staff on non-standard pay scales and to receive the results of the performance appraisals for the Group Chief Executive and the Group Executive Director Team.

1.2 This report proposes enhancing the terms of reference of the Remuneration Committee to become a Remuneration and Nominations Committee and play a formal role in overseeing the appointment of the Group Chief Executive and Group Executive Directors, and associated processes.

2. Rationale

2.1 NHS England's Code of Governance for Provider Trusts (April 2023) states that:

- *The nominations committee or committees of foundation trusts, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the trust, and the skills and expertise required within the board of directors to meet them.*

- *There may be one or two nominations committees. If there are two, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chair).*

- *The chair or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chair.*

- *Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should have governors and/or independent members in the majority.*

2.2 MFT has a Council of Governors' Nominations Committee responsible for making recommendations to the full Council of Governors on the appointment, re- appointment (including Terms of Office), and remuneration of the Chairman and Non-executive Directors. It also provides assurance to the Council of Governors on the robustness of the annual appraisal processes for the Chairman and Non-Executive Directors.

2.3 In light of the Code of Governance, MFT is also required to have a Nominations Committee which is responsible for the identification and nomination of Executive Directors and associated processes.

2.4 It is proposed that this is enacted by amending the terms of reference of the existing Remuneration Committee to develop it into a Remuneration and Nominations Committee whilst retaining a separate Council of Governors' Nominations Committee focusing on matters in relation to the Group Chairman and Non-Executive Directors.

2.5 The draft Terms of Reference for the proposed Remuneration and Nominations Committee are included in appendix A. The Committee will retain the functions of the existing Remuneration Committee whilst adding the additional duties required of a Nominations Committee for Group Chief Executive and Group Executive Director Team.

3. Recommendations

3.1 The Board is asked to approve these terms of reference, enabling the next Remuneration Committee on the 13th September to begin to deliver its expanded scope and duties.

Appendix A

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

REMUNERATION AND NOMINATIONS COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

The Remuneration and Nominations Committee has been formally constituted by the Board of Directors in accordance with its Standing Orders.

2. MEMBERSHIP

The membership of the Committee will consist of.

- Group Chairman
- Group Non-Executive Directors

The Group Executive Director of Workforce & Corporate Business will attend every meeting to advise the Committee. Other members will be co-opted on to, or invited to attend, the Committee as necessary.

The Trust Board Secretary (or nominated deputy) will service the Committee and provide appropriate support to the Chair and Committee members.

3. QUORACY

No business should be transacted at a meeting unless at least the following members are present.

- Group Chairman
- Three Group Non-Executive Directors

4. FREQUENCY OF MEETINGS

The Committee will meet as required and at least once a year.

5. OVERVIEW

The Committee has been established by the Group Board of Directors to.
:

- Receive annual performance summaries for the Group Chief Executive and Group Executive Directors.

- Ensure that proper systems exist to advise on the appropriate level of remuneration for the Group Chief Executive, the Group Executive Directors and other staff paid on non-standard pay scales.

- Review the structure, size and composition of the Board of Directors and ensure robust succession plans are in place.

- Oversee the recruitment process for Group Executive Directors and the Group Chief Executive and nominate for appointment candidates to fill posts within the Committee's remit.

- Provide assurance to the Board of Directors in relation to compliance with NHS England's Fit and Proper Persons Framework.

6. SCOPE AND DUTIES

Remuneration

To receive the annual performance summaries for the Group Chief Executive and the Group Executive Directors

To determine the framework or broad policy for the remuneration of the Group Chief Executive, the Group Executive Directors and other staff paid on non-standard pay scales (Very Senior Managers on local Terms & Conditions; Other Medical & Dental Staff on ad hoc salaries etc.) with responsibility to monitor the comparative remuneration of senior staff covered by the NHS Agenda for Change.

To approve specific salaries for staff on non-standard pay scales noting the requirement to seek national/ministerial agreement for salaries over specified levels.

To determine the framework or broad policy for the application or removal of national or local incentive payments e.g. Clinical Excellence Awards.

To advise on and oversee contractual arrangements for such staff including a proper calculation and scrutiny of termination payments, taking account of relevant national guidance and legal advice.

To understand the equality impacts of the decisions the Committee makes and pay due regard to the diversity of Committee members and consider the impact of any gaps in representation on decision making.

Nomination

To regularly review the structure, size, diversity and composition (including the skills, knowledge and experience) required of the Board of Directors and make recommendations to the Board with regard to any changes.

To consider and agree proposals for succession planning for the Chief Executive and other Executive Directors, taking into account the challenges and opportunities facing the Trust and the skills and expertise needed at the current time and in the future.

Be responsible for identifying, and nominating for appointment, candidates to fill posts within the Committee's remit, as and when they arise.

Be responsible for identifying and nominating a candidate, for approval by the Council of Governors, to fill the position of Chief Executive.

Before an appointment is made, to evaluate the balance of skills, knowledge and experience on the Board of Directors and, in the light of this evaluation, agree a description of the role and capabilities required for a particular appointment.

To consider any matter relating to the continuation in office of any Executive Director at any time including the suspension or termination of service of an individual as an employee of the Trust.

To receive assurance reports on behalf of the Board of Directors in relation to compliance with the requirements set out within NHS England's Fit and Proper Persons Framework as it relates to appointments to the Board of Directors and annual FPPR checking and attestation process.

The Committee/Group will constitute sub-committees or sub-groups, as required, to support delivery of its duties.

7. AUTHORITY

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

8. REPORTING

The Committee will provide a report to the Board of Directors after each meeting.

9. REVIEW

These Terms of Reference will be reviewed at least annually.

10. KEY PERFORMANCE INDICATORS

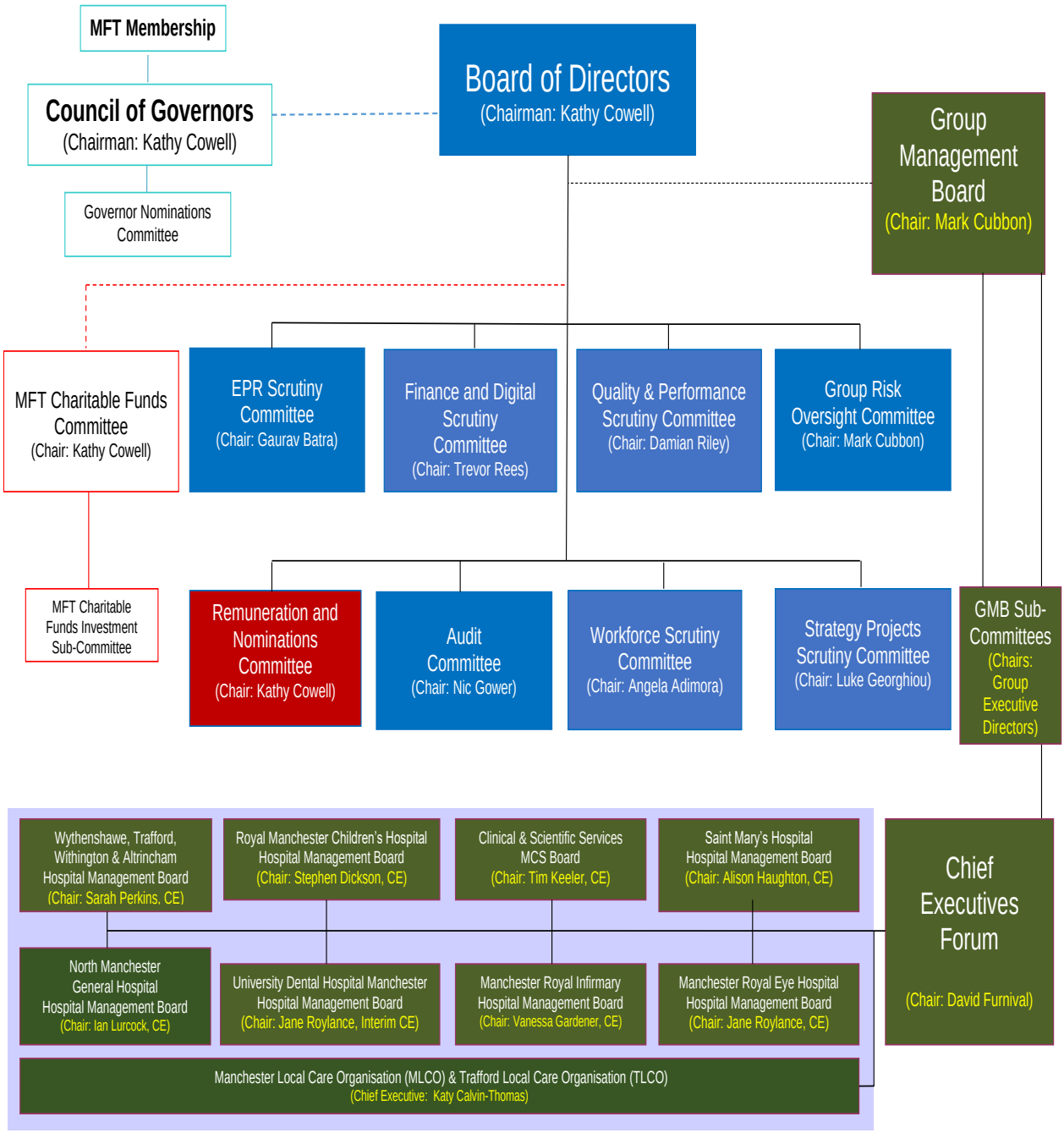
These Terms of Reference will be measured against the following key performance indicators.

- 75% attendance of all listed members or nominated deputy.
- 100% coverage of duties over a 12 month period.
- 100% of scheduled meetings take place.
- training needs of the participants will be identified and relevant training provided.

11. SUB-COMMITTEES/SUB-GROUPS

The Committee does not have any formal sub-committees or sub-groups.

12 . REPORTING STRUCTURE CHART (see overleaf)


MFT Membership
Council of Governors
(Chairman: Kathy Cowell)
Governor Nominations Committee
Board of Directors
(Chairman: Kathy Cowell)
Group Management Board
(Chair: Mark Cubbon)
MFT Charitable Funds Committee
(Chair: Kathy Cowell)
EPR Scrutiny Committee
(Chair: Gaurav Batra)
Finance and Digital Scrutiny Committee
(Chair: Trevor Rees)
Quality & Performance Scrutiny Committee
(Chair: Damian Riley)
Group Risk Oversight Committee
(Chair: Mark Cubbon)
MFT Charitable Funds Investment Sub-Committee
Remuneration and Nominations Committee
(Chair: Kathy Cowell)
Audit Committee
(Chair: Nic Gower)
Workforce Scrutiny Committee
(Chair: Angela Adimora)
Strategy Projects Scrutiny Committee
(Chair: Luke Georghiou)
GMB Sub-Committees
(Chairs: Group Executive Directors)
Wythenshawe, Trafford, Withington & Altrincham Hospital Management Board
(Chair: Sarah Perkins, CE)
Royal Manchester Children's Hospital Hospital Management Board
(Chair: Stephen Dickson, CE)
Clinical & Scientific Services MCS Board
(Chair: Tim Keeler, CE)
Saint Mary's Hospital Hospital Management Board
(Chair: Alison Haughton, CE)
North Manchester General Hospital Hospital Management Board
(Chair: Ian Lurcock, CE)
University Dental Hospital Manchester Hospital Management Board
(Chair: Jane Roylance, Interim CE)
Manchester Royal Infirmary Hospital Management Board
(Chair: Vanessa Gardener, CE)
Manchester Royal Eye Hospital Hospital Management Board
(Chair: Jane Roylance, CE)
Manchester Local Care Organisation (MLCO) & Trafford Local Care Organisation (TLCO)
(Chief Executive: Katy Calvin-Thomas)
Chief Executives Forum
(Chair: David Furnival)