NHS
Manchester University
NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS' MEETING

Meeting Date: 8TH MARCH 2021

(DUE TO THE IMPACT OF THE ONGOING COVID-19 NATIONAL & LOCAL EMERGENCY RESTRICTIONS, THE MEETING WAS NOT HELD IN A PUBLIC SETTING)

37/21 Board of Directors' (Public) Meetings

The Board noted that in response to the ongoing COVID-19 National Emergency and the UK Governments' social distancing requirements currently in place, meetings of the Trust's Board of Directors and Council of Governors had not been held in a public setting since mid-March 2020. It was further noted that all meetings with Group Non-Executive Directors and Governors were being conducted remotely via 'Electronic Communication' *(Microsoft Teams)* in keeping with the MFT Constitution – October 2017 *(Annex 7 – Standing Orders – Section 4.20 - Meetings – Electronic Communication – Page 108)* with scrutiny undertaken and assurance provided on the Trust's ongoing response to the pandemic during weekly 'virtual' Briefing Sessions with Group NEDs, regular Group Chairman / Governor 'virtual' Surgeries, and, 'virtual' Council of Governors and selected Board Sub-Board Committee meetings.

The Board also noted that whilst today's meeting (08/03/2021) was not held in a public setting, the agenda and supporting documents were posted on the MFT Public Website (https://mft.nhs.uk/board-meetings/board-of-directors-meeting) and members of the public invited to submit any questions and/or observations on the content of the reports and documents presented / discussed to Trust.Secretary@mft.nhs.uk.

38/21 Apologies for Absence

There were no apologies.

39/21 Declarations of Interest

There were no declarations of interest received for this meeting.

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

40/21 Minutes of the 'virtual' Board of Directors' Meeting held on 11th January 2021

It was noted that the Minutes of the 'virtual' Board of Directors' meeting held on 11th January 2021 were approved at the Board meeting (not held in Public due to the ongoing COVID-19 National Emergency Restrictions).

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

41/21 Group Chairman & Group Chief Executive's Reports

i) MFT reached its 50,000th Covid-19 vaccination during March 2021 which marked a huge milestone in ensuring colleagues, affiliates, patients and carers had received their vaccinations. A huge thank you to all vaccinators across MFT clinics and all teams supporting them in ensuring the smooth running of the programme.

ii) MFT will be welcoming North Manchester General Hospital (NMGH) into the MFT Group on 1st April 2021**.** This will be a momentous occasion and a significant milestone in the completion of the Single Hospital Service for the City of Manchester and Trafford.

iii) Construction work on the life-saving new HELIPAD at MFT was set to be completed at the beginning of March 2021.

iv) Congratulations to Mr Stephen Dickson who had been appointed Chief Executive for Royal Manchester Children's Hospital and its services across the City.

v) Welcome to Ms Mandy Nagra, who had started in post as the new Chief Executive for Wythenshawe, Trafford, Withington & Altrincham (WTWA).

vi) Acknowledgement of Mr David Cain's last attendance at the MFT Board of Directors prior to his retirement.

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

42/21 Update on the Trust's ongoing response to the COVID-19 National Emergency

<u>General Update, Performance Standards & Recovery Programme</u>

The Group Chief Operating Officer (COO) presented an overview of MFT's continued response to the COVID-19 National Emergency, including ongoing planning and impact on 'long-waits', staff testing, performance against national NHS constitutional standards, and, further development of the MFT Recovery Planning.

The Board particularly noted that a 3rd Wave of COVID-19 in January 2021 necessitated a further period of national lock down that remained in place in February and, to date, March 2021. It was also noted that MFT had witnessed two peaks of COVID-19 in-patient attendances during January (423 patients), and, end-January / early February (453 patients which represented 93% of the Wave 1 COVID-19 peak which occurred on the 14th April 2020 with 487 inpatients). It was reported that on 4th February 2021, MFT had a total of 64 COVID-19 inpatients in Critical Care facilities (level 2 & 3 beds) which represented 62% of the Wave 1 peak (104 CC patients).

The Group COO explained that a key difference between the first and second/third Waves of COVID-19 (November 2020 and January 2021) was the number of non-COVID patients that had required treatment at the same time as COVID attendances had remained high. She also explained that in line with the increased escalation levels, MFT Strategic Group had made the decision to reduce routine elective activity from the start of November 2020, in order to release bed and staff capacity to support critical care. The Board recognised this had continued in January and into February (2021), and as a result, had impacted on the Trust's recovery workstreams and performance against national standards.

The Board noted in the report presented that in response to the increased COVID position in the Quarter 3 (2020/21), the MFT Strategic Group had prepared plans for future Waves, which aligned with national and regional guidance. It was explained that the decision-making process to support Group escalation and its associated consequences, continued to be led by the Group Chief Operating Officer (and AEO); Joint Group Medical Directors; Group Chief Nurse and other Group Executive Directors.

The Group COO confirmed that ongoing consideration of reductions in the Trust's elective and outpatient activities during the 3rd Wave of COVID-19 had been undertaken through the MFT Strategic Group and agreement to reduce activity had been taken in order to meet Trust and Hospital/MCS site demand on critical care and ward beds. The Board was reminded that the key priorities remained; Protection of Specialist Hospital and Service activity; Mutual aid and equalisation of COVID-19 / elective activity across all MFT Sites; Reduction / cessation of non-essential activities i.e. meetings; Reduction of Outpatient Activity to release clinical staffing – phased approach to minimise reductions; and, Reduction of Elective Activity to release clinical staffing (NB: this was to be preceded by a request for mutual aid to GM Gold as part of a phased approach to minimise reductions).

It was confirmed that in mid-January 2021, the Trust was asked by Greater Manchester Gold Command (GM Gold) to support delivery of a super surge plan for adult critical care capacity to OPEL Level 3, stage 3. It was explained this meant that Trust's across Greater Manchester would need to extend COVID-19 care into enhanced care and non-critical care areas.

The Group COO pointed out that a further difference with previous Waves of COVID-19 was that during January and February 2021, the Trust had also been required by national teams to extend mutual aid across both Greater Manchester and inter-regionally to the Midlands. It was recognised that without this approach, these regions may not have been able to meet the health demands of their populations.

The Board was advised that the Recovery and Resilience Board (RRB) had been driving the ongoing Recovery programme with a much greater focus on operational delivery. It was explained that Transformation activities associated with the elective, cancer, outpatient, urgent care and long-term conditions programmes reported to the RRB alongside updates of EPRR activities and key enablers such workforce, estates and informatics.

The Board recognised that from the ongoing incidence of COVID-19 from March 2020, and specifically the extended impact of the 2nd and 3rd Waves previously referenced, that recovery would be both challenging and complex. The Group COO explained that previous recovery plans had focussed on the operational workstreams required to maintain and reshape services to respond to the immediate pandemic situation.

The Group COO went on to explain that there a permanent shift in operating models across MFT and the wider GM system was required to respond and recover from COVID-19 and this would entail significant demands in terms of staff engagement and leadership capacity. The Board was advised that the several key principles (duly noted in the report presented) had been developed to underpin MFT's Recovery whilst maintaining patient safety, minimising potential harm associated with long waits, and continuing to acknowledge the extraordinary role that staff had played through the pandemic to date and support them through Recovery. It was recognised that robust organisational development and Transformational support would be required to engage and support teams to develop and embed new ways of working.

The Board was reminded of the profound impact of the 3rd Wave of COVID-19 on the shape and size of the waiting list at MFT ('Long-Waits') due to the continued need to stand down elective activity for significant periods of time since March 2020. It was recognised that activity cessation and changes in patient behaviour had meant that the NHS as a whole was now facing a large backlog of non-COVID care. Particular attention was drawn to the significant rise in the volume of >52-week waiters and based on data available at the start of February 2021, this showed patient breach dates from now until end of March 2021; with a worse-case 'do nothing' scenario projected that there could be c.25,000 patients which would have breached 52 weeks by the end of March 2021 (split c.20,600 at MFT and c.4,400 at North Manchester General Hospital).

The Group COO confirmed that both MFT and NMGH continued with ongoing performance management of Hospital/MCS delivery and clinical validation/priority work to ensure that the number of long waiters was minimised where possible.

An overview of the Trust's Urgent Care and 'Flow' (Discharge Planning) was noted along with the Trust's development of a robust process to meet the objective of prioritising treatment of clinically urgent patients (site based MESH - Manchester Emergency & Elective Surgical Hub). It was noted the MFT Group MESH had been mobilised to ensure oversight and effective use of resources across MFT sites, including Independent Sector capacity already agreed for use of MFT. It was explained that the MESH was chaired by one of the Joint Group Medical Directors and had a wide clinical and operational representation from Group. It was also responsible for overseeing the process for referral of cancer patients to GM Cancer Hub, if required.

Attention was also drawn to the Trust's key activities and workstreams in relation to out-patients with a re-basing exercise of Phase 3 activity projections undertaken by hospitals at the end of December (2020) / early January (2021). It was acknowledged that the prolonged impact of the 3rd Wave of COVID-19 in January 2021 had adversely impacted on delivery against outpatient activity plans across most of the MFT hospital sites. It was confirmed that Hospitals/MCS continued to work on delivery of actions plans aimed at delivering further improvements, and were being held accountable by the MFT Group.

The Board also noted that as at 18th February 2021, lateral flow test kits had been distributed to over 24,000 staff and a cumulative total of 163,792 tests had been undertaken and reported by staff; with the number of staff who had reported a positive lateral flow test being 643 (0.41% of tests reported). The Board was reminded that the programme had aimed to support the Trust's understanding of how COVID was being transmitted, and to help to reduce the level of community transmission in the region as well as nosocomial infection rates within MFT; this programme had run alongside focused outbreak testing of symptomatic staff.

The Board noted MFT's (inc NMGH) latest performance status presented in the report under the key headings of Urgent Care & Planned Care (RTT & 52wks, Diagnostics, and, Cancer).

In conclusion, the Board note the contents of the update report as presented.

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

Update on the COVID-19 Vaccination Programme

The Board of Directors recalled that whilst the vaccination programme, which had commenced in MFT on 16th December 2020, was being managed at the national level, Regions had been given operational responsibility for ensuring delivery (Public Health Functions agreement for 2020/21) and this had been delegated to Greater Manchester Health and Social Care Partnership (GMHSCP) through the Section 7a agreement. The Board was reminded that the SRO for the vaccination programme was Professor Cheryl Lenney, Group Chief Nurse and the MFT programme was being led by the Corporate Director of Nursing and the Chief Pharmacist, who provided support and guidance to the Workstream Leads.

The Group Chief Nurse confirmed that the MFT staff vaccination programme was estimated to be completed by the end of May 2021 and that to date c.18,000 staff had been vaccinated and circa 12,500 affiliates/associates. It was also reported that 77% of MFT staff had booked or received the first vaccine. It was explained that Affiliates/Associates of MFT added approximately an additional third to the overall staff numbers giving MFT an overall staff population of circa 38,000 to vaccinate. It was further noted that 64% of staff who identified as BAME had taken up the vaccination offer.

The Group Chief Nurse explained that vaccinations were delivered across MFT (NMGH, MRI, Wythenshawe & Trafford) in clinics to those who meet the JCVI eligibility criteria in cohorts 1 – 4 in collaboration with Manchester Health and Care Commissioning and Trafford Care Commissioning Group. The Board was also advised that work was ongoing to support staff who were vaccine hesitant with key groups identified, as: young women because of fertility or pregnancy and breast-feeding concerns, black British, and, staff in the lower AFC bands 2-4. It was explained that these groups mirrored community groups being targeted by MHCC to encourage vaccine uptake.

The Board noted the 'Strategic Context' of the Vaccination Programme as described and it was also explained that in order to ensure the safe delivery of the vaccine, frameworks, policies and a series of standard operating procedures were in place to support safe delivery of the vaccination programme. The Board received assurance that the COVID-19 Vaccination Strategic Group provided final approval of the standard operating procedures and any supporting documentation with *Situation Reports* (Sitreps) submitted regionally and nationally regularly in line with requests received, providing a range of information including vaccination uptake. It was explained that Staff COVID-19 vaccination reports were distributed weekly and communicated with MFT line managers to facilitate targeted wellbeing conversations.

The Group Chief Nurse confirmed that a coordinated and creative engagement plan had been implemented to ensure that all people offered the vaccine had the information required to make an informed decision. It was explained that a staff engagement group, including representation from groups who were hesitant to take up the offer, was in place to increase the staff uptake of the vaccine along with a bespoke information pack to support managers in holding wellbeing discussions with staff who had not accepted or had declined the offer of vaccination.

The Board received an overview of the Vaccination Programme governance arrangements and it was especially noted that a sustainable long-term plan was under development to transition the programme to 'business as usual' (and this would include dialogue with stakeholders including MHCC, TCCG and GMHSCP).

In summary, the Board acknowledged that MFT's COVID-19 vaccination leadership team were running an effective vaccination programme in a rapidly changing environment. It was also recognised that the programme had delivered 45,446 vaccines as of 17th February 2021 based on JCVI guidance and cohort requirements and that further targeted support had been identified for those staff who were hesitant to take up the vaccination offer.

The Board also noted that MFT would continue vaccinating members of the Manchester and Trafford population based on national guidance and as required by partners. It was also underlined that MFT would continue to work with GM colleagues to define the future operating models for the COVID-19 vaccination programme.

The Board of Directors noted the content of the report and especially the significant progress of the vaccination programme and commended the Group Chief Nurse and her teams for their continued energy and focus on delivery to date.

Decision:	Update report noted.	**Action by:** n/a	**Date:** n/a

<u>Update on COVID-19 Infection Prevention Control Response (inc. updated IPC BAF) and Nosocomial Infections</u>

The Group Chief Nurse presented a report which provided an update on Nosocomial Transmissions of COVID-19, progress on the Nosocomial Infection Dashboard, and, the deployment of temporary isolation facilities.

The Board was advised that the NHSE Infection Prevention Control Board Assurance Framework (IPC BAF) had been updated in February 2021 to include 43 new indicators. The Board especially noted the IPC BAF which was included as an Appendix in the report where the new indicators were included (with examples cited) along with a comprehensive list of where Board oversight had been demonstrated (inc. the review of the IPC BAF at several Board meetings and a range of sub-committees throughout 2020/21).

The Group Chief Nurse went on to describe the current position and it was noted that the most recent figures from the Scientific Advisory Group for Emergencies (SAGE) accessed 18th February 2021 indicated the latest reproduction number (R) rate of coronavirus (COVID-19) in the North West was 0.7 to 0.9. It was noted this compared to an R rate of 0.7 to 1 for the previous week.

There Board was advised that there was a direct relationship between the transmission of the virus in the community with the transmission within health care settings and the number of newly confirmed cases and COVID-19 in-patient burden for MFT were duly noted in the report now presented.

The Group Chief Nurse described the implementation of 'Actions' from COVID-19 Outbreak Reviews and emphasised that the Trust continued with an unrelenting focus on IPC measures including but not exclusive to hand hygiene, correct use of PPE, social distancing and strict adherence to IPC practice for interventional procedures. She also explained that screening of inpatients continued as per national screening recommendation done on day 1,3,5-7 and weekly thereafter with improved virology turnaround times of samples (processed within 17 hours of receipt in the laboratory).

It was also confirmed that there was a senior IPC Team member on-call to provide advice and support to the on-site Management teams regarding patient flow.

The Group Chief Nurse went on to explain that the current Trust Policy, based on guidance form NHSE/I, was to close a ward when a COVID-19 outbreak was declared and implement control measures. She confirmed that the closure of wards had caused a significant impact to patient flow and may have contributed to an ncrease in the risk of cross transmission amongst patients where there was increased movement of patients across the hospitals. In addition, it was also noted there were potential consequences to care as patients who required specialist care may not always be able to be admitted to a specialist ward where there was an existing outbreak. In response, and following consultation with the Trust IPC Expert Group, the Board noted the listed changes made to the MFT Policy.

The Board also received an overview of the COVID-19 Dashboard which was due to be launched in the coming weeks. It was noted that the Dashboard, when fully implemented (on completion of the 6 phases) would be able to provide ward level data on COVID-19 patient placements, screening compliance, and bed days lost. It was acknowledged that the expectation was that the Dashboard would provide both strategic and operational level data and would be used as MFT moved forward to measure and manage all alert organisms.

The Group Chief Nurse described the introduction of Enhanced Isolation Facilities within the Trust (20 Clinell Redirooms) to provide additional isolation capacity. It was explained that a Standard Operating Procedure (SOP) had been developed for the use of Redirooms- which would include, a risk assessment process to identify suitable patients, decontamination between each patient use and when to change the canopy.

The Board also noted that the Joint Group Medical Directors were leading a programme of work with Medical Director colleagues across GM to assess the clinical outcomes of patients who had acquired COVID-19 infections whilst in hospital. It was also pointed out that discussions were underway to formalise the duty of candour to ensure patients were kept informed of their infection status whilst in the Trust's care.

In conclusion, the Group Chief Nurse explained that prevention and management of COVID-19 nosocomial infections was multifaceted and had been evolving throughout the pandemic, as the organisation learnt more about the COVID-19 virus and how it was transmitted. She also explained that prevention of transmission was the role of all staff and started with adherence to good IPC practice. The Group Chief Nurse emphasised that the safety of patients was paramount and there was a continuing focus and investment in practice and the environment of care to prevent the transmission of the virus.

The Board acknowledged that whilst there was evidence that the number of new cases of COVID-19 amongst in-patients was declining, there was no room whatsoever for complacency as outbreaks of infection continued to occur.

The Board of Directors noted the actions and progress to reduce the transmission of COVID-19 across all MFT services and sites.

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

43/21 Group Chief Finance Officer's Report

The Group Chief Finance Officer reminded the Board that during the first half of the year, as a response to the COVID-19 pandemic, the NHS financial framework was amended. She explained that all Trusts were put on a block contract, with an adjusting 'top-up' made retrospectively to bring the Trust to breakeven. It was noted this provided stability in the short-term as the Trust responded to the first wave of the pandemic and as it began to restore services during the recovery phase.

The Group Chief Finance Officer went on to explain that the financial regime for the second half of the year maintained the block payments to Trusts broadly unchanged from the first half of the year. In addition, it was reported that a system-wide (i.e. Greater Manchester) funding pot had been allocated by the national team and this had now been apportioned to each organisation within GM. The Group Chief Finance Officer explained that each organisation was expected to manage local costs, including COVID-19 costs, within this and for MFT, the exception to this was that any Nightingale costs would be supported nationally.

The Board was reminded that the Trust had agreed a financial plan for the second half of the year which required the Trust to achieve a breakeven position. The Group Chief Finance Officer confirmed that the Trust had exceeded the target for December 2020 and on a 'Year to Date' basis, had delivered a surplus of £9.4m which was £10.4m ahead of the plan. She also confirmed that this was as a result of lower than planned elective activity due to the ongoing impact of COVID-19 on the Trust; the underspend was increasing on a monthly basis.

The Board noted the current 'Run Rate' position as presented in the report along with the remedial action to manage and maintain control of expenditure; even during the pandemic.

The Group Chief Finance Officer also confirmed that formal notification had been received that the current financial regime would remain in place at least for Q1 of 2021/22 and the Control Totals implemented at Hospital/MCS/LCO level would be reviewed and refined in light of this guidance, to reflect the constraint at Trust level.

The Board noted that as at 31st January 2021, the Trust had a cash balance of £310.9m and this remained higher than plan due to the "double-payment" of the block contract in April 2020 (which would be recovered in March 2021) and also due to the level of accruals and provisions.

The Group Chief Finance Officer explained that the Trust's capital plan reflected the result of negotiations across Greater Manchester to bring the total planned spend across Greater Manchester into line with the new capital envelope. She also reported that up to January 2021, £70.3m of capital spend was incurred which was lower than had been planned, however the forecast remained to deliver the plan.

The Board noted the Income & Expenditure Account for the period ending 31st January 2021 as presented in the report along with the summary overview of the Trust's Waste Reduction Programme and Key Run Rates Areas. Attention was also drawn to the 'Statement of Financial Position', 'Capital Expenditure', and, 'Aged Debt' which was a focus of the Finance Workplan during 2020/21 as the level of outstanding debt continued to be subject to close scrutiny.

In conclusion, the Board noted that:

- Strong financial governance and control had been maintained as the Trust moved into the final few weeks of the financial year;

- Hospital/MCS/LCO Control Totals would be formally issued to Chief Executives and their accountability for delivery of these would result in a strengthening of the discipline on forecasting. In particular to ensure that the financial implications of decisions on service changes were understood and taken into account in the decision-making process; and,

- It was of paramount importance that decisions were not made that commit to the Trust to recurrent new expenditure without the appropriate level of scrutiny.

Decision:	The Group CFO's Report was Noted	**Action by:** n/a	**Date:** n/a

44/21 Update on Strategic Developments

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

Key areas of focus were noted under the main National and North West Regional headlines with particular attention drawn at the outset to the Government's White Paper – '*Integration and Innovation: working together to improve health and social care for all'* (with proposals grouped under four headlines, namely, 'Working together to support integration'; 'Stripping out needless bureaucracy'; 'Enhancing public confidence and accountability'; and, 'Additional proposals to support social care, public health and quality and safety'). It was noted that on current timeframes and subject to parliamentary business, the legislative proposals would begin to be implemented in 2022 and would form a critical part of recovery from the COVID-19 pandemic.

The Group Executive Director of Strategy also reported that the timetable for producing 2021/22 Annual Plans / Phase 4 COVID-19 recovery plans reported to the Board of Directors in January 2021 was withdrawn in view of the COVID-related pressures that the system was under. He explained that the process was not expected to resume before April 2021.

The Board was also advised that the North West had recently bid to be designated as a *Genomic Medicine Service Alliance* (GMSA). It was explained that alliances were part of the next stage of the NHSE led Genomics strategy in the NHS in England and it was intended there would be seven across the NHS. The Group Executive Director of Strategy was pleased to report that MFT had now been notified that the bid was successful, and the Trust would be working closely with the NW Regional Medical Director to develop the Alliance (which would be hosted by MFT).

In conclusion, the Board noted the updates in relation to strategic developments both nationally and regionally.

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

45/21 Update on the NMGH transaction process and redevelopment plans

The Board recalled that NHS England / Improvement (NHS E/I) had established a process to dissolve Pennine Acute NHS Hospitals Trust (PAHT) in such a way that MFT acquired North Manchester General Hospital (NMGH) and the remaining PAHT sites transfer to Salford Royal NHS Foundation Trust (SRFT).

The Group Executive Director of Workforce & Corporate Business re-confirmed that MFT was firmly committed to the acquisition of NMGH and work to deliver this objective, in collaboration with SRFT and PAHT, was progressing well. He also reminded the Board that as part of the transaction process, a Business Case for the proposed acquisition was considered and approved by the Board of Directors at the Extraordinary Meeting on 14th December 2020.

The Board of Directors noted that during the Transaction and Disaggregation Committee meeting held on 22nd February 2021, it was confirmed that SRFT had written to NHS E/I requesting a deferral of the acquisition of the Bury, Oldham and Rochdale sites and services, so this transaction would not now proceed on 1st April 2021. It was explained that SRFT's stated intention was to resubmit their Business Case and to seek to complete the transaction by 1st October 2021.

The Board was reminded that MFT's acquisition of NMGH would proceed as planned at 1st April 2021 but the legal mechanism would be slightly different – a prior commercial transaction rather than statutory transaction. It was explained that a briefing and communications process was rolled out to staff and key stakeholders at the end of February 2021.

The Board noted that as Bury, Oldham and Rochdale sites and services were not being acquired at 1st April 2021, PAHT would continue to exist as a legal entity, and the PAHT Board would need to remain in place. The Board understood that the Bury, Oldham and Rochdale sites and services would continue to be operated under a management agreement between PAHT Board and SRFT.

The Group Executive Director of Workforce & Corporate Business explained that following approval of the Acquisition Business Case in December 2020, the Board agreed the content of its self-certification at the January 2021 meeting; this was subsequently submitted to the NHS E/I Regional Team for review. He also explained that a minor amendment had been made to this documentation to account for the revised legal mechanism, and a positive response letter had now been received from NHS E/I

The Group Executive Director of Workforce & Corporate Business reported that the decision the Board took in approving the Acquisition Business Case was supported by the extensive Due Diligence exercise that had previously been undertaken. However, it was recognised that the original Due Diligence work had become dated, and so refresh exercises were undertaken in the areas of Clinical, Financial and Workforce Due Diligence. The Board accepted that these reviews had demonstrated that the risk profile overall had not changed materially.

The Board was advised that in order to complete the NMGH acquisition as a prior commercial transaction, a Business Transfer Agreement (BTA) had been developed. It was also explained that the signatories to the BTA were PAHT, MFT and NHS E/I. The Group Executive Director of Workforce & Corporate Business explained that the development of this document had not been problematic, as many of its provisions were specified in the Transactions Agreement that had already been negotiated. It was also confirmed that the BTA required a number of key schedules which specified the services, staff, estate, equipment, contracts, etc that would transfer. However, it was also recognised that all of this information was already required for the Transactions Agreement, and the disaggregation processes had been set up to ensure that the schedules were developed.

The Group Executive Director of Workforce & Corporate Business confirmed that NMGH would continue to have close joint working arrangements with other PAHT services after the acquisition, and an important element of the post transaction arrangements was the Service Level Agreement (SLA) that defined these arrangements. The Board was advised that whilst the intention previously was that the SLA would be between MFT and SRFT (PAHT having ceased to exist), the arrangement would now be between MFT and PAHT (recognising that some of the PAHT services would be managed through a Management Agreement with SRFT).

The Board noted that all of the legal documentation would be signed by the MFT Group Chairman & Group Chief Executive on behalf of the MFT Board of Directors to ensure that the transfer of NMGH to MFT could be completed on 1st April 2021.

The Board also noted related activity in the report presented under each of the following headlines, namely, Transaction activities, Disaggregation, Patient Pathways, Staff alignment, Service Level Agreement (SLA), Post Transaction Integration Plan (PTIP), and, the Management Agreement.

The Group Chief Finance Officer also provided the Board with a summary update on the NMGH Health Infrastructure Programme Business Case with particular attention drawn to the Redevelopment Outline Business Case; the New Hospitals Programme and Final Business Case; the Strategic Regeneration Framework Update; and, Enabling Works.

In conclusion, the Group Executive Director of Workforce & Corporate Business explained that despite the changed transaction mechanism, all of the necessary processes to ensure an effective acquisition of NMGH on 1st April 2021 were still in place and operating well. It was also noted that all activities relating to the redevelopment programme were proceeding satisfactorily, pending feedback from the national team on the OBC.

The Board of Directors received and noted the update report.

Decision:	Update report received and noted.	**Action by:** n/a	**Date:** n/a

46/21 Quarter 3 (2020/21) Complaints Report

The Board received the report which related to complaints and PALS activity across MFT in Quarter 3 (2020/21).

The Board especially noted a brief summary of activity (Complaints and Patient Advice & Liaison Service); Q3 in context (Increase in COVID-19 related complaints, Monitoring of Complaints Process, The Parliamentary and Health Service Ombudsman and Christmas Virtual Visiting); an overview of Complaints and PALS contacts (including a brief analysis of themes); Care Opinion and NHS Website feedback; Improvements made and planned to ensure learning from complaints is embedded in practice; and, supporting information presented in tables and graphs.

In conclusion, the Board acknowledged that the report presented by the Group Chief Nurse provided a concise review of matters relating to Complaints and PALS during Q3 (2020/21). It was also acknowledged that opportunities for learning and service improvement had continued to be identified, and the report had provided highlights of where this had and would take place.

The Group Chief Nurse confirmed that the Trust would continue to monitor complaint response timescales against expected response timescales, providing support to Hospitals/MCS/LCOs when required; continue to review and embed recommendations from National Guidance within MFT's policies; continue to learn from complaints and concerns raised; and, continue to progress the improvements outlined in the report presented.

The Board noted the content of the report and the on-going work of the Corporate and Hospital/MCS/LCO teams to ensure that the Trust remained responsive to concerns raised and learnt from patient feedback in order to continuously improve the patient's experience.

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

47/21 MFT 'Safer Staffing' Bi-Annual Report

The Group Chief Nurse presented a summary overview of the bi-annual comprehensive report on Nursing and Midwifery staffing. The Board noted that the report detailed the Trust position against the requirements of the National Quality Board (NQB) Safer Staffing Guidance for adult wards 2016, and the NHS Improvement (NHSI) Developing Workforce Safeguards Guidance, published in October 2018. The Group Chief Nurse also recalled that the Guidance recommended that the Board of Directors received a biannual report on staffing to comply with the CQC fundamental standards on staffing and compliance outlined in the well-led framework.

The Board of Directors was reminded that the report received in September 2020 outlined the Trusts position against the NQB standards and the details now provided analysis of the Trust nursing and midwifery workforce position at the end of December 2020 along with the actions being taken to mitigate and reduce the vacancy position, specifically within the staff nurse and midwifery band 5 and 6 workforce. The Board also noted that the report included a summary of the Allied Health Professions (AHP) workforce as per the NHSI guidance.

The Group Chief Nurse went on to explain that the COVID-19 pandemic had resulted in the nursing, midwifery and AHP workforce working in new ways, sometimes in unfamiliar settings and outside their usual scope of practice. She pointed out that these changes had often happened rapidly to meet increased demand whilst ensuring the care provided continued to be of high quality. The Board was advised that NHSE/I principles and the NMC regulatory guidance had been utilised by the Trust to support a response and maintain safe staffing measures. It was also explained that coordinated approaches to training, staffing huddles, staff shielding and collaboration between the hospital sites had also supported flexibility within the workforce.

The Board was advised that nursing and midwifery workforce supply continued to be a challenge nationally with the shortfall in registered nurses being well-documented across all NHS organisations. The Group Chief Nurse explained that additionally, the pressure of COVID-19 and the new ways of working had highlighted implications that could exacerbate the current national staffing problem.

The Board especially noted that at the end of December 2020, there was a total of 351.4 (4.6%) qualified nursing and midwifery vacancies across the Group compared to 537.5wte (7.1%) at the same period in the previous year (December 2019). It was acknowledged that that this was a reduction of 186wte vacancies, reducing the vacancy rate by 2.5% over the last 12 months.

The Group Chief Nurse explained that the majority vacancies were within the nursing and midwifery (band 5) workforce and at the end of December 2020, there were 235.6wte (5.8%) compared to 368wte (9.2%) at the same period in the previous year (December 2019). She confirmed this was a reduction of 132.4wte vacancies, reducing the vacancy rate by 3.4% over the last 12 months. The Group Chief Nurse also confirmed that due to the pandemic, the Trust had implemented alternative recruitment strategies with a focus on virtual recruitment and a guaranteed job offer to 'home grown' student nurses and midwives that were due to qualify in September 2021.

The Board noted the improved position in turnover of nursing and midwifery staff along with the positive impact of the Trusts International Recruitment Programme (IR) which continued to provide an additional supply of Band 5 nurses to the workforce. Similarly, the positive impact of Nursing Associates (NARs) employed by the Trust, working across general ward, community and theatre areas, was also duly noted.

The Group Chief Nurse confirmed that sickness absence rate for nursing and midwifery was 3.3% at the start of the pandemic in March 2020 and that since this period, absence had been reported daily due to significant registered staff unavailability and the prevalence of COVID-19 asymptomatic and symptomatic absence. It was further noted that in December 2020, the absence rate for registered nursing and midwifery staff was 10.1% and 6% for AHPs and the staff vaccination programme would ultimately have a positive impact on staff absence as it was expected both symptomatic and asymptomatic absence to reduce as staff develop immunity.

The Board was advised that whilst there was currently no recognised national shortfall within generalist AHP therapists for adult services, there were still shortfalls within the speciality posts such as adult acute Occupational Therapists (OT), Podiatrists and paediatric specialist OTs, Dietetic (DT) and Speech and Language Therapists (SLT).

The Group Chief Nurse explained that daily staffing levels continued to be assessed across each shift to ensure they were adequate to meet patient acuity and dependency needs on each ward and department. She also confirmed that during the pandemic, there had been a requirement to deploy staff to high dependency and adult critical care areas and at times resulting in a more dilute skill mix. The Board received assurance that any changes to skill mix was risk assessed daily by a senior nurse to review the actions being taken to mitigate risk to patient safety.

In conclusion, the Board of Directors received the report and noted progress of work undertaken to support the Trusts pandemic workforce recovery plans and address the nursing, midwifery and AHP vacancy position across the Group.

Decision:	Report received and duly noted	**Action by:** n/a	**Date:** n/a

48/21 Update Report on the Ockenden Review of Maternity Services

The Group Chief Nurse reminded the Board that in January 2021, an update on MFT's response to the seven immediate and essential actions for maternity services arising out of the Ockenden Report had been received and noted.

The Board noted that in responding to the immediate and essential actions, MFT's maternity services had not identified any high-level patient safety risks and did not anticipate this being on the Trust risk register at a level over 15. The Board also recalled that where there were lower level risks it was expected these would be mitigated through agreed actions and monitored as set out in sections highlighted in the report now presented.

The Group Chief Nurse confirmed that the Trust, as requested, had completed the National Assurance Assessment Tool which was reported through the Greater Manchester and East Cheshire Local Maternity Service (GM&EC LMS) to the NW Regional Office on the 15th January 2021. She explained that this provided a greater level of detail not only as to the level of compliance with all 7 IEAs of the Ockenden Report but also NICE guidance relating to maternity, compliance against the CNST safety actions and a current workforce gap analysis. The Board was advised that the Maternity Divisions across the MCS and NMGH had developed a comprehensive action plan to deliver full compliance against each of the workstreams referenced and it was anticipated there would be a national reporting portal developed for the future submission of evidence together with assurance visits.

The Board particularly noted and received assurance that detailed analysis and associated data would be tabled in the following committees for the next year:

- *Obstetric Divisional Quality and Safety Committees*
- *Saint Mary's Hospital Quality and Safety Committee*
- *Saint Mary's Hospital Management Board*
- *Group Quality and Safety Committee*
- *Group Quality & Performance Scrutiny Committee (an MFT Board Sub-Comm*

The Group Chief Nurse went on to explain that Saint Mary's Hospital was working collaboratively with the GM&EC LMS on several actions which required system leadership and implementation and the examples cited in the report were noted by the Board.

The Board was advised that in line with the letter received into the Group on the 11th January 2021, the Trust would await the NHSE/I Co-produced framework including the standard job description and training package for 'Advocates'; and principles for establishing a network to support Listening to Women and Families and support them to contact Advocates. It was explained that this would also include mechanisms for contracting/ funding Advocates to ensure they remained independent. The Board was advised that a delay with this was not considered a patient critical issue and mitigating plans were in place to work with the MVP and GMEC LMS until the new coproduced framework was available for implementation.

The Group Chief Nurse confirmed that the MFT Maternity Service teams had developed an action plan and to address those areas where there was partial compliance and to strengthen some of the areas where there was full compliance, but where it had been recognised that further improvements could be made; the ongoing reporting and monitoring would be via the committees identified previously.

In conclusion, the Board of Directors noted that the Chief Executives of Saint Mary's Hospital and North Manchester General Hospital had reviewed the seven Immediate and Essential Actions highlighted in the Ockenden Report and completed the Assurance Assessment Tool. It was also noted this was overseen by a Group Executive Director, Group Non-Executive Director, and, Board Safety Champions and submitted on the 15th February 2021.

It was confirmed that further regular updates would be provided to the MFT Board of Directors throughout 2021/22.

Decision:	Latest update report noted.	**Action by:** n/a	**Date:** n/a

49/21 Reviewed MFT Constitution

The Board of Directors received and approve the reviewed MFT Constitution (including all supporting Annexes) which had been previously presented to, and, approved by the MFT Council of Governors on the 10th February 2021 in keeping with *Section 44* - 'Amendments of the Constitution' - Sub Sections 44.1.1 & 44.1.2 - pages 22 & 23 (MFT Constitution 2017).

Decision:	Reviewed MFT Constitution (including all supporting Annexes) approved.	**Action by:** n/a	**Date:** n/a

50/21 Equality, Diversity & Inclusion Annual Report (2020/21)

At the outset, the Group Chairman & Group Executive Director of Workforce & Corporate Business confirmed that the Board's HR Scrutiny Committee (Chaired by Mr John Amaechi, Group Non-Executive Director) had recently received and discussed in depth MFT's Equality, Diversity & Inclusion Report (2020/21) which detailed the Trust's performance during 2020 against the objectives of 'Diversity Matters'; the organisation's equality, diversity and inclusion strategy 2019-2023.

It was reported that the HR Scrutiny Committee had particularly noted examples of practice from across the Trust's hospitals, managed clinical services, local care organisation and corporate services and it was confirmed that the report met the Trust's statutory duty under the Equality Act 2010 to report on performance against equality objectives annually and had recently been published on the MFT Public Website.

The Group Executive Director of Workforce & Corporate Business explained that in order to deliver the Trust's equality, diversity and inclusion ambition, a four-year road-map was developed as part of 'Diversity Matters'. The Board was advised that the road-map was intended to identify the implications of the Strategy for the Trust's hospital and managed clinical services, community and corporate services.

The Group Executive Director of Workforce & Corporate Business reported that the Trust was on track to achieving its first year's actions outlined in the road-map. It was also recognised that the actions the organisation needed to focus on, and, where more progress was needed over the coming year, included an approach to reducing the incidence and impact of bullying, harassment and abuse in addition to the second year's actions of the road-map outlined in 'Diversity Matters'.

In conclusion, the Board of Directors received and noted the ED&I Annual Report (2020/21) previously presented and discussed in detail at the HR Scrutiny Committee on 15th February 2021.

Decision:	ED&I Annual Report (2020/21) received and noted.	**Action by:** n/a	**Date:** n/a

51/21 MFT Board Assurance Framework (BAF) 2020/21

The Board of Directors accept the latest BAF (March 2021) which was aligned to the MFT Strategic Aims (2020/21) and also highlighted the continued impact of the ongoing COVID-19 National Emergency.

Decision:	Reviewed MFT Constitution (including all supporting Annexes) approved.	**Action by:** n/a	**Date:** n/a

52/21 Committee Meetings

The Board of Directors noted the following Board Sub-Committee 'virtual' meetings which had taken place during January & February 2021:

- Group Risk Oversight Committee held on 18th January 2021
- Local Care Organisation Committee held on 6th January 2021
- Audit Committee held on 3rd February 2021

The following meetings had been stood down due to the ongoing COVID-19 National Emergency:

- EPR Scrutiny Committee scheduled for 27th January 2021
- Quality & Performance Scrutiny Committee scheduled for 2nd February 2021
- HR Scrutiny Committee scheduled for 16th February 2021

Decision:	Board Sub-Committee 'virtual' meetings held in January & February 2021 noted	**Action by:** n/a	**Date:** n/a

53/21 Date and Time of Next Meeting

The next meeting of the Board of Directors will be held on **Monday, 10th May 2021** at **2pm**.

54/21 Any Other Business

There was no other business and no items for recording on an Action Tracker.

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

(v) Attendance via 'Electronic Co

*(v) Attendance via 'Electronic Communication' (Microsoft Teams) in keeping with the **MFT Constitution – October 2017** (Annex 7 – Standing Orders – Section 4.20 Meetings – Electronic Communication – Page 108)*

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Chief Operating Officer
Paper prepared by:	James Allison, Director of Performance and EPRR
Date of paper:	April 2021
Subject:	Update on MFT ongoing response to COVID
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:	Board of Directors are asked to note the contents of the report
Contact:	Name: James Allison, Director of Performance and EPRR Tel: 0161 276 6718

COVID – UPDATE ON THE TRUST ONGOING RESPONSE

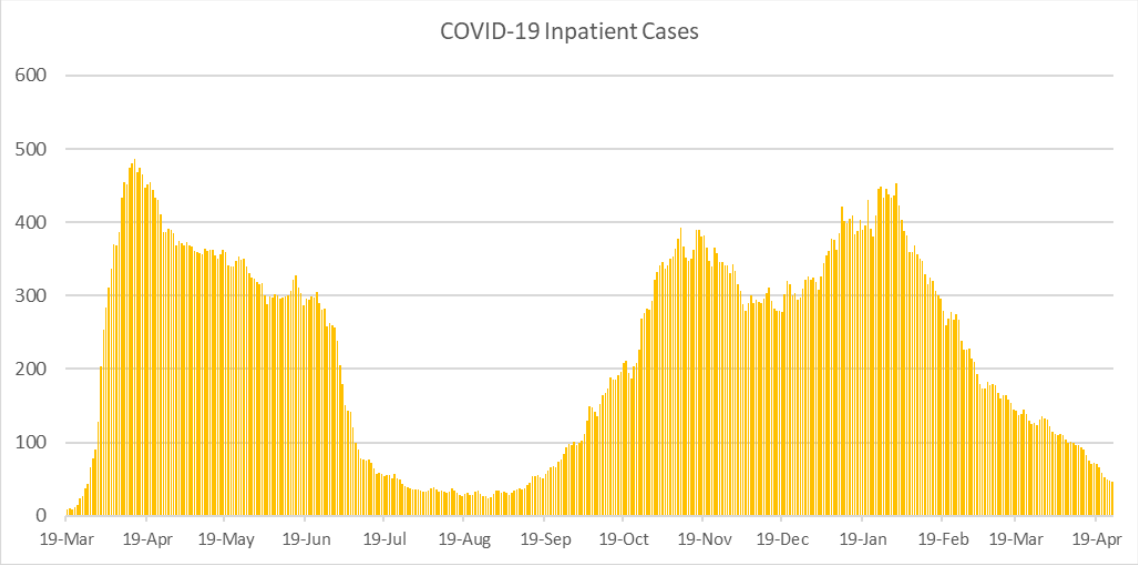
1. PURPOSE

The purpose of this briefing is to provide The Board of Directors with an overview of the MFT response to the Covid 19 pandemic ("Covid"). This also includes ongoing operational planning and performance against national NHS constitutional standards, the impact of Covid on patient wait times, further development of Recovery planning and modelling, and an update on Staff testing.

2. COVID POSITION

- A 3rd wave of Covid in January 2021 necessitated a further period of national lock down, with restrictions partially lifted at the end of March 2021.
- MFT had two peaks of Covid attendances during January.
    - The first peak occurred in the second week of January and saw 423 Covid attendances.
    - A second rise in Covid attendances at the end of January resulted in a peak of 453 Covid patients occupying in-patient beds, with 64 patients in Critical care beds (level 2/3)
- Inpatient Covid numbers of 453 in January represented 93% of the wave 1 Covid peak (487 inpatients, 14th April 2020).
- Since these January peaks there has been a slow decline in Covid inpatient and critical care patient numbers. At 25th April 2021 the Trust had 47 inpatient Covid cases in beds and 13 patients in Critical Care.

Table 1. MFT Covid inpatient cases (March 2020 to April 2021)



3. CONTINUED COVID PLANNING

In response to the increase in Covid incidence in the 3rd and 4th Quarter of the year (Q3 and Q4), the MFT Strategic Group prepared and delivered plans to address this Covid wave, which aligned with national and regional guidance. The decision-making process to support Group escalation and its associated consequences, continued to be led by the Chief Operating Officer (and AEO); Medical Directors; Chief Nurse and the Group Executive Directors.

Individual Hospital / MCS escalation plans approved via the MFT Strategic Group in October, continued during Q4 with a tiered approach to the escalation processes to balance the impact on all activity programmes. MFT Strategic Group took the decision to reduce routine elective activity from the start of November, in order to release bed and staff capacity to support critical care, and this also continued through January, February and into March. As a result, the ongoing response to Covid meant continued impact on the Trust's recovery workstreams and performance against national standards in this period.

During Q4 and into April, consideration has been given by Strategic Group to the potential to partially relax some of the reductions in the Trust's elective and outpatient activities, and restrictions in operating practices. Strategic Group has taken a cautious approach to review and alter key priorities to address Covid:

1. Protection of Specialist Hospital and Service activity
2. Mutual aid and equalisation of Covid / elective activity across all MFT Sites
3. Reduction / cessation of non-essential activities i.e. meetings
4. Reduction of Outpatient Activity to release clinical staffing – phased approach to minimise reductions
5. Reduction of Elective Activity to release clinical staffing. NB: this must be preceded by a request for mutual aid to GM Gold as part of a phased approach to minimise reductions.

Following the slow decline in the number of Covid patients a decision was taken by MFT Strategic Group in early March to stand down Group Tactical meetings, retaining a shadow rota should there be a need to quickly stand up arrangements again to manage any further increase in numbers of Covid inpatients and Critical Care patients, and to ensure coordination of the overall day to day incident management and response to external partners.

During Q4, CSS Colleagues have continued to lead regular conversations at MFT Strategic group on Critical Care bed occupancy across MFT sites. The slow decline in Covid patients requiring Critical Care support across sites from the start of March required a staged approach to reconfiguration. The overarching aim to Critical Care reconfiguration has been to safely increase non-Covid capacity and de-escalate away from non-Critical Care (surge) areas as the incidence of Covid activity declined.

Each stage of reconfiguration continues to be approved by Strategic Group. Workforce, theatre and Critical Care impacts are considered and articulated at each stage. Agreement has facilitated the conversion of Critical Care, theatre recovery and ward areas across sites to non-Covid areas in order to support a phased reintroduction of the Trust's elective recovery programme. Reconfiguration has released nursing and medical support back to substantive duties increasing the availability of additional theatre sessions. It has also re-initiated discussions of Critical Care capacity across MFT sites, with a particular focus on the provision of additional non-Covid Cardiac Critical Care capacity at Wythenshawe.

Activities aimed at planning for and delivering resumption of MFT services has begun. For instance:

- Utilisation of available elective capacity is being undertaken through the Clinical and Operational leadership of The Managed Elective Surgical Hub (MESH);
- Non-essential activities are slowly being reintroduced i.e. specific Committee and programme governance meetings are being re-introduced or returned to pre Covid format; and
- The managed release of clinical staff from Covid wards including Critical Care has allowed Outpatient activity to increase.

At the end of March, NHSE/I planning guidance was published that sets out the planning and delivery priorities for 2021/22, including restoration of services, meeting new care demands and reducing wait time back logs arising as a direct consequence of Covid. MFT is planning and taking actions to improve performance by addressing elective backlogs with a priority on Cancer services, other high priority patients and long waiting patients. The Independent Sector is being utilised where possible to support these operational priorities. Further detail of Recovery actions being taken and governance methods in place are contained within the following sections of this briefing.

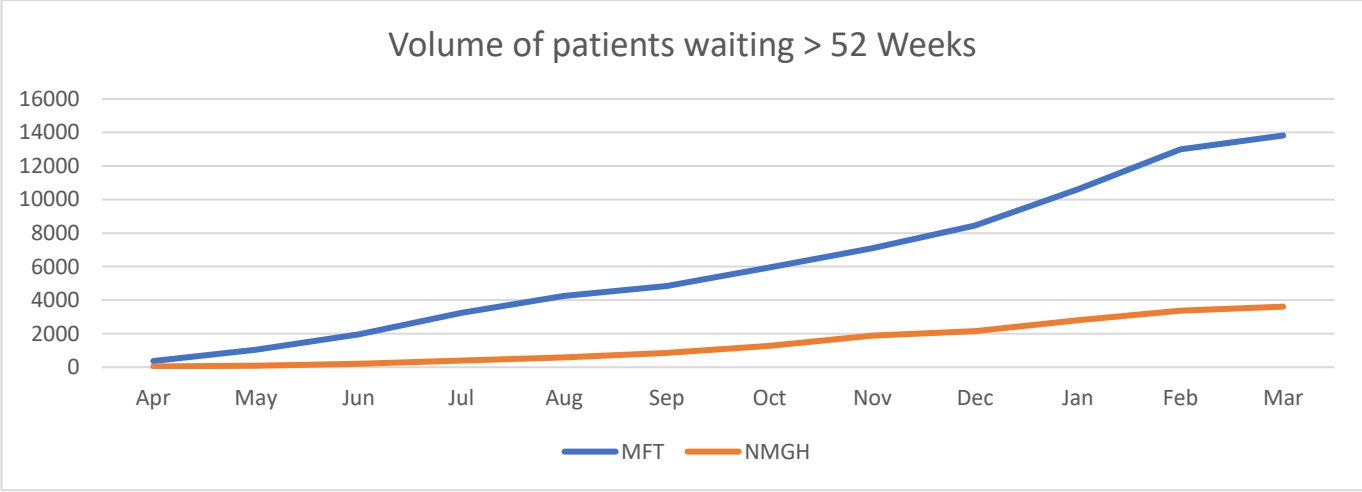
4. IMPACT OF COVID 3RD WAVE ON LONG WAITS

The continued incidence of Covid, and the need to stand down elective activity for significant periods since March 2020 has had a profound impact on the shape and size of the waiting list at MFT. Activity cessation and changes in patient behaviour, means the NHS is now facing a large backlog of non-Covid care.

MFT and NMGH have seen a significant rise in the overall waiting list size and the volume of >52-week waiters across the year. At the end of March 2021, there was a total of 17,433 patients who have waited longer than 52 weeks for treatment. Of this, 13,820 relate to MFT (11.99% of total wait list) and 3,613 relate to NMGH (20.5% of total wait list).

The table below sets out the growth in long waiters across these organisations between April 2020 and March 2021. Further detail is included within section 8 Performance.

Table 2. MFT and NMGH patients waiting > 52 weeks for treatment (March 2020 to April 2021)



The Trust, including NMGH, continues with ongoing performance management of hospital / MCS delivery and clinical validation and priority work across hospital / MCS sites to ensure that the number of long waiters is minimised where possible.

5. RECOVERY PROGRAMME

5.1 RECOVERY PLANNING

The Recovery and Resilience Board (RRB) has been driving the ongoing Recovery programme with a much greater focus on operational delivery. Transformation activities associated with the elective, cancer, outpatient, urgent care and long-term conditions programmes report to the RRB alongside updates of EPRR activities and key enablers such workforce, estates and informatics.

A permanent shift in operating models across MFT and the wider GM system is now required to respond and recover from Covid. This will entail significant demands in terms of staff engagement and leadership capacity. The following key principles have been developed to underpin our Recovery whilst maintaining patient safety, minimising potential harm associated with long waits, and continuing to acknowledge the role that staff have played through the pandemic so far and support them through Recovery:

- How we operate – reshaping the MFT operating model and working collaboratively with GM, regional and national partners to develop our planning;
- Minimising patient harm and maximising patient safety – allocating available capacity based on clinical need and ensuring equity of access using GM resources;
- Supporting and developing staff – prioritising staff wellbeing, recruitment and retention;
- Maintaining a safe environment – focus on Infection Prevention and Control and minimising transmission of Covid; and
- Maximising available capacity – effective use of key resources and accelerating discharge work to ensure where possible patients are treated in the community and in their homes.

Staff at all levels have had to manage significant change in the last year. Robust organisational development and Transformational support will be required to engage and support teams to develop and embed new ways of working.

Following a Group hospital / MCS Senior Leadership engagement session held on 2nd March, Hospitals / MCS developed implementation plans that have been consolidated into an overarching Recovery Plan at Group level. A further engagement session with hospital and corporate Senior leaders and their direct reports was held on 22nd April, and further sessions are being planned. Work continues on the detailed implementation plan for Recovery. Key priorities for the immediate period are:

- Continue the staff vaccinations focused on hard-to-reach groups;
- Maintain asymptomatic staff testing;
- Support for staff health & wellbeing;
- Develop workforce resilience and sustainability;
- Inpatients – including the MESH process, bed de-escalation and maximising capacity, improving discharge processes;
- Urgent and Emergency Care – focus on front door processes and working with partners to reduce unnecessary footfall;
- Out-patients – validation, electronic triage with advice and guidance and virtual clinic activity to maximise effective use of resources;
- Establish Long COVID services – LCO key role player; and
- Maintain dialogue with GM and region to ensure alignment between MFT and GM priority areas

5.2 ELECTIVE CARE - CLINICAL PRIORITIATION / MESH

As a result of the challenging operational environment caused by Covid, effective management of elective waiting lists at hospital / MCS level is required to ensure MFT treats its most clinically urgent patients first given infection prevention and control and staffing constraints. This will play a critical role in delivering elective activity within the next phase of recovery.

MFT has developed a robust process to meet the objective of prioritising treatment of clinically urgent patients based on the Federation of Surgical Specialist Association guidelines. Enhanced site-based MESH (Manchester Emergency & Elective Surgical Hub) groups have meet regularly since the start of the year, one for WTWA, one for North Manchester and one for the Oxford Road site. These groups are clinically led and continue to oversee the validation and prioritisation of single pooled specialty Patient Treatment Lists.

The Group MESH has been mobilised to ensure oversight and effective use of resources across MFT sites, including Independent Sector capacity already agreed for use of MFT. Outputs from the site-based meetings come forward for Group MESH prioritisation of access to theatre capacity, to ensure the patients with highest clinical priority are operated on first and that there is equity of access across specialties and sites.

The Group is chaired by one of the joint Group Medical Directors, and it has wide clinical and operational representation from Group. It also oversees the process for referral of cancer patients to GM Cancer Hub, if required. A Group Director of MESH, on secondment from a Director of Ops role, has been appointed to oversee the processes to support MESH and the Elective Reform Programme. This Reform Programme will address the standardisation of processes across the Elective Pathway necessary to support single Patient Transfer Lists (PTL's) and to align processes with the needs of the Hive Programme, improving quality of care and access for patients.

5.3 RECOVERY MODELLING

During March, the Trust developed, tested and refined a set of initial capacity and demand modelling assumptions for elective recovery planning, ensuring that the most clinically urgent patients will be treated as the priority over longer waiting patients. These plans identified what can be delivered, and in what timeline, within both current / baseline resource and a better case scenario applying a financial contribution from the National Recovery Fund.

At the same time, a parallel piece of work was undertaken by GM Gold to develop a set of planning assumptions aimed at ensuring most effective use of available capacity and equity access across Greater Manchester. MFT gave significant support to this work and there was broad alignment of the capacity and demand assumptions applied at GM and MFT level.

The MFT base case scenario was modelled at a Group / macro level based on the assumption that overall referrals will average 85% of 2019/20 levels in 2021/22, returning to 100% from 2022/23 onwards.

Several additional scenarios were modelled at Trust level alongside the base case, which varied referral and inpatient volumes (+5% / -5% on assumptions). In each of the scenarios, Cancer and Priority 2 performance would be recovered in 2021/22 based on modelled assumptions. Other key outputs of the model were that:

- In the base case scenario, the MFT & NMGH 52-week backlogs would be cleared in Q3 of 2022/23;
- If referrals increase by 5% (to 90%) in 2021/22 the 52-week backlog will still not be cleared by March 2024, even when balancing the system utilising NMGH capacity to treat MFT patients.
- System level management of referrals in & Trust management of consultant to consultant referrals will be key in all scenarios.

At the end of last month, NHSE/I published a series of documents outlining national, system and organisational priorities for 2021/22. These include operational and financial planning guidance for recovery and transformation. This documentation set out expectations of planning at Integrated Care System levels ("ICS") with the support of local NHS organisations to develop agreed operational and financial plans. Six key priorities are identified within the planning guidance for consideration and planning:

1. Supporting the health and wellbeing of staff and taking action on recruitment and retention;
2. Delivering the NHS Covid vaccination programme and continuing to meet the needs of patients with Covid;
3. Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health issues;
4. Expanding primary care capacity to improve access, local health outcomes and address health inequalities;
5. Transforming community and urgent and emergency care to prevent inappropriate attendance at Emergency Departments, improve timely admission to hospital for ED patients and reduce length of stay; and
6. Working collaboratively across systems to deliver on these priorities.

Given uncertainty at this point around the continued pattern of Covid transmission across the first half of 2021/22, there is a lack of clarity on potential levels of non Covid demand and the ability to service that demand. As a result, national planning guidance sets out a limited number of planning assumptions:

- Overall non-elective demand from both Covid and non-Covid returns to pre-pandemic (2019/20) levels from the beginning of 2021/22, subject to the impact of any planned service developments.
- Covid general and acute bed occupancy remains at less than 5% between April and September 2021.
- Infection Protection Control: continued, reliable application of the UK IPC guidance (and therefore implications for productivity and capacity).

MFT continues to work with GM health partners to shape the format, and trajectory / timing of system wide elective recovery planning. The timeline as set out in the 2021/22 priorities and operational planning guidance requires submission at an ICS level of the following:

- Draft activity, workforce and Mental Health numerical and narrative submission - 6th May 2021
- Provider organisation finance plan submission - w/c 24th May 2021
- Final activity, workforce and Mental Health numerical and narrative submission – 3rd June 2021

Similar to the process for the first phase of modelling in early March, a working group has been set up that has met twice a week bringing together representatives from operations (Group and hospital / MCS), clinical and nursing, informatics, finance and workforce colleagues in order to develop the required planning information.

In addition, Informatics Business Analysts aligned to each of MFT's hospital / MCS sites are working alongside operational colleagues to further develop MFT wide and individual site-based activity modelling. At speciality level for instance, this will allow consideration of the varying operating models between sites and the potential use of capacity flexibly to assist the most constrained sites and specialties, maximising efficiencies.

In advance of submission of the MFT draft and financial numerical activity modelling, iterations will be taken through established MFT governance committees including Executive Director Team meetings.

6. PROGRESS ON RECOVERY WORKSTREAMS

In terms of current priority areas for Transformation work and the RRB these continue to be Urgent Care and Flow, Elective Surgery and Outpatients, in line with national, North West region and GM priorities. A performance dashboard continues to be used to monitor outturn and inform the work of each RRB workstream. This section contains a summary of key areas of work.

6.1 URGENT CARE AND FLOW - DISCHARGE PLANNING

Given the extreme pressures on ED and inpatient, critical care bed base as a result of Covid the Trust has continued to work closely with system partners across the final to provide additional focus on effective and timely discharge. Support to further improve processes across the Trust has been provided by the Trust Transformation team.

As a result of work with system partners, MFT saw overall decreases in the number of long stay patients (LOS) during the last quarter of 2020/21. The overall decrease in numbers of patients with 21+ and 14+ day length of stay is shown in the table below.

Table 3. MFT Length of Stay analysis, 21+ and 14+ day patients, Q4 2020-21

MFT	Number of Patients		Level of Decrease	
	1st January	31st March	MFT Patient Numbers	MFT % Decrease
Patients with 21+day LOS	355	284	71	**-20.0%**
Patients with 14+day LOS	523	426	97	**-18.5%**

Length of stay and discharge metrics continue to be monitored on a daily basis at site level and weekly through Strategic meetings. This oversight ensures continued focus on reducing unnecessary LOS and that prompt actions can be taken if there is variation to trajectory. Close working between hospitals/MCS's and LCO as well as community partners will continue post Covid.

6.2 OUTPATIENTS

A re-basing exercise of activity projections was undertaken by hospitals at the end of December / early January. The prolonged impact of the 3rd wave of Covid in Q4 of 2020/2021 has had a significant impact on delivery against outpatient activity plans across most of the MFT hospital sites. Whilst occupancy levels of Covid inpatients started to decline in late March and early April, social distancing requirements remained in place and staff continued to be redeployed.

The proportion of activity that has been delivered virtually across MFT sat at 32% for March. 5.6% of consultations were undertaken via video. MFT has regularly exceeded or met the NHSE / I target of 25% virtual outpatient appointments, either by telephone or video during Q4.

Hospitals continue to work on delivery of actions plans to implement further improvements, and are being held accountable by Group through established performance meetings. Cross-cutting actions plans have been identified and are led by Group. In respect of these transformational activities, roll out plans for Virtual triage are in development. These will integrate the Advice and Guidance function for GP's. Patient Initiated Follow-up (PIFU) plans will enable patients with suitable conditions to manage their condition better without the need to attend routine follow-up where this is not required. This will also help prepare the organisation and patient groups for the introduction of the patient portal available within Hive.

7. STAFF TESTING

The programme of asymptomatic staff testing remains ongoing and has run alongside focused outbreak testing of symptomatic staff. MFT staff and affiliates continue to self-test twice a week, with the aim of helping to reduce the level nosocomial infection rates within MFT and community transmission in the region.

As at 22nd April 2021, a cumulative total of 229,971 tests had been undertaken and reported by staff. The number of staff who have reported a positive lateral flow test is 665 (0.29% of tests reported).

MFT has put in place several actions to encourage participation and recording, including the development of a distribution portal, and an app to submit to streamline the process for staff to regularly record their test results. However, the programme is voluntary and the extremely successful roll out of the MFT Covid vaccination programme in Quarter 4, has contributed to a decrease in the number of tests being recorded regularly by staff in March and April compared to January and February.

8. PERFORMANCE

Urgent Care:

MFT

- Safety remains a key priority for the organisation.
- MFT ended the year ranked 3rd in GM for the 4-hour performance target at March end, and also ranked 3rd for Quarter 4 in total.
- Activity initially reduced during January 2021 as a result of the 2nd period of national lockdown. However, attendance levels recovered during February and March as the incidence and transmission of Covid increased, and at the same time non Covid-attendances remained high.
- Acuity of patients presenting, limitations on bed capacity due to Covid outbreaks and some flow restrictions at times of attendance have again impacted performance Q4.

NMGH

- Q4 attendances were 75% of Q4 2019, and February and March performance were 72.0%.
- Similar to MFT, operational pressures have been evident across Q4 due to flow restrictions, social distancing requirements, Covid outbreaks on wards and staffing sickness absence.
- NMGH had experienced trolley waits in Q3 but improvement actions taken ensured that they ended Q4 with no such waits.

4 Hour Performance	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Q4
MFT 20/21 %	90.18	93.40	91.60	91.80	88.20	86.30	81.07	77.40	76.10	75.95	79.96	82.41	79.69
MFT GM Rank	3	3	2	2	3	3	2	2	3	3	4	3	3
NMGH 20/21%	88.10	87.90	81.00	82.40	79.40	75.80	68.20	69.20	70.00	71.00	72.02	72.30	*
GM %	89.80	93.30	90.50	89.50	86.20	82.40	76.30	74.70	74.30	75.30	79.43	79.97	78.34
National %	90.35	93.50	92.78	92.13	89.25	87.28	84.42	83.84	80.28	78.51	83.92	86.14	83.14

* NMGH quarterly performance is unable to be pulled as it is included within PAT submission

Planned Care:

RTT & 52 Weeks:

MFT

- The number of patients waiting **>**52 weeks has increased during the year due to the factors listed within sections 2, 3 and 4 of this paper.
- Along with treating the most clinically urgent patients, MFT continues to ensure that the longest waiters are prioritised for treatment through the Group and Site MESH committees.
- Further focus has been undertaken to convert face to face appointments to telephone and virtual as noted in section 6.2 of this paper.

NMGH

- Like MFT, the 52-week wait position has seen significant growth and at the end of March is c~3,600 patients.
- Activity has been supported mitigated by use of virtual attendances where possible.

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
MFT	Wait List	98,785	102,318	101,203	102,381	104,150	106,272	106,438	106,706	109,452	111,006	113,659	115,222
	52 Weeks	369	1,042	1,959	3,245	4,260	4,846	5,946	7,100	8,443	10,602	12,999	13,820
	% of W/L >52 weeks	0.4%	1.0%	1.9%	3.2%	4.1%	4.6%	5.6%	6.7%	7.7%	9.6%	11.4%	12.0%
NMGH	Wait List	14,767	14,790	14,250	14,806	14,745	14,375	14,862	15,443	14,992	15,505	16,295	17,653
	52 Weeks	46	99	210	391	583	855	1,269	1,877	2,148	2,798	3,382	3,613
	% of W/L >52 weeks	0.3%	0.7%	1.5%	2.6%	4.0%	6.0%	8.5%	12.2%	14.3%	18.1%	20.8%	20.5%
National position	Wait list *Million	3.94	3.83	3.86	4.05	4.22	4.35	4.44	4.21	4.28	4.31	4.42	Not available
	52 Weeks	11,042	26,029	50,536	83,203	111,026	139,545	162,888	186,310	215,641	288,160	366,194	
	% of W/L >52 weeks	0.3%	0.7%	1.3%	2.1%	2.6%	3.2%	3.7%	4.4%	5.0%	6.70%	8.3%	

Diagnostics:

MFT

- The waiting list size for diagnostic tests at MFT (excl. NMGH) has increased by 1,869 patients between January and March 2021.
- The breach rate for the 6-week standard increased to 27.10% in January but despite the increase in wait list size for both February and March this did not impair performance and there was month on month improvement.
- During March the breach rate was 19.14% of the total wait list for MFT, the lowest rate during the 2020/21 year.

NMGH

- The NMGH breach rate for the 6-week standard has improved significantly from 16.6% in January to 9.9% March.
- The improvement between January and February was as a result of focused work on audiology undertaken in January.

DMO1 Breach rate	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
MFT	46.90%	64.90%	59.90%	48.80%	46.90%	38.70%	32.70%	27.80%	26.30%	27.10%	23.35%	19.14%
NMGH	54.10%	51.30%	45.20%	40.60%	47.10%	43.30%	34.00%	27.80%	31.30%	16.60%	6.30%	9.91%
National	55.70%	58.50%	47.80%	39.60%	38.00%	33.00%	29.20%	27.50%	29.20%	33.30%	28.50%	Not available

Cancer:

MFT and NMGH

- Referrals for suspected cancer had returned at least to pre-Covid levels across MFT sites during Q4, although there is large variability both month on month and between tumour groups.
- Performance against the 62-day standard has been variable in the last quarter of 2020/2021.
- In respect of 2 week waits, WTWA see a considerable number of suspected breast and skin cancer which, by their nature require face to face appointments. Social distancing requirements have impacted throughput and adversely affected performance.
- Referrals surged in early April meaning a period of underperformance, and there is risk to the Breast trajectory remaining on target for recovery during Q1 of the new financial year.
- Head and Neck referrals at WTWA have increased over and above expected levels following the closure of the East Cheshire service.

		Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
MFT	2WW %	93%	83.2	87.7	76.7	63.2	67.9	64.0	68.9	70.8	73.3	69.0	82.9
	31 Day %	96%	93.2	88.1	90.9	94.5	92.0	91.6	92.1	90.9	89.7	87.9	93.2
	62 Day %	85%	64.2	51.3	64.4	69.3	71.8	57.7	55.4	61.1	65.0	60.5	57.1

		Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
NMGH	2WW %	93%	87.6	99.6	98.1	95.5	96.4	93.8	95.8	82.8	58.4	56.2	60.7
	31 Day %	96%	100.0	97.0	98.4	97.8	94.7	98.3	96.9	100.0	98.9	97.6	98.9
	62 Day %	85%	77.7	59.1	64.6	55.2	71.2	70.3	80.0	63.3	79.7	72.7	71.9

MFT and NMGH >104 day and >62 day cancer waits

- MFT has made improvements in reducing the lengthier of the long cancer waits with prioritisation review being undertaken through the Trust MESH process and general PTL management.
- However, within the patient cohort waiting, a proportion of MFT patients (including NMGH) could not be progressed due to patient choice, patient unfit, and late referral.

9. RECOMMENDATION

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

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Alison Lynch, Corporate Director of Nursing
Date of paper:	May 2021
Subject:	COVID-19 Vaccination 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:	• Improve patient safety, quality and outcomes • Improve the experience of patients, carers and their families
Recommendations:	The Board of Directors are asked to note: • The information provided in the report in relation to the COVID-19 Vaccination Programme
Contact:	Name: Alison Lynch, Corporate Director of Nursing Tel: 0161 276 5655

1. Background

1.1. Through the national vaccination programme, the NHS has vaccinated 19 out of 20 people aged 50 and over. High numbers of people have received their second dose; 6.5 million people across England have already received this including 75% of people aged 80 and over as at April 2021.

1.2. The MFT vaccination programme commenced on Oxford Road Campus, MRI OPD, on 16th December 2020, delivering both AstraZeneca and Pfizer vaccines across the sites[1]

1.3. Through the MFT staff vaccination programme, 90.0%[2] have received their first vaccine, the second dose programme for MFT staff will complete in May 2021. 90.07% of staff have either had or booked their 1st dose.

1.4. 100% of MFT staff have been offered the vaccination.

1.5. 80.3% of those staff who identify as BAME have been vaccinated[3]

1.6. Vaccinations are delivered in MFT clinics to those who meet the JCVI eligibility criteria in cohorts 1 – 9 in collaboration with Manchester Health and Care Commissioning and Trafford Care Commissioning Group.

2. Vaccine Programme, Delivery and Supply

2.1. Whilst supply is constrained, the programme has been able to deliver over 93,000 vaccines. The pharmacy team work closely with the vaccine clinic teams to ensure sufficient supply is available to match demand.

2.2. An extensive communication plan is in place to support those staff who have not yet been vaccinated to come forward.

2.3. The vaccination programme will move into its second phase during May to September 2021. This phase aims to continue the vaccination offer to new employees or those who have not yet been vaccinated across the hospital clinics.

2.4. The vaccine continues to be delivered to patient cohorts, including those that have been expanded in line with JCVI guidance. This includes:

- Inpatients
- Identified outpatient paediatrics
- Pregnant women
- Cystic fibrosis patient
- Transplant patients
- Renal dialysis patients, and
- Those with severe allergies

2.5. To support MFT staff, an initiative called 'Your Household' has been established, which allows eligible household and support bubble members of MFT staff to be vaccinated if they meet the JCVI cohorts 1 – 6 criteria, and those aged 50 years and over.

2.6. To support the local community to increase vaccine uptake in groups who may not find it easy to access vaccination through traditional booking routes, the MFT vaccination team have worked closely with MHCC colleagues.

2.7. Walk-in clinics have been established at the Oxford Road site, offering the AstraZeneca vaccine for anyone aged over 50 years, or is over 18 in an at risk group who live in Manchester. The Walk-in clinics have been well received, with over 600 people receiving their vaccine this way.

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[1] Trafford deliver AZ vaccine only

[2] Data accurate at 23rd April 2021, 90.0% including those exempt or have declined. 89.4% excluding exempt or declined vaccination.

[3] Data accurate at 22nd April 2021

2.8. Evening clinics have been established and are open to all staff who would otherwise be unable to attend existing slots and are also available to coincide with the month of Ramadan. The British Islamic Medical Associate notes that having the COVID-19 vaccine does not invalidate the fast, however additional evening slots may be preferred for some staff who wish to book them.

3. Responding to National Guidance

3.1. On 8th April MFT received the announcement from the Medicines and Healthcare[4] product Regulatory Agency (MHRA) and the Independent Joint Committee on Vaccination and Immunisation's (JCVI) conclusion of possible link between the AstraZeneca vaccine and extremely rare blood clots associated with low platelets.

3.2. Advice was provided that although the AstraZeneca vaccine is considered to be safe, however for those aged 29 years of age and under there should be an offer of an alternative vaccine for their 1st dose. Pfizer is offered as the alternative in MFT vaccination clinics.

3.3. Recent responses to updates to PHE's Green Book[5] and the National Protocol used to deliver the vaccine, have been incorporated into MFT policies and procedures.

4. Policies, procedures and guidelines

4.1. To ensure the safe delivery of the vaccine, frameworks, MFT policies and a series of standard operating procedures are in place to support safe delivery of the vaccination programme.

5. Data and reporting

5.1. Situation reports (Sitreps) are submitted regionally and nationally regularly in line with requests received, providing a range of information including vaccination uptake in:

- Frontline Healthcare staff
- Health and Social Care Workers
- Black, Asian and Minority Ethnic (BAME) staff
- Clinically extremely vulnerable staff; and
- Associate projections of vaccine requirements

5.2. A Reporting Working Group is in place to ensure that consistent and timely returns are made and to monitor and improve data quality.

5.3. A vaccination dashboard which summarises progress to date is issued daily.

5.4. Staff COVID-19 vaccination reports are distributed weekly and communicated with line managers to facilitate targeted wellbeing conversations.

6. Communications and Engagement

6.1. A coordinated and creative engagements plan has been implemented to ensure that all people offered the vaccine have the information required to make an informed decision.

6.2. A staff engagement group including representation from 'hard to reach' groups is in place to increase the staff uptake of the vaccine.

6.3. An information pack is in place to support managers in holding wellbeing discussions with staff who have not accepted or declined the offer of vaccination.

6.4. A vaccination inbox is well established, handling enquiries from staff, patients and the general public.

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[4] C1245 MHRA and JCVI announcement regarding AstraZeneca Vaccine and next steps

[5] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/961287/Greenbook_chapter_14a_v7_12Feb2021.pdf

7. Governance

7.1. Vaccination Programme Meetings are held twice weekly, focusing on the strategic planning of the vaccine programme

7.2. A working group is developing options to deliver the vaccination programme to staff and agreed patient groups in a sustainable way through an established vaccine team, including the transition to business as usual.

7.3. The governance team provide a weekly summary of all incidents related to the vaccination clinics. No level 3 or 4 incidents have been recorded to date.

8. Summary

8.1. The COVID-19 vaccination leadership team are running an effective vaccination programme in a rapidly changing environment

8.2. There has been good uptake of the COVID-19 vaccination across MFT staff with 90.0% of staff having received their 1st vaccine, and 90.07% of staff having either had or booked their 1st dose. 80.3% of BAME staff have received their vaccination.

8.3. Walk-in and evening clinics have been established.

8.4. Longer term plans regarding the programme's transition to business as usual and continuing the collaboration with Manchester Health and Care Commissioning and Trafford Care Commissioning Group continue to be developed.

8.5. The current focus is to administer as many vaccines as possible, in line with JCVI guidance, by continuing to provide first and second dose vaccinations to staff groups, whilst offering the vaccine to new patient cohorts and eligible family members of MFT staff.

8.6. The focus will consider vaccine availability, clinics capacity, workforce requirements, and any national directives that may be released.

9. Recommendations

9.1. The Board of Directors are asked to note the content of this report.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse / Director of Infection Prevention and Control (DIPC)
Paper prepared by:	Julie Cawthorne, Assistant Chief Nurse Infection Prevention and Control/Clinical DIPC
Date of paper:	April 2021
Subject:	To provide assurance to the Board of Directors on the Management of Nosocomial Infections
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:	Staff and Patient safety Patient experience
Recommendations:	To note the contents of this report
Contact:	Name: Julie Cawthorne, Assistant Chief Nurse Infection Prevention and Control/Clinical DIPC Tel: 0161 276 4042

1. Introduction

1.1 The Trust is committed to the prevention and management of Nosocomial Infections as demonstrated in the continuing actions and improvement programmes set out in the IPC Board Assurance framework (BAF) updated April 202 (Appendix A).

1.2 Prevention and management of Nosocomial Infections is multifaceted. Actions not covered in this paper are covered in separate papers to the Board of Directors such as the COVID-19 Vaccination programme and staff testing.

1.3 This paper provides an update on Nosocomial Transmissions of COVID-19, progress on the Infection Prevention and Control Development Pathway and the healthcare associated objectives.

2. IPC BAF

2.1 The NHSE/I Infection Prevention Control Board Assurance Framework (IPC BAF) was updated in February 2021 by NHSE/I. An assessment of the 43 new indicators included across five of the IPC standards has taken place. The IPC BAF is included at Appendix A where the new indicators are included (highlighted). Examples of the new indicators include:

- Monitoring of IPC practices
- Testing and isolation strategies
- Cleaning standards and ventilation
- Communication of PHE hands, face, space campaign
- Face masks, including fit testing
- Screening
- Board oversight

2.2. Board oversight is demonstrated as follows, the IPC Board Assurance Framework has been reviewed at the following meetings of the Board of Directors and sub-committees since its publication in June 2020.

- Board of Directors 13th July 2020.
- Board of Directors 14th September 2020.
- Group Infection Prevention and Control Committee (GICC) 14th October 2020.
- Board of Directors (amalgamated into the Board Assurance Framework).9th November 2020.
- Board of Directors 11th December 2020.
- Board of Directors 11th January 2021
- Board of Directors 8th March 2021
- Group Infection Control Committee 20th April 2021

3. Current Position

3.1 The most recent figures from the Scientific Advisory Group for Emergencies (SAGE) accessed 20th April 2021 indicate the latest reproduction number (R) rate of coronavirus (COVID-19) in the North West is 0.6 to 0.9.

3.2 There is a direct relationship between the transmission of the virus in the community with the transmission within health care settings.

3.3 The number of newly confirmed cases and COVID-19 in-patient burden for MFT can be found in Charts 1 and 2 below.

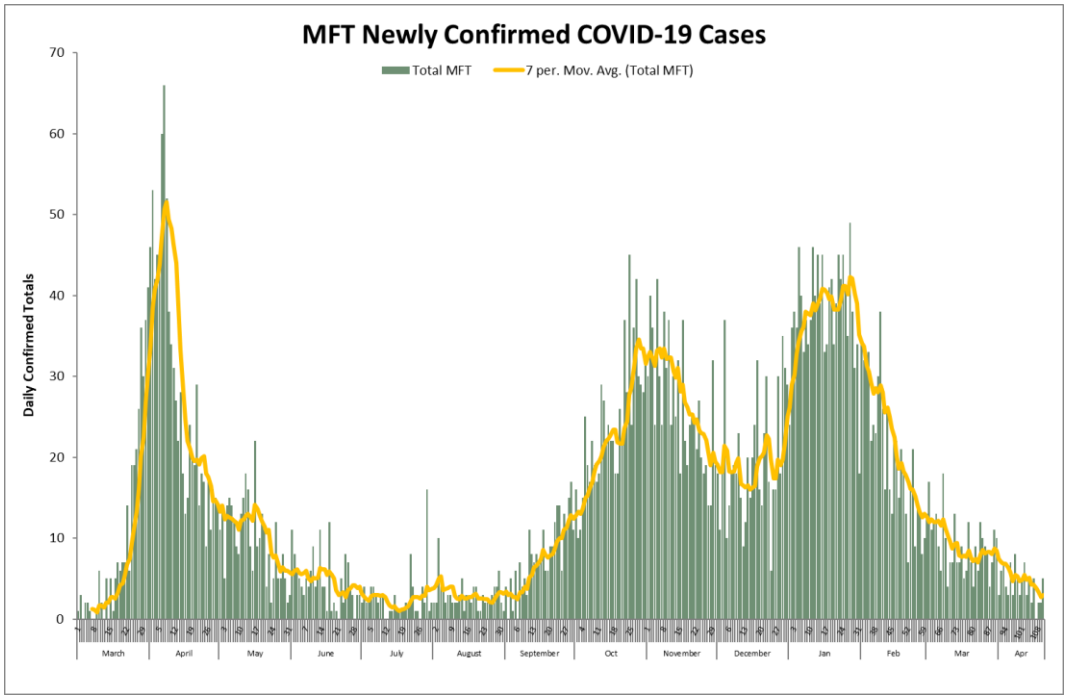


Chart 1- MFT newly confirmed COVID-19 cases presented as MFT total with 7 day moving average, March 2020 – April 2021.

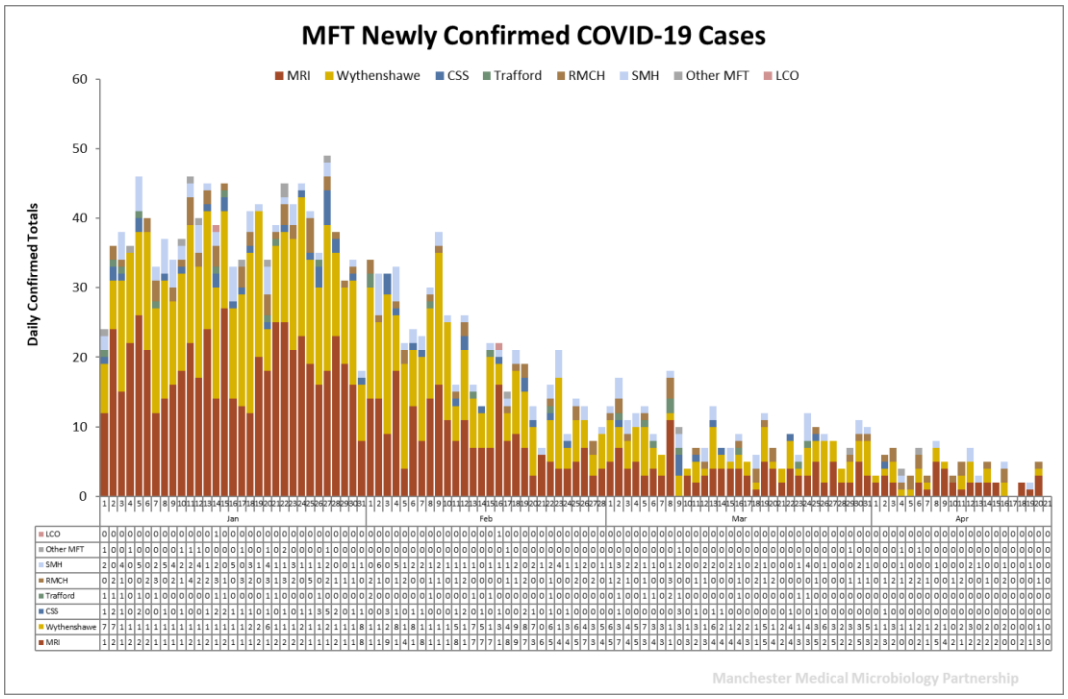


Chart 2 – Daily MFT inpatient burden of COVID-19 cases (laboratory-confirmed cases), January 2021 – April 2021.

3.4 If a case forms part of an outbreak[1] an outbreak is declared, and control measures are implemented. Daily updates on outbreaks are circulated across the Trust. Each outbreak is reported to NHSE/I and monitored daily for 28 days in line with the Trust Outbreak Policy.

3.5. Table 1 below shows the number of COVID-19 outbreaks across MRI, Wythenshawe, Trafford and North Manchester General Hospitals and the Local Care Organisations from September 2020 to date (23rd April 2021)

Table 1: MFT COVID-19 Outbreaks	
September 2020	7
October 2020	21
November 2020	19
December 2020	17
January 2021	22
February 2021	12
March 2021	6
April 2021	1

4. Implementation of Actions from COVID Outbreak Reviews

4.1. There has been a notable downward trend in Hospital Onset COVID Infections (HOCI) and ward outbreaks across the hospitals since February 2021.

4.2. The Trust continues with an unrelenting focus on the fundamentals of IPC measures of hand hygiene, correct use of PPE, social distancing, and strict adherence to IPC practice for interventional procedures. Actions from outbreak reviews have been implemented and are shared via the Directors of Nursing and through ICC.

4.3. Screening of inpatients as per national screening recommendation done on day 1,3,5-7 and weekly thereafter. Screening compliance will form part of the dashboard that is under development by Informatics. In the interim each hospital/MCS is undertaking manual audits of compliance that are actioned at the time. Audit results are reviewed weekly by the Director of Nursing.

4.4. The turnaround time for virology testing of samples has been reduced from 36 hours to 15 hours. In addition, the Trust has implemented Point of Care Testing (POCT) or Lateral Flow Testing (LFT) in adult emergency departments. Patients who test negative for COVID-19 from POCT or LFT are admitted to a non-COVID-19 ward.

4.5. Patients who are re-admitted and have had a positive COVID-19 test within the previous 90 days who are asymptomatic, are admitted to a non-COVID-19 ward to reduce their risk of re-infection.

[1] for the purposes of HOCI, the definition of an outbreak is for two or more cases to occur within the same ward environment within 14 days

4.6 Patients who have tested positive for COVID-19 are stepped down to non- COVID wards after 14 days providing, they have been asymptomatic for 72 hours. This has enabled the Trust to maximize the use of the available bed capacity whilst preventing onward transmission of the virus.

4.7 There is a senior IPC Team member on-call out of hours seven days a week to provide advice and support to the on-site Management teams regarding patient flow.

4.8 The guidance on flexible use of clinical pathways, including elective and non-elective admissions is under review in line with national guidance, as the number of new cases of COVID-19 continues to fall. This will facilitate patient flow, patient safety and ensure the best use of in-patient beds.

5. Fit Testing for FFP3 Disposable Respirators

5.1 In order to ensure an uninterrupted supply of FFP3 disposable respirators existing masks will be replaced with a choice of two alternative UK manufactured brands.

5.2 A task and finish group has been convened with key stakeholders, including hospital/MCS representatives, to oversee the transition between products through a phased approach during April and June 2021.

5.3 In line with requirements of the The IPC Board Assurance Framework (BAF) the central Fit Test training database is being aligned to local databases held by hospitals/MCS/LCO.

6. The Infection Prevention and Control Development Pathway (IPCDP)

6.1 Further to a review of GM specialist workforce capacity for IPC, an 'Infection Prevention and Control Development Pathway' (IPCDP) has been commissioned and is overseen by the Chief Nurse. The framework is intended to support the development of skills and knowledge in IPC for all healthcare workers. It has been designed to assist development from a fundamental awareness of IPC to a more specialist understanding, enhancing behaviours and skills. There are three pathways in place:

- Foundation – aimed at broadening participants understanding of IPC and application to everyday practice in all areas.
- Intermediate – aimed at further learning for staff in relation to application of IPC knowledge into practice
- Advanced – aimed at development of specialist IPC knowledge

6.2 Funds have been secured to implement an e-learning platform and the programme is being tested by GM IPC leads.

6.3 The IDCDP will be implemented across Greater Manchester, overseen by MFT's Chief Nurse / DIPC through a working group attended by IPC leads from hospitals and then rolled out across the NW region.

7. Healthcare Associated Infection (HCAI) Objectives

7.1 There were **14** trust-attributable Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia reported during 2020/2021, compared to a total of eight trust-attributable cases for the previous year. Each incident was investigated, actions taken and discussed at Hospital/MCS Infection Control Meetings. Key issues identified include, compliance with MRSA screening policy and decolonisation therapy.

7.2 There were **189** *Clostridium difficile* Infection (CDI) cases reported during 2020/2021. Of these, **162** were trust-attributable against a trajectory of **132**. Each incident was locally investigated, and actions taken. Key issues identified include, adherence to stool sampling guidance and timely isolation of patients with diarrhoea.

7.3 Led by the Chief Nurse/DIPC, a series of end of year reviews are currently in progress with each hospital/MCS/LCO relating to IPC matters. The reviews focus on the following:

- Overall IPC governance and accountability model
- Incidents of HCAI, investigation, outcome and dissemination of lessons learned.
- Compliance with IPC clinical practice
- Compliance with maintaining a safe environment
- Current IPC risks
- Feedback of learning to the IPC Team which are shared with hospitals/MCS/LCOs and inform the GICC agenda.

8. Clinical Outcomes

8.1 The Group medical directors have supported the development of guidance[2] which has been developed by the North West Structured Judgement Review (SJR) Task and Finish Group. This is a framework for reviewing deaths from COVID-19 nosocomial infection and will capture all the information required.

8.2 The purpose of the framework is to enable reviewers to make informed safety and quality judgements over the phases of care and influence future learning and practice including focussed consideration of key IPC measures. The SJR framework will enable identification of strengths and weaknesses both in the caring process, the systems and environment in which care is delivered, including:

- identification and evaluation of Contributory factors in the acquisition
- Opportunities for learning

[2] COVID-19 Structured Judgement Review Guidance Document NW Region 31st March 2021

9. Sustaining and Improving the Current Position

9.1 There are risks to patient safety from emerging infections both viral and bacterial in origin, that are unpredictable as seen with the pandemic. Transmissible infections are a significant risk to patient care compounded by key challenges such as: the age and condition of some of the trust's buildings, lack of sufficient isolation facilities and antimicrobial resistance.

9.2 To maintain patient safety and reduce the risk of infection it is essential to continue adherence to IPC practices by all members of staff. This includes upholding the principles of 'hands, face, space, ventilation' despite the reducing number of COVID-19 cases in both the community and hospital setting.

10. Summary

10.1 The prevention and management of COVID-19 Nosocomial Infections is multifaceted, and practice has been evolving throughout the pandemic as we learn more about the COVID-19 virus and how it is transmitted.

10.2 Prevention of all transmissible infections, both viruses and bacteria are paramount to patient safety and start with adherence to good IPC practice by all staff.

10.3 There is evidence that the number of new cases of COVID-19 amongst in-patients is declining however, there has been an increase in the number of overall HCAI.

10.4 The Trust is adopting the NW SJR guidance in reviewing deaths relating to COVID-19 Nosocomial Infections.

10.5 The overall reduction in Covid-19 infections is welcomed but practice and attitudes cannot return to pre-pandemic practices and all staff must continue to be vigilant.

11. Recommendation

11.1 The Board of Directors are asked to note the actions and progress, to reduce the risk of transmission of COVID-19 and other HCAI across all our services.

Appendix 1

Infection Prevention and Control Board Assurance Framework V8 April 2021

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes	• **Clinical Sub-Groups / Clinical Advisory Groups are** in place to oversee adjusted or adapted systems and processes approved within hospital settings. • Patient streaming at access points. Emergency Department is zoned to provide designated areas • Screening of non-elective admissions recorded on ED systems and communicated to bed management team • Pathways in place to screen elective patients prior to surgery • Screening of patients prior to admission to community in-patient facilities and recorded in patients notes – SOP in place. • Development of EMIS template to record patients who are COVID-19 positive or self isolating and associated SOP	• Some COVID-19 positive individuals present at hospitals as asymptomatic patients • Audit of community required to ensure SOPs being utilised	• Patient placement guidance in place • Keeping Safe - Protecting You – Protecting Others Document approved and in place • All patients admitted via ED are screened for COVID-19, data is reviewed daily • All women admitted to Delivery Unit are screened for COVID-19. This is repeated at day 3 and day 7. • All women who attend for an elective maternity admission (Induction of labour or elective Caesarean section)

	• Alerting system in place for other healthcare associated infections: (MRSA; CDT; GRE; CPE;MDROs) • Guidance for ambulance trusts in place to support safe pre-alert to hospital trusts https://www.gov.uk/government/publications/covid-19-guidance-for-ambulance-trusts/covid-19-guidance-for-ambulance-trusts • Monthly point prevalence audit of screening swabs) • MFT Guidelines and SOPs available at: https://intranet.mft.nhs.uk/content/important-information-about-covid-19-coronavirus including: • Joint Pathways and Protocols (01.04.20) • Managing patients who meet criteria for COVID testing (12.3.20) • https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases/investigation-and-initial-clinical-management-of-possible-cases-of-wuhan-novel-coronavirus-wn-cov-infection updated 31 July 20 • Risk assessments in place for OPD appointments (Wythenshawe)		have COVID-19 screening 72-48 hours prior to admission • On arrival for all maternity appointments women and partners are screened using symptom checker • All neonates transferred from other units swabbed on arrival • PHE/NHSE/I guidance in place • Revised guidance on '10 point plan' assessed with mitigating actions described https://intranet.mft.nhs.uk/content/important-information-about-covid-19-coronavirus/safe-working-environment

	• Risk Assessments for Interventional Radiology • Risk assessments in place for Maternity and neonatal services		https://intranet.mft.nhs.uk/content/important-information-about-covid-19-coronavirus
Update below • there are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative • Additional requirements • that on occasions when it is necessary to cohort COVID or non-COVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance.	• Patient blue/yellow/green pathways in progress. Patients allocated according to risk category • Plans for identification and management of clusters/outbreaks of COVID-19 in green zones in place • Community inpatient facilities are designated green areas. • Community in-patient facilities have single rooms • MFT Guidelines and SOPs available at: https://intranet.mft.nhs.uk/content/important-information-about-covid-19-coronavirus including: • Hospital Outbreak Control Procedure in place • Policy for Isolation of Infectious Patients • Data collection that is reported externally to the Trust is validated and checked for accuracy by an Executive and the DIPC. • New guidance has been reviewed and pathways assessed as being fit for purpose or updated to include PPE use in low risk pathways	• Hospitals/MCS have progressed zoning plans, define zones including support services and communal access areas (e.g. corridors/lifts)	• Plans in place to address gaps in assurance based on national guidance as available • Revised screening regime introduced 30th November – Day 1.3.7 • Monthly point prevalence audit in place • RMCH/MCS have a covid19 pathway document that outlines where in the Hospital/MCS the various paediatric patient groups are managed (positive, negative and undetermined) in support of flow and ensuring right patient in right place.

	where appropriate (COVID-19 Guidance for the remobilisation of services within health and care settings – Infection Prevention and control recommendations 20 August 2020). • Assessment of "social distance" of beds in all in-patient areas completed. Risk assessment in place for reduction of social distance and bed numbers monitored in 3 times daily capacity meeting		
• compliance with the PHE national guidance around discharge or transfer of COVID-19 positive patients	• Screening protocols in place for patients discharged or transferred to another health care or residential setting in place based on PHE Guidance and incorporated in to Staff and Inpatient Testing Guidelines • Monthly point prevalence audit		
• **all staff (clinical and non-clinical)** are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the	• Appropriate PPE defined by procedures in accordance with national guidance, including: • Face Masks and Covering Guidance • Communication with procurement/materials management	• Issue with supplies of PPE • Occasional conflict between national guidance from NHSE/PHE and guidance from Royal Colleges	• Any conflicting guidance is referred to Clinical Sub-group Chaired by Joint Medical Director for resolution

appropriate setting and context as per national guidance patients and staff are protected with PPE, as per the PHE national guidance	• Education/training sessions for use of PPE to staff • Staff encouraged to raise concerns with line manager and complete incident forms if they consider a shortage of PPE • Escalation plans in place as per trust gold command and GM Gold command • Signage is in place in clinical/non clinical areas. Access to signs that can be adapted for individual areas, and those that must not be adapted are available to print on the Trust intranet • Sanitization Stations are in place at Trust entrances and exits • Audit of PPE and hand hygiene are regularly undertaken – actions in place to improve where required • IPC Safety Officer Audit		• Estates/environment review has progressed with permanent structures to entrances arriving on site by November 20. Temporary structures are in place currently and are sufficient.
• national IPC PHE guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	• Guidance cascaded through Strategic Oversight group • Daily communications email sent to all staff • IPC Team daily visit to clinical areas. have Attendance in wards/departments • Weekend IPC team provision		• The Trust intranet provides a full range of information that is regularly updated and cascaded to all staff via daily communication. Links to the MFT Staff COVID-19 Resource Area are provided

	• IPC team have developed reference posters for staff, with all guidance available on the staff intranet https://intranet.mft.nhs.uk/content/important-information-about-covid-19-coronavirus • The following groups review new guidance/updates and recommend implementation: ❖ High level IPC meeting chaired alternate weeks by DIPC ❖ Clinical subgroup chaired by joint medical director bi-weekly ❖ Clinical Advisory Group weekly chaired by Hospital Medical Director ❖ IPC Operational Group bi-weekly chaired by Hospital Deputy Director of Nursing		https://intranet.mft.nhs.uk/content/important-information-about-covid-19-coronavirus • Regular and up to date information is published in this Resource Area, including the following key topics: ❖ Emergency Planning, Resilience and Response ❖ Employee Health & Well Being ❖ Research and Innovation for COVID-19 ❖ Infection Prevention & Control ❖ Hospital/MCS COVID-19 Resources
• changes to PHE guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	• Response to COVID outbreak managed by Exec leads for EPPR and DIPC through Strategic Gold Command and escalated through this route to the Board of Directors, sub board committees including: ○ Risk oversight committee ○ Group Infection Control Committee ○ Group Infection control committee	• New risks to be identified as guidance changes • New risks may be identified through review of guidance published 20 August 2020 (COVID-19 Guidance for the remobilisation of services within health	• Risks identified on Trust risk register and locally on Hospital/MCS risk registers/regularly updated. • The Trust Board Assurance Framework is continuously updated and submitted to

	• Risk register updated • Risk assessments in place, risk assessment documentation available via the Trust Intranet	and care settings – Infection Prevention and control recommendations).	Board of Directors November 2020. • Weekly meetings with NEDs to keep informed of issues arising through EPRR led by COO • Twice weekly meetings with executive directors provides opportunity to raise issues
• risks are reflected in risk registers and the Board Assurance Framework where appropriate	• There is an over-arching Group IPC risk for COVID-19. Hospitals/MCS/LCO have identified local risks and added them to local risk registers. • Risks managed through Strategic COVID-19 group • Links made to the main Trust BAF, were reviewed at the Board of Directors meeting in November 2020	• Disruption to assurance framework by Suspension of Sub-board Committees due to COVID-19	• Sub committees re-instated • Risks reviewed formally at substantive groups and weekly through EPRR response due to the need to be responsive and adjust in real time • Subgroups have been re-instated in accordance with Trust governance and recovery programme

• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	• Daily alert notifications continued and actioned • Monitoring of incidents of infection • Investigation of MRSA bacteraemia and CDIRCA completion • Accountability meetings with clinical leads re-instated • Hospital/MCS/LCO Infection control committees in place • Extraordinary meetings of COVID expert Group in place • Risk assessments in place address wider HCAI issues for: ❖ 2m social distancing ❖ Contact tracing ❖ Outbreak management ❖ Isolation ❖ Testing • Visibility of Executives and Directors. Frequent observation and review by DIPC, AMD and IPC team to address environmental issues as well as clinical practice	• Three week period of non-toxin testing for CDI due to Aerosol generating procedures (resolved)	• All CDI patients clinically reviewed & PCR tested. • Alternative method for toxin testing implemented • Risk assessment and reports escalated • Investment in environmental mitigation: ❖ A number of Clinell Ready Rooms have been purchased and will be put in place in designated/agreed areas ❖ Enhanced cleaning ❖ Partitions & physical barriers

• Monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice. • staff adherence to hand hygiene? • Staff social distancing across the workplace • staff adherence to wearing fluid resistant surgical facemasks (FRSM) in : • a) Clinical setting • b) non-clinical setting	• Resources that support staff to comply with IPC practices are in place: ❖ Effective systems in place to support control of HCAI's ❖ Policies are in place for the prevention and management of HCAI's ❖ Systems are in place to ensure that resources are allocated to effectively protect people, including staff ❖ PPE is readily available ❖ Education & Training is in place ❖ Facilities are in place to support good hand hygiene: these include hand sanitization stations, sufficient hand wash facilities, sufficient supplies ❖ Signage is clear ❖ Communication channels are in place ❖ IPC staff are present on wards • Various monitoring tools are in place to support compliance with IPC practice; including	• Policies are in place to support managers in addressing specific concerns that relate to adherence to IPC measures	• Escalation process in place to local senior management team

	❖ Hand hygiene ❖ PPE audit ❖ Increase in frequency of audits on outbreak wards • Data is collected monthly and Feedback to Directors of Nursing to address areas of concern		
• Monitoring of staff compliance with wearing appropriate PPE, within the clinical setting • consider implementing the role of PPE guardians/safety champions to embed and encourage best practice	• IPC nursing champions are in place in all hospitals /MCS/MLCO; specifically, their work includes: ❖ role modelling best practice ❖ monitoring compliance ❖ sharing good practice, and ❖ challenging non-compliance.		
• Staff testing and self-isolation strategies are in place and a process to respond if transmission rates of COVID-19 increase • Additional requirement • implementation of twice weekly lateral flow antigen testing for NHS patient facing staff, which include organisational systems	• Staff testing and isolation strategies are in place as part of the Trust Staff and Inpatient Testing Guidelines. • Staff PCR testing is routinely undertaken in identified high risk areas (where highly vulnerable patients receive treatment) and in areas where an outbreak occurs • Lateral Flow Testing is in place across the Trust, with clear guidance in place to ensure isolation and PCR testing follows a	• Access to external test results • Compliance with staff reporting LFT results	• Staff asked to report external test results to absence manager • Communication strategy in place to remind staff to report LFT results • Improvements planned to the way in which compliance with routine PCR testing in high risk areas is monitored

in place to monitor results and staff test and trace • additional targeted testing of all NHS staff, if your trust has a high nosocomial rate, as recommended by your local and regional infection prevention and control/Public Health team.	positive LFT test. • Staff with positive results advised to follow national guidance • App in place to support ease of reporting LFT results		• COVID Testing Strategy Group will monitor compliance through refreshed Terms of Reference
• Training in IPC Standard Infection Control and transmission-based precautions are provided to all staff.	• A series of IPC training packages are included in staff training profiles. • Practical training packages for donning and doffing (both for aerosol generating procedures (AGP's) and non AGP's) are in place via E learning. • An Infection Prevention & Control Development Pathway is newly developed and in place to assist staff development from fundamental awareness of IPC to specialist understanding. The IPCDP is available to registered and non-registered clinical staff.		• Compliance with training is monitored
• IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training.	• The Trust learning hub includes a series of COVID-19 Training Resources. Examples include a series of 'essential skills' training. • Trust wide local induction include COVID-19 IPC measures • Specific COVID-19 training is in		

	place in identified areas, for example the Emergency Department, Respiratory,		
• All staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work.	• The PHE campaign 'Hands Face Space' is visible across the Trust • There is clear signage at all access egress points as well as in all clinical areas • Regular reminders are distributed via trust-wide daily communications		
• All staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance • Additional Requirement • there are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace	• Staff attend the Trust mandatory training programme at the commencement of employment. • Practical competency training is in place which includes Hand Hygiene, use of PPE, donning and doffing • PPE Stocks are regularly monitored across all areas and there is an escalation procedure for areas where there has been increased demand • The Trust procurement team work closely with the IPC teams to ensure stock levels are maintained • The PHE campaign 'Hands Face Space' is visible across the Trust • National guidance is received by the Trust via EPRR email address and directly to Chief Nurse and Medical Directors. Timely		

• national IPC national guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way • changes to national guidance are brought to the attention of boards and any risks and mitigating actions are highlighted • risks are reflected in risk registers and the board assurance framework where appropriate • Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	distribution of updates are then cascaded, reviewed and implemented through: ❖ Clinical Sub-Group ❖ High Level Infection Prevention & Control Group • Risks related to related to Infection Prevention & Control are assessed using robust risk assessment processes. They are reviewed and reflected in the Board of Directors Board Assurance Framework		
• That Trust Chief Executive, the Medical Director or the Chief Nurse approve and personally signs off, all daily data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner.	• The Chief Nurse/DIPC is responsible for all data submissions • The IPC Board Assurance Framework has been reviewed and assessed at each Board of Directors meeting since it was developed. It is also received by Sub-Committee's of the Board of Directors.	• Easily accessible information in one place to support sign off requires development.	• A COVID-19 infection dashboard is under development. Once implemented this will provide Trust, hospital and ward overview of nosocomial infections. The purpose is to provide

• This Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board			further clarity of a range of information in order to support nosocomial infection prevention and management.
• Ensure Trust Board has oversight of ongoing outbreaks and action plans • there are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas	• The Trust Board receive regular information from the Chief Nurse/DIPC on nosocomial transmission of COVID-19 • Nosocomial infection reports are presented and discussed at the following meetings: ❖ COVID-19 Strategy Group ❖ High Level Infection Prevention & Control Group ❖ Group Infection Control Committee (a sub-committee of the Trust Board) ❖ Council of Governors meetings	• See above	• See above

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • designated teams with appropriate training to care for and treat patients in COVID-19 isolation or cohort areas	• Programme of training for redeployed staff including use of PPE, maintaining a safe environment • Bespoke training programme for Clinical leaders to become PPE expert trainers • IPCT undertake regular reviews/ and provide visible presence in cohort areas • Staffing levels increased	• Redeployed staff may not be confident in an alternative care environment.	• Increase of IPC support to COVID -19 Wards • Use of posters/videos FAQ's • Multiple communication channels – daily briefing/dedicated website • Increased Microbiologist and ICD support • Expert Virology support • 7 day working from IPC/Health and Wellbeing
• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	• Liaison between Trust/PFI partners and partnership working • Domestic staff are fit tested and trained in donning and doffing PPE • Use of posters/videos FAQ's • Staff training records and roster allocations available as evidence of this for all areas. • Hospital Estates & Facilities Matron provides oversight of training and standards of practice (NMGH)	• Anxiety of staff working in COVID-19 Wards.	• Domestic staff have access to EHWB services • Increase of IPC support to COVID -19 Wards • (see access to environmental investment)

• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE national guidance • Assurance processes are in place for monitoring and sign off terminal cleans as part of outbreak management	• PHE guidance is adhered in line with decontamination in outbreak situation. • Use of HPV/UVC in addition to PHE guidance • Group Estates and Facilities Decontamination Policy is in place and available via the Trust intranet • E and F/PFI partners and IPC Team have reviewed cleaning frequencies in line with updated guidance • Terminal clean sign-off processes are in place	• Anxiety of staff working in COVID-19 Wards.	• Domestic staff have access to EHWB services • Increase of IPC support to COVID -19 Wards • Use of posters/videos FAQ's • Walk rounds led by IPC to review cleanliness of hospital facilities - undertaken with cleaning management teams.
• increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE national guidance	• PHE guidance is adhered in line with decontamination in outbreak situation. • Use of HPV/UVC in addition to PHE guidance is deployed in high flow areas such as ED • Increased cleaning in wards where there has been a cluster/outbreak of COVID-19 amongst patients who were previously negative • Cleaning twice daily and providing additional enhanced cleaning in high risk/outbreak areas		• Review of domestics rota by facilities to ensure staff rosters are sufficient to cope with the increased demand and that the service provision includes all clinical and non-clinical areas.

• attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas	• additional frequency of cleaning schedules in place • staff are trained to respond to revised cleaning requirements and additional cleaning in place for sanitary and high touch areas.		• Domestic cleaning in ED and assessment areas 12 hours a day after every patient use of facilities
• cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine,as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	• Routine cleaning in all areas (clinical and non-clinical undertaken using a combined detergent and Chlorine 1,000 parts per million solution. • Used in accordance with manufacturers recommendation as described in the Trust Cleaning Policy, adhered to, as per COSHH data sheet held by facilities.	• Cleaning Policy Requires updating (pending new national guidance on cleaning standards)	• Cleaning policy to be updated once National Standards agreed. Current policy is appropriate and in use.
• manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products as per national guidance	• See above		
• 'frequently touched' surfaces, eg door/toilet handles, patient call bells, over-bed tables and bed rails, should be	• Enhanced cleaning specifications in place for clinical and non-clinical areas		

decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids • electronic equipment, eg mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily • rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	• Trust Policy for working safely based on PHE guidance is in place • Increased cleaning in public areas for high touch points (e.g. stairwell hand rails / lift call buttons) have ben put in place across all sites to meet PHE guidance. • staff are trained to respond to revised cleaning requirements and additional cleaning in place for sanitary and high touch areas		
• linen from possible and confirmed COVID-19 patients is managed in line with PHE national guidance and the appropriate precautions are taken	• Linen managed according to national guidance for foul/infected linen, Trust Policy in place – updated July 2020 • Staff in COVID-19 areas are wearing 'scrubs' – laundered through Trust laundry • Guidance on how to care for uniform published on Trust intranet		

• single use items are used where possible and according to Single Use Policy	• Single use items used according to local policy based on national guidance.	• Policy due for review in January 2021 pending review of National Cleaning Standards	• Policy will be updated by IPC Team
• reusable equipment is appropriately decontaminated in line with local and PHE national policy	• Re-useable equipment decontaminated in line with national guidance • Decontamination group is sub-group of Group ICC		• Decontamination group meeting re-instated from May 2020
• Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission	• No mechanical ventilation system in waiting areas, use of electronic fans discouraged	• Old estate unable to provide good ventilation in areas • Local weather conditions may make it difficult to maintain internal temperature if door and windows are open	• Considering use of window and other air filtration systems of ventilation in older estate
• Ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air • monitor adherence environmental decontamination with actions in place to mitigate any identified risk	• Air filtration units (filtrex and Dentair unit) deployed in areas following AGP's in ENT and dental • Windows opened where possible • Monitoring of cleaning is in place, following suspension at the height of the pandemic this is gradually being reinstated • Systems and processes are in place for decontamination of shared equipment	• Old estate unable to provide good ventilation in areas • Local weather conditions may make it difficult to maintain internal temperature if door and windows are open	• Considering use of window and other air filtration systems of ventilation in older estate

• monitor adherence to the decontamination of shared equipment			
• There is evidence organisations have reviewed the low risk COVID-19 pathway, before choosing and decision made to revert to general purpose detergents for cleaning, as opposed to widespread use of disinfectants.	• The Estates and Facilities team continue to clean all surfaces (excluding flooring) using Chlor Clean disinfectant as per IPC advice. • In the event that the IPC team review the low risk pathway Estates & Facilities team would work with the cleaning management team to re-introduce GP detergents in appropriate location		• Continued the use of Chlor-clean across all areas of the adult Trust due to high community prevalence and risk of outbreaks
• Ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment.	• Non-clinical areas are regularly inspected, and any issues are responded to in liaison with the cleaning management teams. • E&F team respond to any reporting incidents or concerns raised to resolve issues effectively.	• Site inspections are undertaken using checklists in clinical areas	• Trust wide incident reporting effectively used to escalate concerns.

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lnes of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained	• Appropriate policies reviewed and approved by the AMC • Specific antimicrobial policies related to COVID-19 are available on the Trust's Microguide platform. • Bimonthly antimicrobial stewardship committee (AMC) meetings are continuing (virtual platform) • Monthly antimicrobial stewardship (AMS) audits on all ward areas • Microbiology support available 24 hours a day. • Antimicrobial prescribing advice available from pharmacy 24 hours a day • ICU ward rounds • Increased AMS support to COVID-19 cohort areas • Ad-hoc reporting to Clinical Subgroup identifying areas of concern in terms of antimicrobial prescribing.	• Monthly AMS audits are being redeveloped to better inform prescribing practices. New audit proforma was introduced in June 2020 and is subject to ongoing review. • Audits and review of AMS practices and prescribing needs to be sustainable whilst the hospital is split into zones. Previously these audits would be done by AMS pharmacists who now must not cross over zones.	• Plans in place to introduce virtual AMS ward rounds to COVID-19 cohort areas. This needs Trust wide support which is being reviewed in terms of: ○ Clinical engagement ○ IT infrastructure ○ Staffing and resources

• mandatory reporting requirements are adhered to and boards continue to maintain oversight	• Quarterly reports from AMC to Trust IPC and Medicines Optimisation Board from AMC		

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting	• Policies/guidance in Acute sector updated to reflect pandemic • End of Life Policy adapted for current need • Controlled entrance & exits to Trust to minimise risk of cross infection • Policy reviewed following further guidance and flexed to meet the needs of individual patients and patient groups whilst still minimising the opportunity for transmission • NHS guidance for 'Visiting healthcare inpatient settings during the COVID-19 pandemic' and the subsequent North West Good Practice Guide have been assessed		• Guidance regularly updated in line with NHSE/I • Risk assessments in place for Maternity and neonatal services • Specific work plan addressing access for maternity partners – key areas are early pregnancy and 12 weeks scans • Guidance in place for visitors • Significant flexibility in guidance to allow for compassionate visiting • Additional technology

	• Visiting Policy available via Trust Intranet and information published on the Website		(tablets and phones) issued to all in-patient areas to facilitate communication with loved ones / advocates.
• areas in which suspected or confirmed COVID-19 patients are being treated are clearly marked with appropriate signage and have restricted access	• Appropriate floor markings and signage in place being overseen by Hospital task and finish groups to ensure with blue/yellow/green areas • Dedicated entrances for blue/yellow/green patients where possible • Signage on entrances, signs are available to download and print via Trust Intranet • Screens in place at reception areas • Available guidance: o Coronavirus Restricted Access Measures Guidance May 2020	• Plans need to be flexible as situation changes	• Hospitals to re-assess as situation evolves. • Learning from outbreaks includes: ❖ Quick isolation and lock down of identified areas ❖ Testing and tracing of staff – Lateral Flow Testing in place for a time limited period
• information and guidance on COVID-19 is available on all Trust websites with easy read versions	• Dedicated website for all COVID related information/policies	• Risk that information may be out of date	• Website regularly updated by Comms/EPPR Team

• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	• Preadmission Screening processes in place for elective patients • Screening processes in place for NEL (see previous) • Compliant with PHE guidance on screening patients being transferred to residential care • Where possible patients transferred in from referring hospitals are isolated until negative screen. When single rooms not available alternative models are used, such as cohorting • NMGH: Transfer documentation updated to include COVID status and individualized swabbing schedule (including for contact patients)	• Insufficient single rooms and isolation facilities	• Risk assessments in place • Environments investment (see previous pods/curtains/2m space) • SOP in place for maternity to use single and cohorting bays when required. Space in bays has been assessed by IPC to maximise distance between women.
• There is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice.	• Written information is available for patients and visitors • There is signage across all areas of the hospitals, including PHE campaign 'hands face space' messages. • Entrances and exits have manned stations to guide and challenge visitors /staff if appropriate	• Lack of concordance amongst some patients/visitors	• Local escalation process in place

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Systems and processes are in place to ensure: • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection, as per national guidance	• Patient streaming at access points in place at all ED access areas • See previous on streaming	• See environmental issues and age of estate	• Patient placement guidance in place • Keeping Safe - Protecting You – Protecting Others Document approved and in place • All patients admitted via ED are screened for COVID-19, data is reviewed daily https://intranet.mft.nhs.uk/content/important-information-about-covid-19-coronavirus/safe-working-environment https://intranet.mft.nhs.uk/content/important-information-about-covid-19-coronavirus

• mask usage is emphasized for suspected individuals	• All patients encouraged to wear masks where clinically appropriate • Policy in place for wearing of facemasks in all areas • IPC Safety Officer Audits of in-patient areas		
• ideally segregation should be with separate spaces, but there is potential to use screens, eg to protect reception staff	• Trust review of working practices including working environment • Screens in place • PPE such as visors in place		• See previous
• for patients with new-onset symptoms, it is important to achieve isolation and instigation of contract tracing as soon as possible	• Covid and non-Covid clinical areas defined across the Trust. • All Non- elective admissions tested and elective admissions as per guidance in Hospital SOPs • Patients who develop symptoms are tested again and the trust has PHE guidance in place on the testing of patients at 5-7 days and every 7 days thereafter. • Recently updated and revised screening in place at 1,3,7 days from 30th November 2020 • Trust has an internal test and trace policy • Outbreak policy in line with NHSE guidance • Outbreaks contained and reported to NHSE/I using IIMARCH (Information, Intent, Method, Administration, Risk Assessment,		• Patient placement guidance in place • Keeping Safe - Protecting You – Protecting Others Document approved and in place • See previous

	Communication, Humanitarian issues) documentation and daily sitrep reports • NMGH: Outbreak / Surveillance meeting 3 times weekly chaired by DoN to oversee correct management of outbreaks and contact tracing of patients and staff		
• patients with suspected COVID-19 are tested promptly	• Screening of non-elective patients in place • Hospitals/MCS have put in place pre 48hour testing for elective admissions • Screening of patients prior to admission to community in-patient facilities and recorded in patients notes – SOP in place/being developed • MFT site of PHE host laboratory and has capacity for extensive screening • DnaNudge in place at MRI and in process at Wythenshawe	• Turnaround time of tests and supply of testing reagents • Limited access to rapid (Cepheid) PCR testing	• Prioritisation of rapid testing for most high risk patients • Patients with suspected COVID-19 are assessed and cohorted according to clinical evaluation • Lack of Testing reagents escalated nationally • Pathway being developed for elective pathway patients who have been previously covid positive
• patients who test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced	• patients are cohorted according to clinical presentation • Outbreak policy implemented		

• patients that attend for routine appointments and who display symptoms of COVID-19 are managed appropriately	• OPD services and community clinic services are using technology to undertake consultations where possible • Signage on entrances advising pathway for symptomatic patients. • Message on MFT phone services • Trust policy on managing patients who present with symptoms in place • All patients screened for symptoms on arrival (NMGH)		• New guidance has been reviewed and pathways (COVID-19 Guidance for the remobilisation of services within health and care settings – Infection Prevention and control recommendations 20 August 2020).
• Screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases.	• Guidelines are in place to ensure that all patients are screened in accordance with national guidance i.e. prior to admission for elective treatment and on admission for non-elective patients. All patients screened on day 3, 5-7, and every 7 days thereafter	• Manual monitoring in place at present	• Automated monitoring process being developed for Dashboard
• Staff are aware of agreed template for triage questions to ask.	• Staff are aware of and are use agreed triage questions, all patients screened for COVID-19 symptoms on admission • All patients streamed through a respiratory/non-respiratory pathway in ED's.		

• Triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible.	• Staff are trained in the use of triage questions		
• Face coverings are used by all outpatients and visitors	• Written information is available for patients and visitors • There is signage across all areas of the hospitals, including PHE campaign 'hands face space' messages. • Entrances and exits have manned hygiene stations to guide and challenge visitors /staff if appropriate	• Not all patients/visitors are willing/able to comply	• Risk assessment undertaken. • Local escalation process is in place
• Face masks are available for patients and they are always advised to wear them	• FRSM available for all patients and visitors	• Not all patients are willing/able to comply	• Risk assessment undertaken. • Local escalation process is in place
• Provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients (particularly when moving around the ward) if this can be tolerated and does not compromise their clinical care.	• All patients are requested to wear a facemask when moving from their bed unless there are clinical indications otherwise	• As above	• Consideration of the process of monitoring patient compliance with wearing face masks into an existing audit document - April 21

• monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so)			
• For patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative.	• All patients with new onset symptoms are tested and isolated. Risk assessment undertaken of all potential contacts		
• Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly. • there is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document	• All patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly. • Regular audits of patient testing guidance takes place, with actions in place to improve where required		• Regular reports to be received by the Trusts COVID Testing Strategy Group to ensure robust monitoring of compliance

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • all staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	• Programme of training for all staff and those who are redeployed including use of PPE, maintaining a safe environment in accordance with PHE guidance. • Register of staff training and fit testing for FFP3 masks are maintained by hospitals/MCS • Bespoke training for Clinical leaders to become PPE expert trainers • Mandatory training in place • (See previous re PPE and fit testing)	• Staff anxiety about risks of exposure to COVID -19	• Increase of IPC support to COVID -19 Wards • Prompt response to clusters/outbreaks of COVID-19 • Plans for staff testing in high risk situations. • Use of posters/videos FAQ's • Multiple communication channels – daily briefing/dedicated website • Increased Microbiologist and AMD support • Expert Virology support • 7 day working from IPC/Health and Wellbeing • New guidance has

			been reviewed and pathways assessed as being fit for purpose or updated to include PPE use in low risk pathways where appropriate (COVID-19 Guidance for the remobilisation of services within health and care settings – Infection Prevention and control recommendations 20 August 2020).
• all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	• Local information and guidance in place for COVID areas and non-COVID areas • PPE Infection Control Policy in place • PHE guidance in place • Donning and doffing videos available on the Trust intranet based on national guidance • Designated donning and doffing areas have relevant guidance and instruction displayed • Audit of PPE and hand hygiene undertaken August 20 – actions in place to improve where required • See previous on fit testing		

• a record of staff training is maintained	• Register of staff training and fit testing for FFP3 masks are maintained by hospitals/MCS/LCO		
• appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	• Re-use of PPE to be used in extremis and agreed with Strategic oversight group following a risk assessment • Standard Operating Procedures developed for decontamination of visors • Staff advised to undertake a risk assessment if there are shortages of PPE for example NMC guideline	• Escalation in shortages of PPE	• Staff asked to complete an incident form and escalate to their manager
• any incidents relating to the re-use of PPE are monitored and appropriate action taken	• Staff advised to complete an incident form and report to their manager • Daily review of incidents submitted by risk management team		
• adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk	• Audit of compliance undertaken regularly, actions taken to improve compliance and reduce risk where required		

• hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance	• Hand dryers are not used in accordance with trust policy • Guidance in public areas		
• guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	• posters and guidance in place https://intranet.mft.nhs.uk/content/hospitals-mcs/clinical-scientific-services/infection-control/hand-hygiene		
• staff regularly undertake hand hygiene and observe standard infection control precautions	• Monthly audits of hand hygiene compliance • Increase of audits on increased activity areas • Mandatory ANTT assessments annually • Hand Hygiene Policy in place • ANTT Policy in place • Audit of PPE and hand hygiene undertaken August 20 – actions in place to improve where required		
• staff understand the requirements for uniform laundering where this is not provided for on site	• Staff advised on how to decontaminate uniforms in accordance with NHSE guidance • Temporary staff changing facilities identified on COVID-19 wards		

	• Staff on COVID-19 areas wearing scrubs laundered through hospital laundry		
• all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household display any of the symptoms.	• HR policies in place for staff to report on absence manager system if they are symptomatic • Trust complies with national guidance • EHWB service provides staff support • Employee Health and Well Being Service COVID-19 Guidance and Support available at: https://intranet.mft.nhs.uk/content/corporate-services/employee-health-and-wellbeing/untitled-page_8	• Staff shortages due to COVID -19	• Escalation to Strategic oversight group of low staffing numbers. • Activity to be titrated by staffing levels • Escalation processes in place and monitored through EPRR including reducing elective programme as required
• Separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas.	• There is separation of patient pathways at Emergency access points. • Use of one-way flow systems and restricted access /egress points in place in all diagnostic centers • Staff communal areas have clear signage and there are staggered breaks to facilitate reduced contact • Footfall reduced where possible	• Not always possible to maintain 2m distance in all areas because of building design constraints	• Local Risk assessment undertaken, and partitions used where appropriate.

• Hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as:
  • hand hygiene facilities including instructional posters
  • good respiratory hygiene measures
  • maintaining physical distancing of 2 meters wherever possible unless wearing PPE as part of direct care.
  • staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace
	• Additional Hand hygiene facilities available at all entrances/exits to the hospital buildings and at entrances and exits to clinical areas.
	• All seating facilities in communal areas are marked to encourage 2m distancing
	• Corridor floors signed to say keep left
	• There is signage across all areas of the hospitals, including PHE campaign 'hands face space' messages.
	• Social media campaigns remind staff and public to follow public health guidance outside the workplace
		• Whilst staff are reminded to maintain social distancing when travelling to work, it is not possible to monitor compliance	

• Frequent decontamination of equipment and environment in both clinical and non-clinical areas.	• Enhanced cleaning in place for high risk vicinities such as amber areas (COVID-19 Indeterminate areas) where there is rapid turnover of patients with an unknown COVID-19 diagnosis. • Enhanced cleaning in place for wards where there is an outbreak • Disposable wipes available in communal toilet facilities		

• Clear visually displayed advice on use of face coverings and facemasks by patients /individuals, visitors and by staff in non-patient facing areas.	• Written information is available for staff and visitors • There is signage across all areas of the hospitals, **including PHE campaign 'hands face space'** messages. • Entrances and exits have manned hygiene stations to guide and challenge visitors /staff if appropriate		
• A rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals).	• The Trust is able to access PHE support directly through its on-site PHE laboratory • Local population, regional and national surveillance intelligence is presented by Trust expert virology team (linking with the on-site PHE lab as above) • A member of the Health Protection Team is a committee member of the Group Infection Control Committee • Expert virologists work closely with the IPC team and AMD for IPC to present surveillance data at: ❖ High Level Infection Control Meeting ❖ Clinical Sub-Group /Advisory Groups ❖ Trust Testing Strategy Group • The surveillance data informs rapid decision making, supports outbreak	• Reliance on staff reporting Pillar 2 test results	• Staff requested to report external testing results to absence manager

	management and guides practice and policy development. • Surveillance of all new patient cases of COVID-19 are reported in a timely manner • Staff results available through EHWB for staff tested on-site • All new patient results reviewed on a daily basis and acted upon by IPC and clinical teams		
• Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation	• Investigations completed and IIMARCH forms submitted for 2 or more cases of HOCI. • All incidents of HOCI are reported on Ulysses/Datix for review and completion • Outbreaks are reviewed 3 times a week meeting chaired by Director of Nursing, or Deputy Director of Nursing		
• Robust policies and procedures are in place for the identification of and management of outbreaks of infection	• Outbreak Policy is in place • Outbreaks reviewed 3 times a week meeting chaired by Director of Nursing, or Deputy Director of Nursing • The Procedure for Managing an outbreak is provided to the relevant ward/department manager for completion at onset of outbreak.	• Closure of beds due to outbreaks impacts on patient flow	• Senior IPC cover available out with working hours available to undertake a risk assessment with senior on-site team • Updated guidance for closure of wards based on risk assessment

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • patients with possible or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	• patients are cohorted according to clinical presentation • Community inpatient facilities have single rooms • risk assessment undertaken in yellow areas to cohort patients according to risk of onward transmission • Isolation of Infectious Patients Policy in place • See previous on environment	• Lack of side rooms for isolation and also number of toilet facilities per ward • Geographical location of support services (e.g. Radiology) and provision of essential services (e.g. monitoring for Cardiac patients)	• Risk assessment undertaken in decision to allocate blue/yellow and green areas based on environment and geographical location • Review of footprint of services across all hospitals to reduce risk of cross infection • Risk assessment undertaken based on symptoms (e.g. isolation of patients with diarrhea)
• areas used to cohort patients with or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	• programme of review of air flow and ventilation undertaken throughout the pandemic	• Lack of side rooms for isolation and also number of toilet facilities per ward • Geographical location of	• Risk assessment undertaken in decision to allocate blue/yellow and green areas based on environment and geographical

		support services (e.g. Radiology) and provision of essential services (e.g. monitoring for Cardiac patients) • some areas of estate particularly old and in poor condition	location • Review of footprint of services across all hospitals to reduce risk patient occupancy, flow and activity adjusted to align to the environment • Good IPC practice implemented in all areas of cross infection
• Restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff.	• In COVID-Wards and Outbreak wards, measures have been put in place to restrict footfall • A Visiting Policy is in place which restricts access	• Staff need to leave the ward for rest/refreshment	• Food for staff delivered to high risk areas. • Breaks in Communal restrooms are staggered • Volunteers to support way finding
• Areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas.	• Clear sign posting in place • Restricted access using keypad where appropriate	• Regular re-configuration of wards due to changing demand for Blue/green areas	• Estates and facilities have regular meetings with hospitals to review signage

8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individual	• UKAS accredited PHE laboratory conducting testing for NW of England • Posters to support training for staff on how to take a swab		• Frequency of testing ensures staff competence
• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	• Screening of non-elective patients in place • Hospitals/MCS putting in place pre 48 hour testing for elective admissions • Policy for staff screening developed • MFT site of PHE host laboratory and has capacity for extensive screening • See previous on testing	• Lab capacity	• New equipment on line for full functionality December 2020 .
• screening for other potential infections takes place	• Screening for alert organisms continued in line with trust policy.		
• Ensure screens taken on admission given priority and reported within 24hrs.	• Tracking system on electronic records systems, chameleon and Allscripts, prompts screening • DNA Nudge used for rapid assessment in agreed emergency department locations		
• Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available.	• Turnaround times measured -planned programme of monitoring.	• Travel time for specimens from site to laboratory dependent on Transport	• Additional transport runs put in place where the laboratory is not on site

• Regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data). • screening for other potential infections takes place • that all emergency patients are tested for COVID-19 on admission. • that those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise. • that those emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission. • that sites with high nosocomial rates should consider testing COVID negative patients daily. • that those being discharged to a care home are being tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge	• The Staff and In-Patient COVID-19 Testing Guidelines reflect national guidance in routine and responsive testing. • Screening for other potential infections has continued throughout the pandemic • Testing is undertaken through PHE laboratory in accordance with PHE guidance	• Trust Testing Strategy Group to receive regular reports to monitor compliance – under development	

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • staff are supported in adhering to all IPC policies, including those for other alert organisms	• Programme of training for redeployed staff including use of PPE, maintaining a safe environment in accordance with PHE guidance. • Bespoke training for Clinical leaders to become PPE expert trainers • Mandatory training in place • Plans for staff testing in high risk situations. • Use of posters/videos FAQ's • Multiple communication channels – daily briefing/dedicated website • Increased Mircrobiolgist and AMD support • Expert Virology support • 7 day working from IPC/Health and Wellbeing	• Staff anxiety about risks of exposure to COVID -19	• Increase of IPC support to COVID -19 Wards • Prompt response to clusters/outbreaks of COVID-19

• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	• Any changes are received and discussed at key strategic meetings: ❖ High Level IPC meeting ❖ Clinical Sub-Group • This review can be weekly and at times daily • Guidance updated on intranet and communicated daily via email • Cascade system in place across the Group		
• all clinical waste related to confirmed or possible COVID-19 cases is handled, stored and managed in accordance with current national guidance	• All waste associated with suspected or positive COVID-19 cases is treated as normal infectious waste (orange waste stream sent for alternative treatment to render safe before incineration or landfill) • Staff follow Trust waste management policy • Healthcare waste e-learning module is mandatory for all clinical staff, based on waste management policy. • All bins are labelled to indicate which streams they have been designated for.	• Since the outbreak of COVID-19 there have been changes to advice from government regards waste (in particular initial categorisation of COVID-19 waste as Category A (similar to Ebola), a national Standard Operating Procedure and numerous Regulatory Position Statements from the Environment Agency) – the changing guidance has been challenging to communicate clearly	• New refreshed waste guidance and communication document currently in production (for healthcare staff, porters and cleaners)and will be circulated Trust-wide • Guidance will be regularly assessed as the situation evolves and national guidance is updated. • Temporary approach to waste audits being developed • Fortnightly meeting of all relevant staff involved in waste management at each site to share

		with staff. • Queries around disposal routes for visitor PPE – options for disposal which are both legal and practical are not currently clear. • COVID-19 precautions have meant Waste Team are no longer able to visit all wards to carry out waste pre-acceptance audits and establish that staff are following waste management policy. • There have been some waste related incidents whereby clinical waste (potentially infectious waste, associated with COVID-19 cases) has been disposed of by staff as general domestic waste.	emerging risks and issues associated with waste. • Weekly conference call between Trust and its main clinical waste collection provider (SRCL) • Trust also has access to “national cell” (Environment Agency, Cabinet office, etc) who are managing waste nationally at a strategic level through COVID, as well as national NPAG group. • Regards community waste, draft options paper prepared to inform future policy and process – further scoping details still required and options will then be taken forward through the appropriate channels

		• Gaps have been identified in relation to clear policy and process in relation to waste generated by COVID-19 cases and non-COVID-19 cases in the community	
• PPE stock is appropriately stored and accessible to staff who require it	• Materials management team asses local stock levels and replenish every 2- 3 days • Update on stock levels circulated to DIPC/IPCT	• Shortages in supply	• Escalation process in place • Re-useable respirators provided for staff working in high risk areas place
10 Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	• EHWB Policy in place • Employee Health and Well Being Service COVID-19 Guidance and Support available at: https://intranet.mft.nhs.uk/content/corporate-services/employee-health-and-wellbeing/untitled-page_8		

	• All staff complete a COVID-19 self-risk assessment, electronically stored • Staff have access to a wide range of physical and psychological support services provided by the Employee Health and Wellbeing Service. • Staff who are working remotely can also access support. • Details of all EHW Services are provided on the intranet or Learning Hub so are easily accessible to everyone, whether onsite or working remotely. • EHW/OH advice and support is availabe to managers and staff 7 days a week.		
• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	• Training records held		
• consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance	• Staff not moved from COVID areas • Strict adherence to PPE guidance and practice • Staff testing policy in place	• Limited by access to reagents	• Prioritisation based on clinical and staff need

• all staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	• Trust policy in place		• Instructions in place not to travel to and from work in uniform
• consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas	• Workplace guidance in place		• Adaptation of space to increase opportunity of break staggering
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	• HR policies in place for symptomatic staff to report on absence manager system. Positive results are fedback via the EHW Clinical Team - ensuring advice and support • HR policies in place for staff to report on sickness absence via the Absence Manager system. • All Trust protocols comply with National guidance and are kept under constant review. HR advice and support is provided to managers. • Regular comms and briefings ensure that staff are aware of policies and procedures as well as the support available to them. • Trust policy align with national guidance		• Absence monitoring • Follow up and contact by line manager
• staff who test positive have adequate information and support to aid their recovery and return to work	• EHWB service provides staff support • Staff receiving positive results are supported by an EHW Clinician to	• Some staff may choose to access alternative community test centres which	• Staff can contact Silver Command, Workforce Bronze, their line manager or the HR Team to seek advice

	obtain advice and receive information regarding next steps, recovery and return to work.	means the results will not be known by the line manager and may be received via text message.	on next steps having received their result via text. • Coronavirus (Covid-19) – Line Manager FAQ (fact sheet)
• That risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff.	• Risk assessments are in place and monitored through HR		
• Staff who carry out fit test training are trained and competent to do so.	• Staff are locally trained by staff who are trained and assessed as competent to do so.		
• All staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used.	• Staff are fit tested for FFP3 respirators	• Change in availability of make and model of FF3 respirators can cause anxiety and disruption	• The trust has procured additional fit testing machines to facilitate easy access to testing for FFP3 • Procurement alert the trust in advance of changes to make and model of FFP3 available
• A record of the fit test and result is given to and kept by the trainee and centrally within the organisation.	• There are local databases of all staff who are fit tested for FFP3 respirators. The data base is updated regularly		

• For those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods.	• As above • Staff are fit tested for alternate FFP3 masks	• Centralised system to be developed to allow regular review by the Board	
• If member of staff fails to be adequately fit tested a discussion should be had regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm. A documented record of this discussion should be available for the staff member and held centrally within the organization.as part of employment record including Occupational health.	• There are Trust Policies in place based on national guidance agreed with HR and EHWB		
• Following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record.	• There are Trust Policies in place based on national guidance agreed with HR and EHWB		

• Boards need to have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board.	• Register of staff training and fit testing for FFP3 masks are maintained by hospitals/MCS/LCO	• Centralised system to be developed to allow regular review by the Board	
• Health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone.	• Risk assessments are undertaken locally and mitigating actions undertaken		
• Staff are aware of the need to wear facemask when moving through COVID-19 secure areas.	• Written information is available for staff and visitors • There is signage across all areas of the hospitals, including PHE campaign 'hands face space' messages. • Entrances and exits have manned hygiene stations to guide and challenge visitors /staff if appropriate		

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Finance Officer
Paper prepared by:	Karen Brown, Programme Finance Director Rachel McIlwraith, Operational Finance Director
Date of paper:	April 2021
Subject:	Financial Performance for Month 12 2020/21
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Maintaining financial stability for both the short and medium term
Recommendations:	• Strong financial governance and control is essential as the Trust transitions into 2021/22 • Hospital/MCS/LCO Control Totals had been formally issued to Chief Executives and work is progressing for 2021/222. In particular to ensure that the financial implications of decisions on service changes are understood and taken into account in the decision-making process. • It is of paramount importance that decisions are not made that commit the Trust to recurrent new expenditure without the appropriate level of scrutiny in particular due to the changing funding basis in 2021/22.
Contact:	Name: Jenny Ehrhardt, Group Chief Finance Officer Tel: 0161 276 6692

Executive Summary

1.1	**Delivery of financial Control Total**	In the first half of the year, as a response to the COVID-19 pandemic, all Trusts were put on a block contract, with an adjusting 'top-up' made retrospectively to bring the Trust to breakeven. This provided stability in the short-term as the Trust responded to the first wave of the pandemic and as it began to restore services during the recovery phase. The financial regime for the second half of the year maintained the block payments to Trusts broadly unchanged from the first half of the year. In addition, a system-wide (i.e. Greater Manchester) funding pot has been allocated by the national team and was apportioned to each organisation within GM. Each organisation was expected to manage local costs, including Covid costs, within this. For MFT, the exception to this was that any Nightingale costs were supported nationally. The Trust had agreed a financial plan for the second half of the year which requires the Trust to achieve a breakeven position based on the funding confirmed at that point in time. More recently additional funding for annual leave costs (a further £17.8m) and the shortfall on non NHS income (£19.2m) has been made available. The Trust delivered a breakeven position excluding this funding and a £37.1m surplus after this funding is taken into account. The Trust has continued to underspend on aspects such as clinical supplies due to reduced activity but has reviewed its commitments and exposure to risk arising from decisions taken in the current year and has made appropriate provisions. Overall the surplus broadly follows the expected trajectory from the M11 position (£17m surplus) with some additional accruals and provisions and with the addition of the non NHS income funding.
1.2	**Run Rate**	Strong financial governance and control remains essential, particularly in the face of an extraordinary and challenging operating environment and a revised framework for 2021/22. Hospitals will continue to report each month against their projected forecasts, in addition to reporting their position against the Control Totals. A preliminary piece of work has been undertaken to identify the Trust and Hospital underlying run-rates, and intentions/aspirations as a key step in developing financial plans for 2021/22. This work will be refined as the national picture becomes more certain, in particular regarding proposed investments that in previous years would have generated additional income but which may now prove unaffordable in a revised financial regime. This work will be refreshed in line with activity recovery trajectories as the position evolves. Further work is also ongoing at GM level regarding the distribution of the GM system funding across organisations.
1.3	**Remedial action to manage risk**	The "expenditure led" financial regime that was in place in Months 1-6 of this financial year presents significant risk to the Trust, through the changed behaviours which it drives. Through the governance structures, there has been a consistent message that maintaining control of expenditure is key even during the pandemic. The change in future funding arrangements and the weakening of the links between activity and income is also a factor, particularly with regard to previously approved business cases that relied upon additional clinical income.

		The Control Totals implemented at Hospital level will be reviewed and refined in the light of this guidance, to reflect the constraint at Trust level.
1.4	**Cash & Liquidity**	As at 31st March 2021, the Trust had a cash balance of £271.2m. This remains higher than plan due to the level of accruals and provisions including capital creditors.
1.5	**Capital Expenditure**	The capital plan reflects the result of negotiations across Greater Manchester to bring the total planned spend across Greater Manchester into line with the new capital envelope. This plan has not been amended for the final additional below. Up to March 2021, £135.1m of capital spend was incurred, including £56m in the month of March. The total slightly exceeded the previous planned spend of £131.9m however the additional spend against the system envelope of £4.7m has been approved. The reported position is helpful in the context of significant constraints on the 2021/22 programme.

Financial Performance

Income & Expenditure Account for the period ending 31st March 2021

	NHSI Revised Plan - Oct 20	Year to date Actual - M12	Year to date Variance
INCOME	**£'000**	**£'000**	**£'000**
Income from Patient Care Activities			
Commissioner Block Payments - CCGs / NHSE	1,482,477	1,552,249	69,772
National Top Up Funding 1-6	141,509	141,507	-2
National Top Up Funding 7-12 Covid - £32.465m	32,465	32,465	0
National Top Up Funding 7-12 - Nightingale	10,212	11,426	1,214
National Top Up Funding 7-12 - Non NHS Income	0	19,183	19,183
NHSE - Cost passthrough drugs (increase above threshold)	20,839	27,345	6,506
Cost passthrough - Independent Sector	14,290	10,818	-3,472
GM System Funding 7-12 £51.985m	51,985	51,985	0
Wales	5,057	4,877	-180
Additional Funding outside financial envelope		1,762	1,762
Lateral flow funding £200k		200	200
Other (Other devolved / IOM / NORs)	2,444	3,822	1,378
Public Health England	382	374	-8
Local authorities	38,207	38,617	410
Sub -total Income from Patient Care Activities	**1,799,867**	**1,896,630**	**96,763**
Private Patients/RTA/Overseas(NCP)	7,000	7,488	488
Total Income from Patient Care Activities	**1,806,867**	**1,904,118**	**97,251**
Training & Education	64,421	63,651	-770
Research & Development	62,239	62,580	341
Misc. Other Operating Income	67,851	116,568	48,717
Other Income	**194,511**	**242,799**	**48,288**
Total Income	**2,001,378**	**2,146,917**	**145,539**
EXPENDITURE			
Pay	-1,156,340	-1,235,629	-79,289
Non pay	-776,694	-805,448	-28,754
Total Expenditure	**-1,933,034**	**-2,041,077**	**-108,043**
EBITDA Margin (excluding PSF)	**68,344**	**105,840**	**37,496**
Interest, Dividends and Depreciation			
Depreciation	-27,575	-27,902	-327
Interest Receivable	60	30	-31
Interest Payable	-40,829	-40,783	46
Loss on Investment		-94	-94
Dividend	0	0	0
Surplus/(Deficit) Adjusted performance re system achievement	**0**	**37,091**	**37,091**
Surplus/(Deficit) as % of turnover		**1.7%**	
Transfers by Absorption		**2,979**	**2,979**
Impairment	**-73,170**	**-77,526**	**-4,356**
Non operating Income	**6,185**	**5,321**	**-864**
Depreciation - donated / granted assets	**-798**	**-758**	**40**
	-67,783	**-32,894**	**34,890**

£13.8m of income received via CCGs during Months 1-6 has been recategorised to R&I and Misc Other income in line with final accounts reporting at year end - this is in line with NHSI gidance in M8 - the plan values reflect this change

Notional income from the apprenticeship fund and matched expenditure of £2,681k has been included as per the NHSI return

In line with national planning requirements the Trust submitted a revised financial plan for the second half of the year, at the time of submission the nationally set planning assumptions were predicated on activity recovery in line with the Phase 3 letter and no second wave of Covid19. The Trust submitted a plan demonstrating a breakeven position.

NHSI have therefore adopted the first six months of actual income/expenditure and the submitted plan for the second six months as the basis of monitoring returns and this combined position is shown as the planned YTD values in the I & E Account table above.

Clearly the clinical / operational position is substantively different from the planning assumptions, however in the main the underspends associated with the non delivery of activity are more than compensating for the additional costs of responding to Covid demands. The Trust has reviewed its commitments and exposure to risk arising from decisions taken in the current year and has made appropriate provisions. As such the underlying position at the end of March was a breakeven position. Additional funding for the costs of annual leave and for the shortfall on non-NHS income has been confirmed with values od £17.8m and £19.2m respectively. These adjustments take the position to a surplus of £37.1m against the breakeven plan.

The total Patient Care income received is now showing as over recovered by £69.8m against the commissioner block payments – this apparent over achievement relates to the contribution to pension costs at £44m with the offset included in pay expenditure together with the additional funding for Annual Leave costs at £20.6m there were also some additional funding streams re specific investments such as Mental Health in the final months of 2020/21 which are matched by spend.

Funding shown against Nightingale (over recovery £1.2m) and vaccination (£1.8m) is matched by additional expenditure. The other key change since M11 is the inclusion of £19.183m of additional funding to cover the modelled shortfall on Non NHS Income from Months 7-12.

An element of Education and Training income has been deferred to 2021/22 driving the apparent under performance.

Misc Other Operating income is showing overperformance and this is largely matched by increased expenditure in particular regarding the notional funding for national procured PPE which is then also shown as a notional cost in Non Pay at £28.1m, together with the notional income from the apprenticeship fund at £2.7m which is also matched by notional spend within non pay – this reflects the reporting requirement for NHSI. c £4m of CEA funding due to a change in payment route of Clinical Excellence awards where the actual income is now shown under “Misc other operating income” as opposed to CCG block income.

Pay costs are showing an apparent significant overspend in month of £69.8m however this includes the pension spend £43.9m in month and annual leave accruals £17.78m in month which are matched by income. Non Pay costs include the 28.1m notional recharge for PPE together with additional costs re CPT income elements including drugs and Nightingale.

Key Run Rate Areas

1. Waste Reduction Programme

Within the Hospital Control Totals is an implied Waste Reduction target, which aligns to the WRP targets set previously and the tables below outline the actual delivery against target. Hospitals/MCSs reported delivery of £22.1m slightly below the 22.4m forecast at Month 11 for schemes that had progressed to L3 or higher on WAVE. It should be noted that the 21/22 forecast value has reduced to £15.3m suggesting that circa £6.8m is non recurrent. The Turnaround team are now working with Hospitals/MCS/LCOs on plans for 21/22 and making sure that the recurrent run-rate as we move into the new financial year is managed carefully.

MFT Summary

Workstream	Actual 20/21 Position			
	Plan (YTD) £'000	Actual (YTD) £'000	Variance (YTD) £'000	Financial BRAG
Hospital Initiative	3,491	3,755	264	108%
Contracting & income	1,332	1,169	- 163	88%
Procurement	6,251	5,088	- 1,163	81%
Pharmacy and medicines management	759	573	- 186	76%
Length of stay	-	-	-	
Outpatients	153	153	-	100%
Theatres	226	446	220	197%
Workforce - medical	2,731	2,920	189	107%
Workforce - nursing	3,075	3,044	- 31	99%
Admin and clerical	1,232	1,077	- 155	87%
Workforce - other	2,912	2,910	- 2	100%
Blood Management	13	11	- 3	81%
Budget Review	1,128	953	- 175	84%
Total (L3 or above)	**23,302**	**22,099**	**- 1,203**	**95%**

Summary against Target 20/21	Act/F'cast
Target	23,679
Actuals/Forecast (L3 or above)	22,099
Variance to Target	- 1,580
Value of schemes below L3 (M1-12)	2,022
Variance to target	443

Financial BRAG

The BRAG Rating in the table above is the overall financial risk rating based on the criteria defined below. There are many individual schemes within each main savings theme, and at a detailed level there will be a range of ratings within each theme. An example is Divisional Non Pay where Corporate is risk rated green where as the overall scheme is risk rated Red.

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

Hospital / MCS / Division targets and actual delivery

Hospital / Division	20/21 Target	20/21 Actual/Forecast	20/21 Variance	% Variance
MRI	7,005	6,986	-19	0%
RMCH	2,375	1,779	-596	-25%
St Mary's	2,339	2,017	-322	-14%
EYE & DENTAL	857	727	-130	-15%
WTWA	857	4,019	3,162	369%
CSS	3,259	2,843	-416	-13%
Corporate	2,525	1,051	-1,474	-58%
LCO	865	2,677	1,812	209%
Grand Total	**20,082**	**22,099**	**2,017**	**10%**

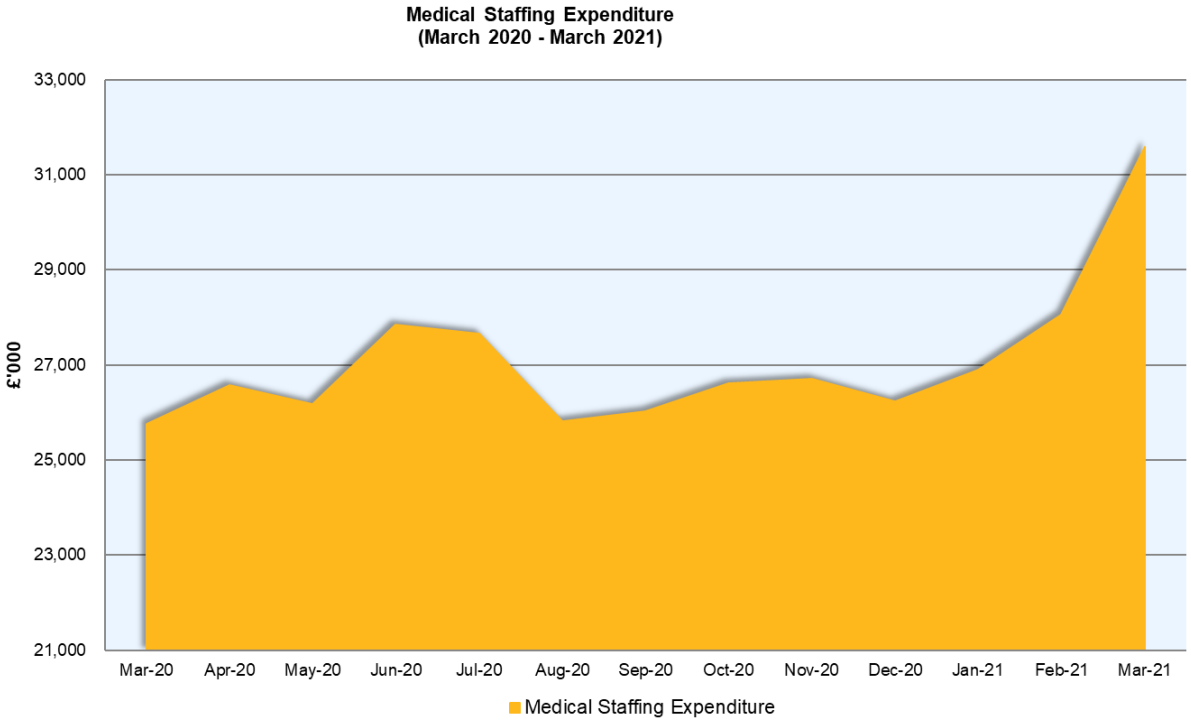
2. Agency spend by Staff Group and Hospital / MCS

Staff Group	Average M1-3 (19/20) £000's	Average M4-6 (19/20) £000's	Average M7-9 (19/20) £000's	Average M10-12 (19/20) £000's	Average M1-3 (20/21) £000's	Average M4-6 (20/21) £000's	Mth 7 (20/21) £000's	Mth 8 (20/21) £000's	Mth 9 (20/21) £000's	Average M7-9 (20/21) £000's	Mth 10 (20/21) £000's	Mth 11 (20/21) £000's	Mth 12 (20/21) £000's	Average M10-12 (20/21) £000's
Consultant	-284	-268	-302	-275	-333	-261	-427	-196	-108	-244	-187	-244	-611	-347
Career Grade Doctor	-89	-29	-36	-103	-35	-29	-73	-35	-39	-49	-20	-28	-36	-28
Trainee Grade Doctors	-247	-253	-125	-84	-72	-104	-239	-163	46	-119	-188	-293	-146	-209
Registered Nursing Midwifery	-574	-530	-511	-531	-303	-266	-326	-263	-343	-311	-173	-273	-282	-243
Support to Nursing	-48	-45	-18	-41	-15	-34	-22	-38	-77	-46	-98	-86	-118	-101
Allied Health Professionals	-83	-72	-109	-72	-64	-172	-245	-156	-176	-192	-199	-388	-99	-228
Other Scientific and Theraputic	-141	-105	-20	27	-72	-14	-54	-52	-30	-45	-39	-35	54	-7
Healthcare Scientists	-8	-73	-118	-55	-62	-72	-161	-27	-143	-110	-41	-64	-298	-134
Support to STT / HCS	-32	-39	-58	-39	-17	-16	-1	3	-21	-6	28	7	-8	9
Infrastructure Support	-101	-40	-165	-98	-117	-104	-61	-29	-140	-77	-83	-375	-339	-266
Grand Total	**-1,607**	**-1,454**	**-1,462**	**-1,271**	**-1,090**	**-1,071**	**-1,609**	**-956**	**-1,029**	**-1,198**	**-999**	**-1,780**	**-1,883**	**-1,554**

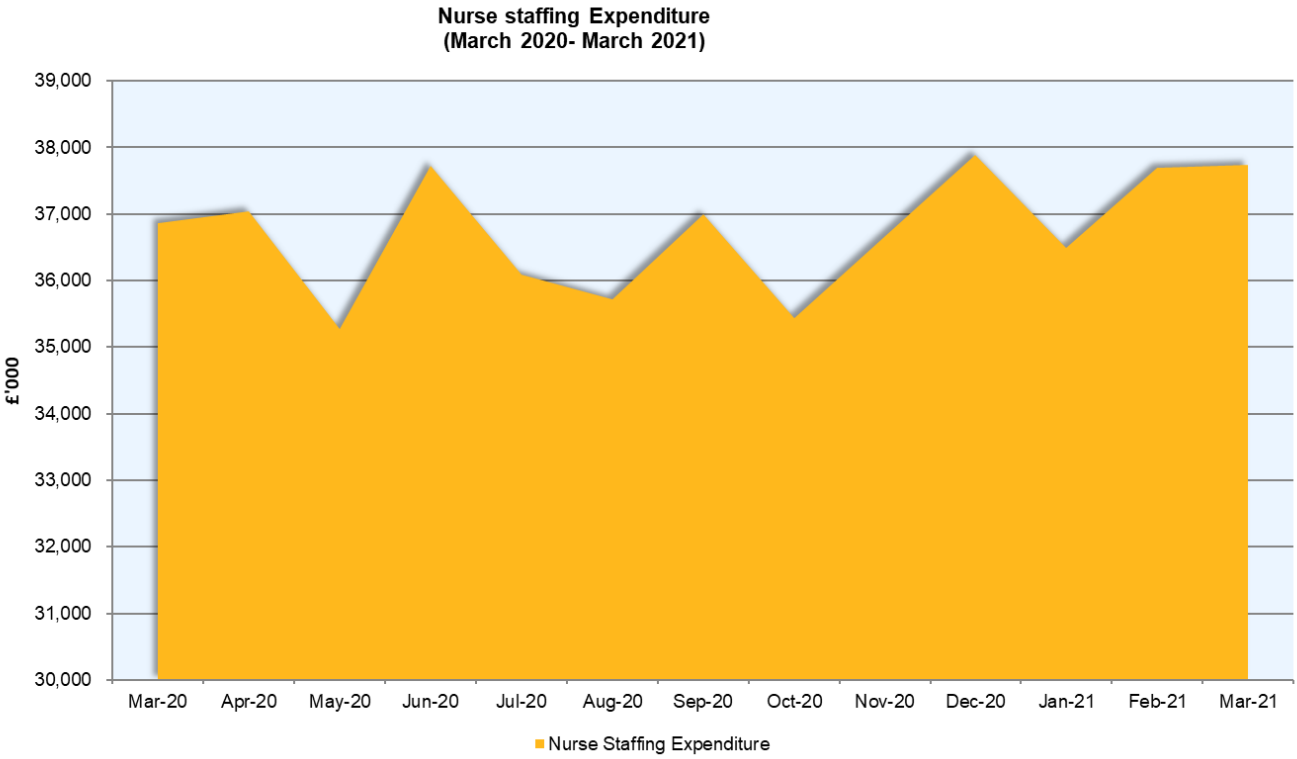
Hospitals	Average M1-3 (19/20) £000's	Average M4-6 (19/20) £000's	Average M7-9 (19/20) £000's	Average M10-12 (19/20) £000's	Average M1-3 (20/21) £000's	Average M4-6 (20/21) £000's	Mth 7 (20/21) £000's	Mth 8 (20/21) £000's	Mth 9 (20/21) £000's	Average M7-9 (20/21) £000's	Mth 10 (20/21) £000's	Mth 11 (20/21) £000's	Mth 12 (20/21) £000's	Average M10-11 (20/21) £000's
Clinical & Scientific Support	-191	-218	-156	73	-101	-219	-421	-179	-313	-304	-202	-464	-367	-345
Manchester LCO	-44	-43	-110	-156	-152	-94	-83	-96	-54	-77	-45	-81	-137	-88
MRI	-680	-534	-226	-534	-286	-223	-496	-342	-273	-370	-262	-479	-655	-465
REH / UDH	-82	-91	-82	-73	-23	-11	-51	-55	-43	-50	-26	-45	-50	-40
RMCH	-78	-94	-156	-109	-130	-101	-135	-55	-91	-94	-69	-102	-81	-84
Saint Mary's Hospital	-24	-36	-33	-33	-18	-34	-57	-39	-64	-53	-60	-68	-41	-56
WTWA	-412	-390	-532	-372	-199	-265	-292	-192	-166	-217	-245	-443	-256	-314
Corporate	-99	-40	-162	-66	-182	-116	-5	8	-25	-7	-85	-85	-268	-146
Research	2	-8	-5	0	1	-8	-70	-5	0	-25	-5	-13	-29	-16
Total	**-1,607**	**-1,454**	**-1,462**	**-1,271**	**-1,090**	**-1,071**	**-1,609**	**-956**	**-1,029**	**-1,198**	**-999**	**-1,780**	**-1,883**	**-1,554**

Agency spend rose sharply in February, and this has continued into March. It is noted that while the overall spend increased by £103k there were changes to spend incurred in M12 across AHPs and Healthcare Scientists. Spend will be closely monitored over the forthcoming months as the Trust looks to increase activity levels. Agency spend remains an area of scrutiny and is one of the key finance indicators in the AOF.

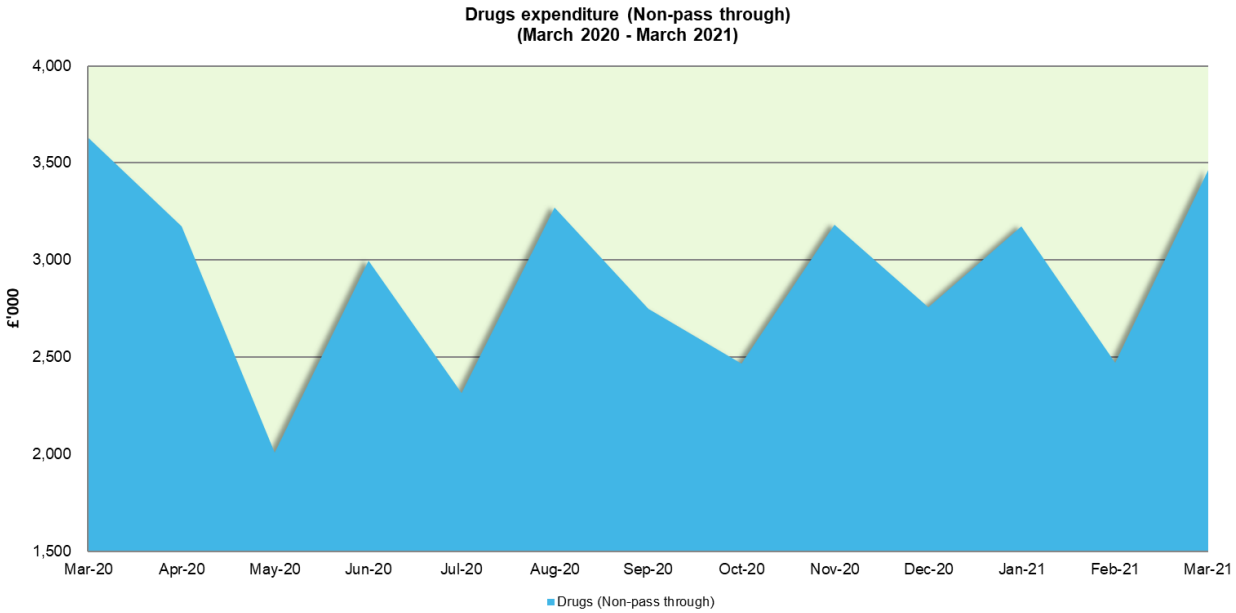
3. Medical Staffing:



4. Nurse staffing:



5. Prescribing:



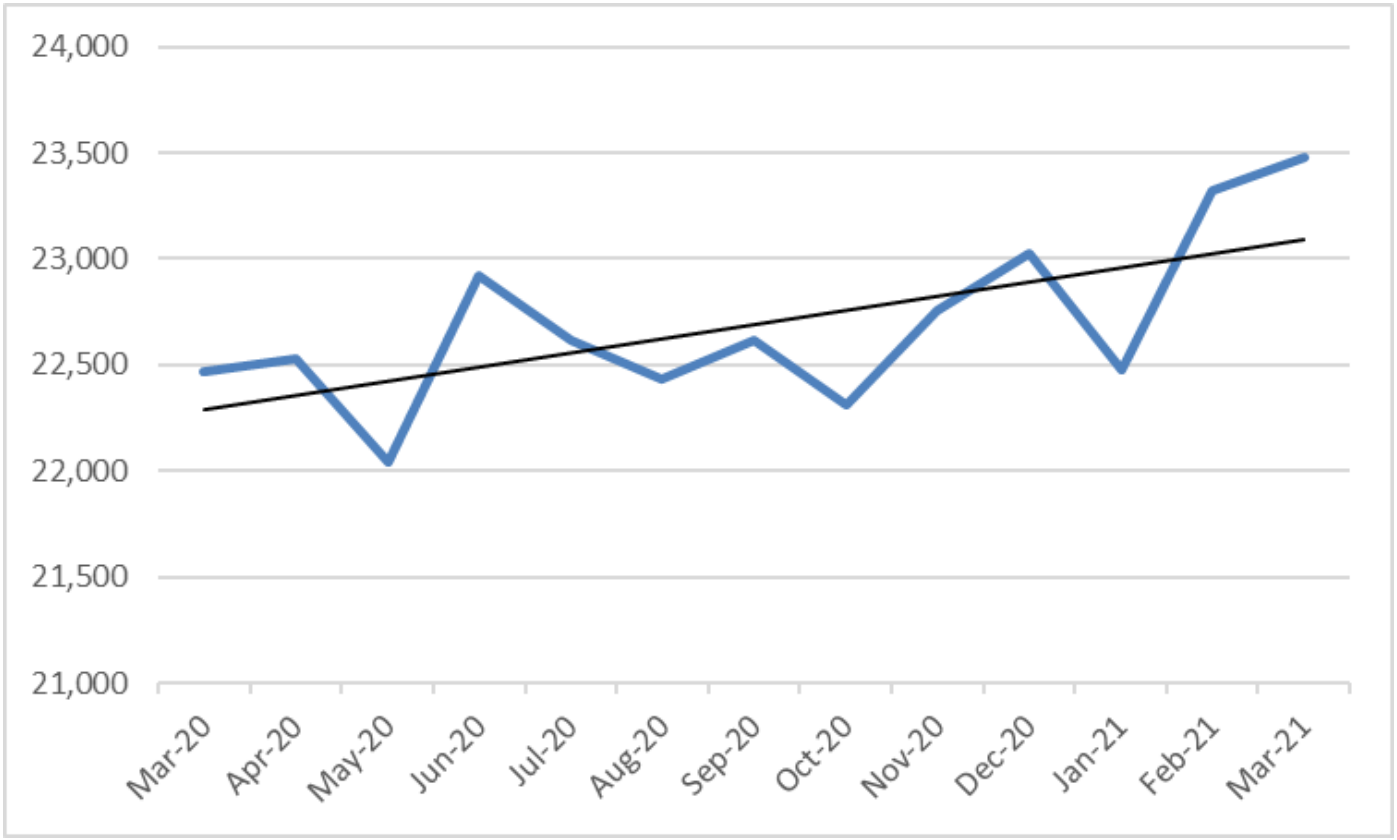
6. Staffing numbers

Staffing numbers have increased slightly in March 155 or 0.7%, increases relate primarily to Trainee Grade Doctors and Support to Nursing with a reduction in Registered nursing. A comparison of March 2021 to March 2020 shows an overall increase of 4.75%.

	Whole Time Equivalent (WTE)												
	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Allied Health Professionals	1,302	1,304	1,288	1,272	1,296	1,279	1,283	1,271	1,287	1,298	1,276	1,301	1,306
Career Grade Doctor	331	333	328	317	311	333	339	355	363	373	361	449	447
Consultant	1,189	1,201	1,171	1,206	1,190	1,218	1,222	1,242	1,252	1,217	1,222	1,241	1,240
Healthcare Scientists	953	939	950	944	945	932	944	958	965	978	950	974	983
Infrastructure Support	2,255	2,294	2,339	2,352	2,328	2,369	2,366	2,381	2,439	2,475	2,533	2,633	2,624
Other Scientific and Theraputic	872	862	861	903	925	929	947	948	953	970	938	959	949
Registered Nursing Midwifery	7,422	7,606	7,302	7,399	7,241	7,080	7,350	7,274	7,586	7,742	7,380	7,840	7,785
Support to AHPs	145	147	144	144	141	131	131	131	129	128	126	129	128
Support to Clinical	2,732	2,716	2,672	2,676	2,682	2,698	2,695	2,692	2,692	2,710	2,642	2,737	2,722
Support to Nursing	3,314	3,186	3,078	3,533	3,518	3,522	3,293	3,101	3,108	3,190	3,085	3,175	3,367
Support to STT HCS	737	724	712	841	762	730	734	735	739	757	742	740	746
Trainee Grade Doctors	1,215	1,215	1,196	1,335	1,275	1,209	1,314	1,226	1,242	1,191	1,222	1,141	1,178
Grand Total	**22,468**	**22,527**	**22,040**	**22,922**	**22,613**	**22,431**	**22,618**	**22,315**	**22,754**	**23,029**	**22,477**	**23,319**	**23,474**

	Whole Time Equivalent (WTE)												
	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
RMCH	2,207	2,258	2,209	2,305	2,327	2,268	2,231	2,211	2,259	2,321	2,214	2,311	2,285
CSS	3,803	3,846	3,774	3,808	3,753	3,778	3,863	3,896	3,947	3,992	3,880	3,999	4,061
Corporate Services	1,290	1,302	1,316	1,542	1,344	1,330	1,365	1,371	1,457	1,469	1,517	1,614	1,784
UDHM	263	263	255	257	248	252	253	260	253	244	244	257	247
Facilities	296	296	299	302	303	302	301	313	313	316	318	330	324
MLCO / TLCO	2,508	2,534	2,510	2,557	2,541	2,512	2,528	2,497	2,527	2,516	2,524	2,564	2,596
MRI	4,007	3,946	3,786	3,964	3,956	3,942	3,995	3,902	3,981	4,039	3,909	4,090	4,060
R&I	525	526	534	539	540	532	534	534	536	535	544	556	549
MREH	536	536	524	537	536	534	567	558	542	557	527	547	544
SMH	2,144	2,161	2,177	2,246	2,263	2,213	2,181	2,133	2,196	2,210	2,124	2,229	2,197
WTWA	4,889	4,860	4,656	4,865	4,803	4,767	4,799	4,639	4,743	4,830	4,676	4,824	4,828
Total WTE	**22,468**	**22,527**	**22,040**	**22,922**	**22,613**	**22,431**	**22,618**	**22,315**	**22,754**	**23,029**	**22,477**	**23,321**	**23,475**

The above values are drawn from the ledger as opposed to the ESR system and reflect paid WTEs.

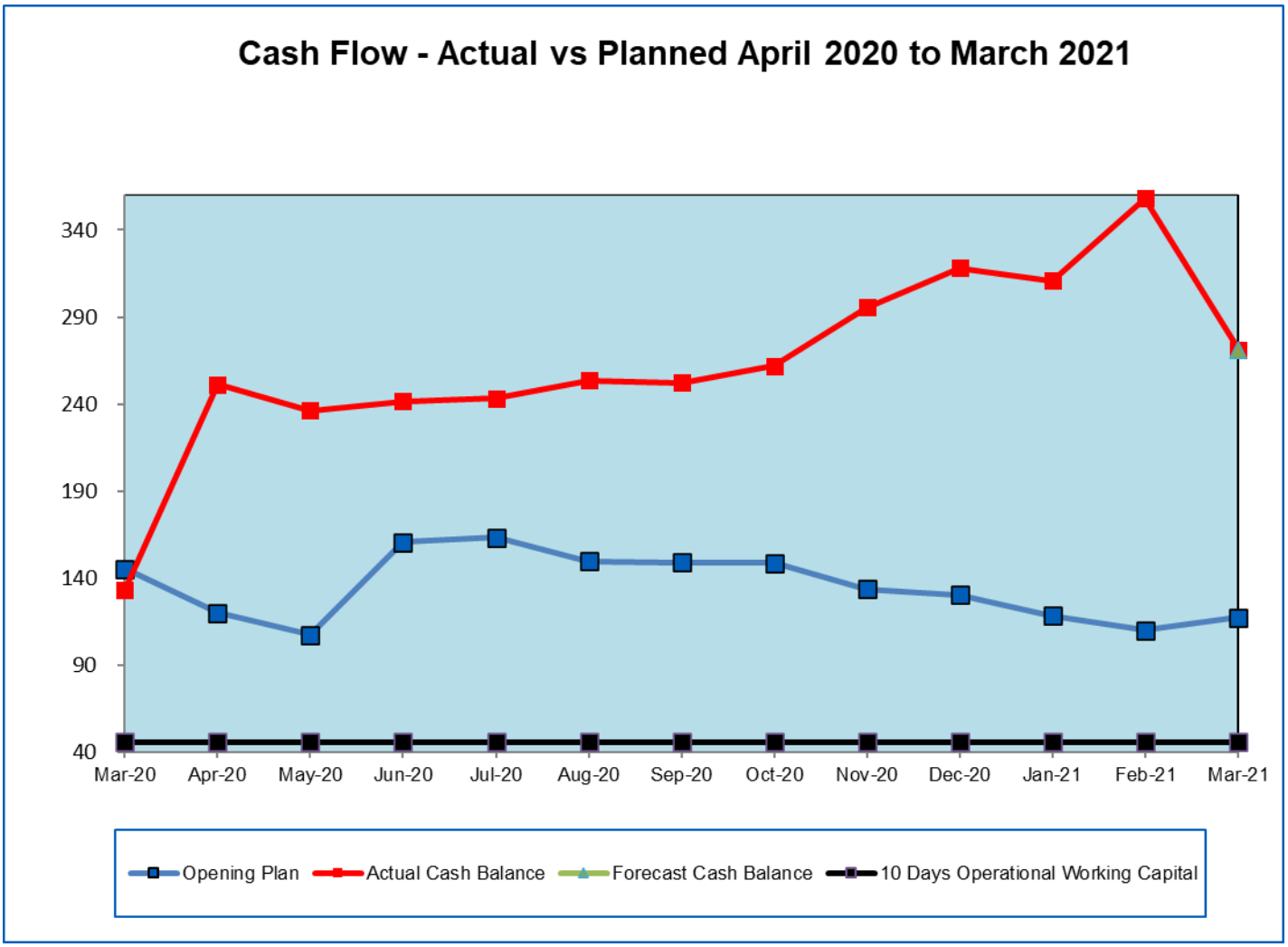


Statement of Financial Position

	Opening Balance 01/04/2020 £000	Actual Year to Date 31/03/2021 £000	Movement in Year to Date £000
Non-Current Assets			
Intangible Assets	4,006	4,666	660
Property, Plant and Equipment	608,068	642,391	34,323
Investments	1,592	1,498	(94)
Trade and Other Receivables	6,329	5,644	(685)
Total Non-Current Assets	**619,995**	**654,199**	**34,204**
Current Assets			
Inventories	18,618	21,893	3,275
NHS Trade and Other Receivables	79,356	80,813	1,457
Non-NHS Trade and Other Receivables	37,302	27,756	(9,546)
Non-Current Assets Held for Sale	210	210	0
Cash and Cash Equivalents	133,281	271,200	137,919
Total Current Assets	**268,767**	**401,872**	**133,105**
Current Liabilities			
Trade and Other Payables: Capital	(12,844)	(33,594)	(20,750)
Trade and Other Payables: Non-capital	(175,409)	(283,079)	(107,670)
Borrowings	(20,173)	(20,292)	(119)
Provisions	(13,417)	(29,553)	(16,136)
Other liabilities: Deferred Income	(18,435)	(35,084)	(16,649)
Total Current Liabilities	**(240,278)**	**(401,602)**	**(161,324)**
Net Current Assets	**28,489**	**270**	**(28,219)**
Total Assets Less Current Liabilities	**648,484**	**654,469**	**5,985**
Non-Current Liabilities			
Trade and Other Payables	(2,599)	(2,599)	-
Borrowings	(391,455)	(374,951)	16,504
Provisions	(14,635)	(16,622)	(1,987)
Other Liabilities: Deferred Income	(3,442)	(3,817)	(375)
Total Non-Current Liabilities	**(412,131)**	**(397,989)**	**14,142**
Total Assets Employed	**236,353**	**256,480**	**20,127**
Taxpayers' Equity			
Public Dividend Capital	208,994	258,929	49,935
Revaluation Reserve	49,424	63,492	14,068
Income and Expenditure Reserve	(22,065)	(65,941)	(43,876)
Total Taxpayers' Equity	**236,353**	**256,480**	**20,127**
Total Funds Employed	**236,353**	**256,480**	**20,127**

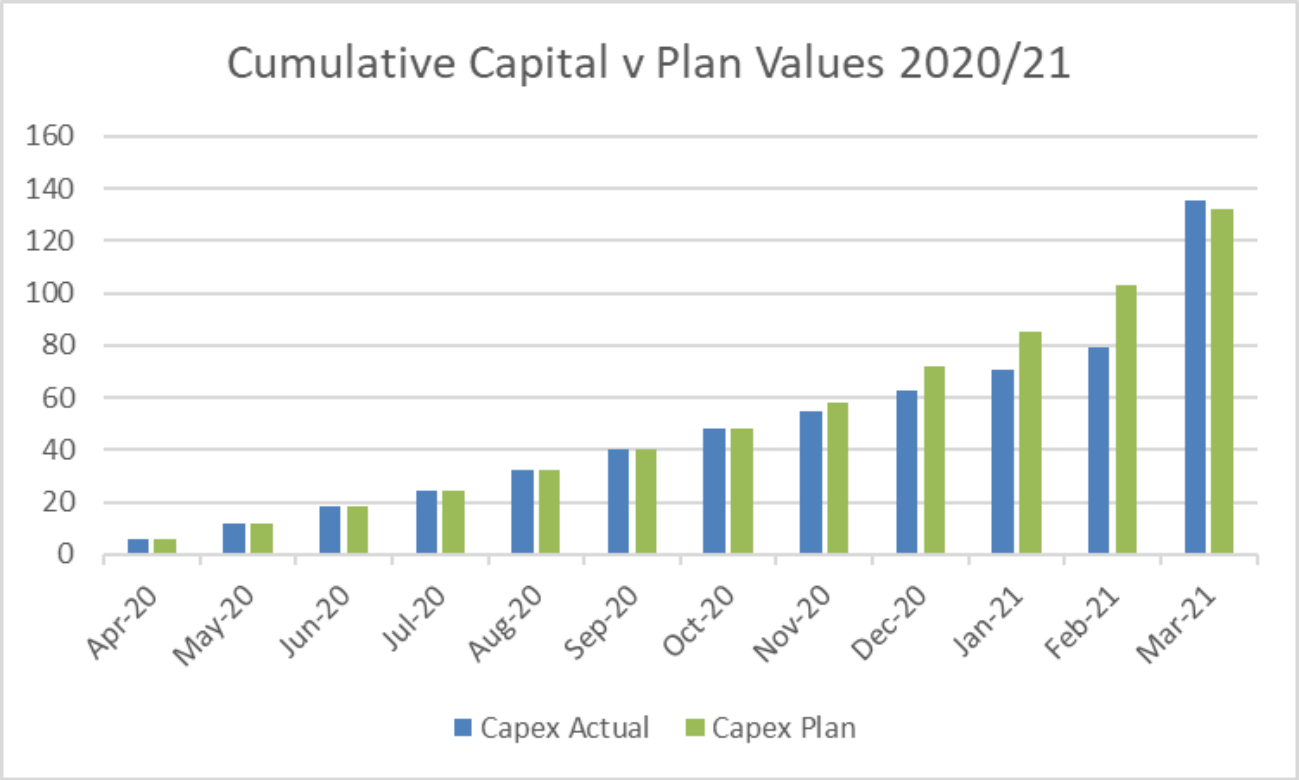
The most significant change on the SoFP in month 11 is the reduction in Cash balances from £358m to £271m which reflects the recovery of the Commissioner income block payment - this is largely offset by the reduction in provisions that previously allowed for the repayment of this income.
As expected at year end the level of accruals has increased as final transactions are posted including the annual leave provision and the level of fixed assets reflects the significant spend in M12 offset by impairment.

Cash flow



The reduction in cash reflects the recovery of the double payment made in April 2020.

Capital Expenditure



The chart above sets out the capital plan and actual expenditure on a cumulative basis. The plan value shown is the profile prior to the final adjustment from the NW i.e. the plan is as at the Month 8 report at £131.9m. The Trust's capital plan for 2020/21 reflects the result of negotiations across Greater Manchester to bring the total planned spend across Greater Manchester into line with the new capital envelope.

The Trust brought forward elements of spend from 2021/22 to compensate for anticipated slippage in order to make full use of the approved level of spend within the capital envelope.

The chart above shows the recovery of the cumulative underspend at the end of February during March which is a good outcome overall and reflects the level of focus on delivery and compensating actions in the final weeks of the year as additional approvals were enacted.

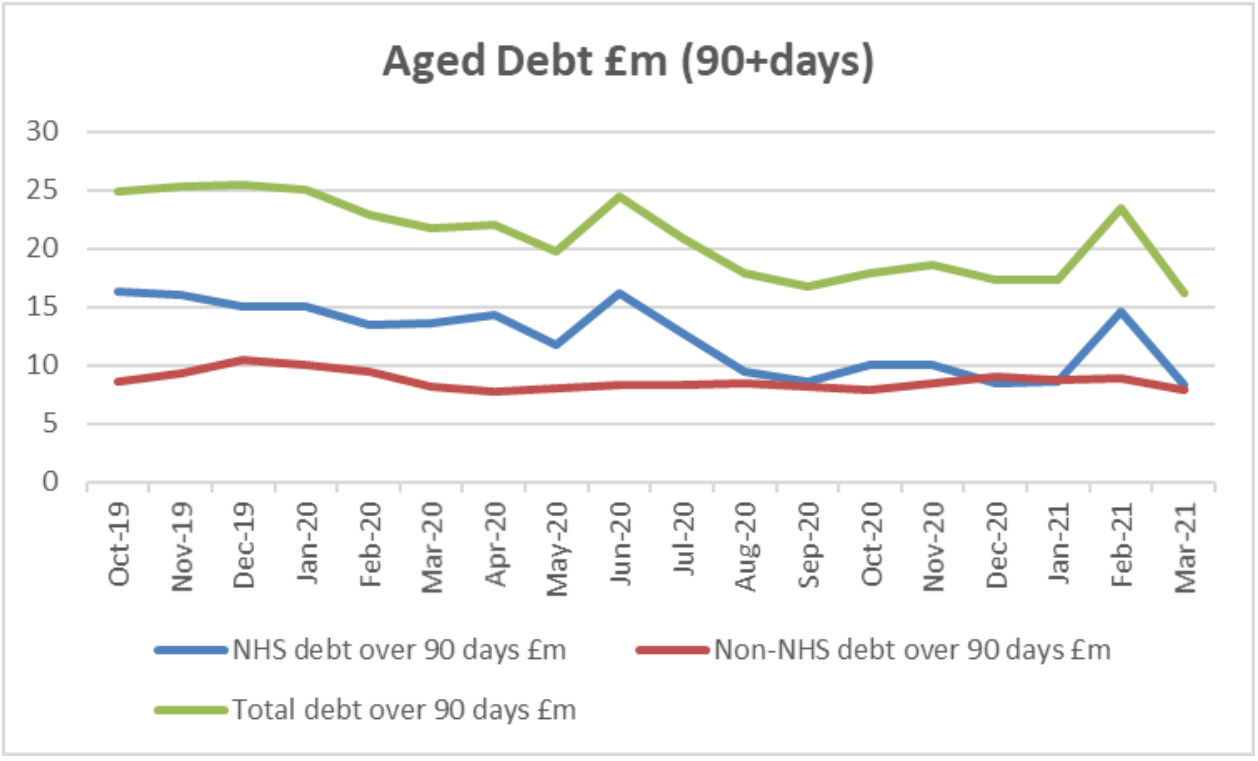
Aged debt

Aged Debt is a focus of the Finance Workplan during 20/21 as the level of outstanding debt continues to be subject to close scrutiny.

Total invoices raised that remain unpaid at the end of March 2021 stands at £31.7m, a substantial decrease from the February figure of £41.7m and a reduction of £12m from April 2020 (£43.7m). Of that balance, 51.1% of the invoiced value was raised over 90 days ago, an improvement from the 56.5% in February. The major reduction in balances relates to the 90 Days + category as well as the 60-90 Days category. The Debtors team to continue to actively communicate with debtors to resolve issues and obtain settlement.

	0-30 days (£)	30-60 days (£)	60-90 days (£)	90 DAYS + (£)	Grand Total (£)	% 90 DAYS +
Feb	11,956,133	3,302,390	2,849,150	23,547,518	41,655,191	56.5%
Mar	8,331,313	5,877,397	1,281,613	16,163,598	31,653,921	51.1%
Movement	- 3,624,820	2,575,007	- 1,567,537	- 7,383,919	- 10,001,270	

It is crucial that the benefits of the work undertaken across Greater Manchester to manage inter-provider debt more closely and to reduce transaction costs for these intra-NHS charges is not lost.



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:	April 2021
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: Darren Banks, Group Executive Director of Strategy Tel: 0161 276 5676

1. Introduction

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

2. National Issues

2021/22 Priorities and Operational Planning Guidance

The 2021/22 Priorities and Operational Planning Guidance was published by NHE England on 25 March 2021. It describes the key challenges for 21/22 which include restoring services, meeting new care demand and addressing backlogs, supporting staff recovery and addressing inequalities. It identifies six priorities, as set out below, with a number of specific areas for action under each (see attachment A).

A. Supporting the health and wellbeing of staff and taking action on recruitment and retention
B. Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19
C. Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services
D. Expanding primary care capacity to improve access, local health outcomes and address health inequalities
E. Transforming community and urgent and emergency care to prevent inappropriate attendance at ED, improve timely admission to hospital for ED patients and reduce length of stay
F. Working collaboratively across systems to deliver on these priorities

The financial settlement that accompanies the guidance has been set for the first half of the year only. The funding for the second half of the year will be agreed once there is greater certainty around the circumstances facing the NHS later in the year.

Effective partnership working across systems is at the heart of the plans and this is reflected in the process. Plans are to be submitted at the ICS level and will increasingly be monitored and assessed at the ICS level reflecting the shift in emphasis with performance at system level is becoming more important than at the level of the individual organisation.

White Paper - Integration and Innovation: working together to improve health and social care for all

The Priorities and Operational Planning Guidance requires systems to prepare to establish statutory arrangements for formalising partnership working set out in the White Paper 'Integration and Innovation: working together to improve health and social care for all', subject to the legislation progressing through parliament. For Greater Manchester this is dovetailing with the work to review the Health and Social Care Partnership.

The timeline for establishing the new arrangements is set out below:

Q2	Confirm proposed governance arrangements for the Health and Care partnership and the NHS ICS body
Q4	Submit ICS NHS Body constitution for approval with NHS England and NHS Improvement
1 April	Establish new ICS NHS Body

During 2021/22 the following will be published to support providers to work in collaboration:

- Updated FT code of governance
- Updated guidance on the duties of Foundation Trust Council of Governance
- Updated memorandums for accounting officers of Foundation and NHS Trusts
- New guidance under the NHS Provider Licence that good governance for NHS providers includes a requirement to collaborate

Diagnostic Imaging Networks

NHS England has published guidance on the establishment of diagnostic networks. Networks will be responsible for asset management, financing, quality, staffing and location of all elective and non-elective imaging. These networks will be essential to help capacity keep pace with growing demand and will be critical to support elective recovery post-pandemic.

Under the Provider Federation Board, colleagues from across Greater Manchester are working on plans to establish Imaging and Pathology networks for GM.

3. Greater Manchester Issues

Community Diagnostic Hubs

Colleagues across MFT, Manchester and Trafford Local Care Organisations, Manchester Health and Care Commissioning and Trafford CCG have been developing plans to establish Community Diagnostic Hubs (CDH) to cover Manchester and Trafford. National capital and revenue funding is being made available in 21/22 and the plan would see a CDH established at Withington Community Hospital in the first instance, with a CDH at NMGH to follow in-line with the wider site redevelopment. The plans would also see the establishment of Digital Ophthalmology Diagnostic Hubs at Altrincham Hospital and Manchester Royal Eye Hospital. Initial bids are being submitted to the regional team in early May with a decision expected in June.

4. MFT

Annual Planning

The MFT Annual Plan is being developed as part of a single process that brings together the production of the MFT Annual Plan, Hospital / MCS Annual Plans and our input to the Greater Manchester submission (as described in section 2). A first draft of the MFT Annual Plan is in development and a session to seek the views and input of the Council of Governors has been planned for 25 May. It is expected that the final version of the plan will be presented to the Board of Directors in July.

5. Actions / Recommendations

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

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
Date of paper:	April 2021
Subject:	Update on the NMGH transaction and redevelopment 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:	To complete the creation of a Single Hospital Service for Manchester with minimal disruption whilst ensuring that the planned benefits are realised in a timely manner.
Recommendations:	The Board of Directors is asked to: • Note the content of this report.
Contact:	Name: Peter Blythin, Group Executive Director of Workforce and Corporate Business Tel: 0161 701 0190

1.0 Introduction

1.1 Progress on the North Manchester programme of work continues to be good. The acquisition of NMGH has been successfully completed by a commercial transfer (see Part A below), and the Outline Business Case for the site is currently being reviewed by the national team (see Part B below).

Part A – acquisition of North Manchester General Hospital

2.0 Background

2.1 The original independent review undertaken by Sir Jonathan Michael (2016) determined that there were significant benefits to be achieved by bringing the acute hospitals in Manchester together into a Single Hospital Service. The merger of University Hospitals of South Manchester NHS FT (UHSM) and Central Manchester University Hospitals NHS FT (CMFT) to form Manchester University NHS FT (MFT) was achieved in 2017.

2.2 Since then, work has been progressing to transfer and integrate North Manchester General Hospital (NMGH) into MFT. NHS England / Improvement (NHS E/I) established a process to dissolve Pennine Acute NHS Hospitals Trust (PAHT) in such a way that MFT could acquire NMGH and the remaining PAHT sites could transfer to Salford Royal NHS Foundation Trust (SRFT). The planned date for these transactions was 1st April 2021.

2.3 It was subsequently agreed that the SRFT acquisition should be deferred and that the MFT acquisition of NMGH should proceed on the planned date, as a Prior Commercial Transaction (PCT). The full process (including the dissolution of PAHT) will be completed through a subsequent Statutory transaction. SRFT's stated intention is to resubmit their Business Case and to complete the transaction by 1st October 2021.

3.0 Acquisition processes

3.1 The MFT Board approved the Acquisition business case on 14th December 2020 and the Board self-certification on 11th January 2021. Following submission of the self-certification, the NHS E/I regional team wrote to MFT on 26th February confirming that there were no issues or concerns. The NHS E/I national team also wrote to the parties on 19th March 2021 confirming that the analysis of the financial models had not identified any issues or concerns. The MFT Board approved the signing of the Transactions Agreement, the PCT Business Transfer Agreement and associated documentation at its meeting on 8th March 2021.

3.2 Final amendments to the key legal documents were agreed during week commencing 15th March, and the content of the various Schedules was finalised during week commencing 22nd March. The full range of legal documents is listed below:

- Transactions Agreement
- NMGH Business Transfer Agreement (MFT, PAHT and NHS E/I)
- Legacy Management Agreement
- Service Level Agreement
- Transfer of Title

- Memorandum of Occupation
- Management Agreement (PAHT and SRFT)

3.3 The execution of the documents was undertaken on the afternoon of Tuesday 30th March 2021. For MFT, execution was generally by the signatures of the Chairman and Chief Executive, under the authority delegated to them at the Trust Board meeting on 8th March 2021. There were two exceptions to this arrangement: the Transfer of Title was executed as a Deed, and the Service Level Agreement was signed by the Chief Financial Officer. On the basis of these execution processes, the legal transfer of NMGH to MFT was completed on 1st April 2021.

3.4 The following key statistics can be noted in respect of the acquisition of NMGH:

- 3,027 individuals (2,650.66 Whole Time Equivalents) transferred employment
- Annual turnover of NMGH is £214m
- 109,341 A&E attendances per annum
- 18,267 elective and 35,642 admitted patients per annum
- 228,786 outpatient attendances per annum
- 3,568 births per annum
- Bed capacity in excess of 500
- Site approximately 28Ha
- Catchment population of approximately 400,000

3.5 It is important to recognise the collaborative work and support of the PAHT and SRFT teams, along with NHS E/I in achieving the acquisition of NMGH.

4.0 Transaction and Day 1 activities

Updates on key transaction and Day 1 activities can be provided as follows:

- Communications activities were escalated in the run in to the transaction date. In addition to the regular weekly newsletters and monthly Team Talk update, welcome videos were provided from the Chairman and each of the MCS Chief Execs. The Group CEO also took part in a Special Team Talk event on Wednesday 31st March, which attracted in excess of 130 participants.
- Correspondence has been completed with CQC, and the achievement of the acquisition has been confirmed. This will now result in the issuing of revised certificates by CQC.
- All staff alignment processes were completed as planned, and confirmatory letters were sent to staff from 15th March onwards. 3,027 members of staff were listed on the workforce schedules and successfully transferred.
- Information for all transferring staff has been successfully incorporated into ESR and other workforce systems. The payroll transfer processes were undertaken in the middle of April, and this supported a successful payroll run at the end of the month.
- There were issues with the e-mail transfer process on 1st April, and the decision was taken to roll-back the merge arrangement. Corrections were made to the process and it is reimplemented on Tuesday 6th April.

5.0 Ongoing work

5.1 A number of key areas of activity are the subject of further work, particularly where it was agreed to postpone further debate until after the NMGH acquisition had been completed. This includes ongoing action on the processes for policy migration and harmonisation, and the arrangements for intranet hosting of policies.

5.2 The operation of the Service Level Agreements is likely to require active management, recognising that these arrangements are now more formal than previous processes.

5.3 The Statutory process to deliver the SRFT acquisition and wind up PAHT will still be required, and this will also serve to finalise the transfer of risks and liabilities in respect of NMGH.

5.4 Arrangements to maintain collaboration with PAHT and SRFT have been set out, and closely resemble the previous processes. The continued role of the PAHT Board is expected to be very beneficial in ensuring the on-going disaggregation work proceeds fairly and effectively.

5.5 Revised arrangements have also been established to ensure effective joint working within MFT, such that disaggregation from PAHT service structures can be progressed, and single service models can be developed across the Trust.

5.6 The MFT North Manchester Programme Board will provide oversight to the work and report to the North Manchester Scrutiny Committee as appropriate.

Part B – Redevelopment of North Manchester General Hospital

6.0 NMGH HIP Business Case Update

6.1 NMGH Redevelopment Business Case and the New Hospital Programme

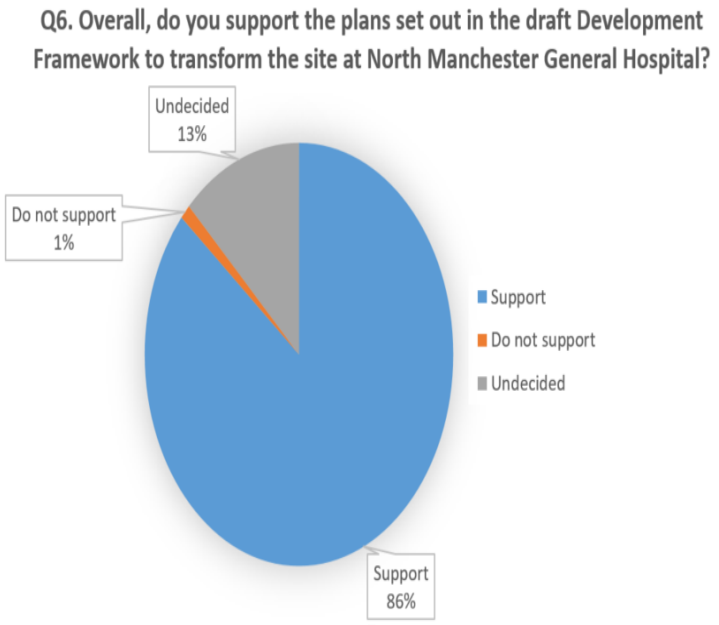
Following submission of the Outline Business Cases in January 2021, initial feedback has been now been received by the Trust. The feedback requires the Trust, along with the other identified 'frontrunners', to respond to emerging national guidance in relation to the proposed standardisation of hospital design across the New Hospitals Programme. We will continue to work closely with the New Hospitals Programme team to align the NMGH case with the developing national strategy.

As reported previously, the redevelopment project will experience delay to the 'main build' whilst the alignment is developed, however this does not affect the initial phases of the project, namely the provision of the new modular office accommodation, the demolition of Limbert House and Trust HQ and the construction of the new Multi Storey Car Park and Cycle Hub which already have their full funding confirmed.

6.2 Strategic Regeneration Framework Update

The public consultation period for the Strategic Regeneration Framework (SRF) formally closed on 29 January 2021.

Feedback has been overwhelming positive with 86% of respondents indicating their support for the proposals. The team reviewed the SRF in light of the specific comments received.



The City Council's Economic Scrutiny Committee endorsed the SRF and the Executive Committee approved the document on the 17 March 2021.

6.3 Enabling Works

The following areas of activity continue to progress funded by the approved Enabling Works packages:

- The next phase of Enabling Plan funding (£14m) has now been approved by Treasury and written confirmation received by the Trust. This directly funds the demolition of Trust HQ and surrounding groundworks.

- The proposed Multi-Storey Car Park and Cycle Hub planning application has been approved by the City Council and the contractor formally selected (Morgan Sindall).

- The installation of the decant accommodation required to provide ongoing office space for those affected by the commencement of enabling works has commenced on site.

- A Hoarding Strategy is in development to ensure that the opportunity provided by site hoardings to tell the story of North Manchester and communicate the vision of the masterplan is maximised.

6.4 Programme and Milestones

Milestone	Date	Status
HIP Team established	November 2019	Achieved
Stage 1 Briefs Developed (all sub cases)	17 January 2020	Achieved
Masterplan 'Zoning' agreed	17 January 2020	Achieved
Strategic Outline Case (SOC) submitted	31 January 2020	Achieved
Enabling Works Report submitted	31 March 2020	Achieved
SOC Endorsement (NHSE-I and DHSC)	30 April 2020	Achieved August 2020
Enabling Plan endorsement (NSHE-I and DHSC)	30 April 2020	Achieved August 2020
RIBA Stage 1 Report Finalised	30 May 2020	Achieved

RIBA Stage 2 Commencement	5 August 2020	Achieved
Masterplan Engagement (Staff)	June/July 2020	Achieved
Initial Masterplan Engagement	Summer 2020	Achieved
OBC Gateway Review	September 2020	Achieved
Draft Strategic Regeneration Framework endorsed by MCC	November 2020	Achieved
Enabling Works start on site	November 2020	Achieved in December
Trust Board endorsement of the NMGH Outline Business Case	January 2021	Achieved
NMGH Outline Business Case submitted (Redevelopment and Digital)	December 2020	Achieved January 2021
Strategic Regeneration Framework endorsed by Manchester City Council	March 2021	Achieved
MSCP and Cycle Hub planning application approval expected	March 2021	Achieved
New Hospitals Programme Team (central) Review of NMGH Proposal expected	April 2021	Initial Feedback Received.
Decant Accommodation fit out completed	July 2021	On Target.

7.0 Conclusions

7.1 Despite the deferral of the SRFT transaction, NMGH successfully transferred to MFT on 1st April 2021, and this completed the five-year programme to bring the hospitals in Manchester together into a single service.

7.2 The Statutory transaction is expected to take place at 1st October 2021, and this will deliver the dissolution of PAHT and the transfer of all its assets and liabilities. Routine Board reports on the transaction will be recommenced in advance of the Statutory transaction.

7.3 Engagement and collaboration will be maintained with PAHT/SRFT to ensure effective management of on-going disaggregation processes. Going forwards the focus will be on involving NMGH in the creation of stronger and more reliable clinical services across the city, delivering the redevelopment of the NMGH site, and contributing to the wider regeneration of North Manchester and surrounding areas.

7.4 The review process for the Outline Business Case is continuing, and the Enabling Works will proceed in the meantime.

8.0 Recommendations

The Board of Directors is asked to:

- Note the content of this report.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce and Corporate Business
Paper prepared by:	Alwyn Hughes, Director of Corporate Services / Trust Secretary
Date of paper:	May 2021
Subject:	NHSI FT Self-Certification Requirements (2021)
Purpose of Report:	Indicate which by ✓ • Information to note • Support • Accept • Assurance • Approval ✓ • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Failure to meet the range of conditions of the NHS Provider Licence for a licensed provider can lead to NHSI (Monitor) imposing compliance and restoration requirements or monetary penalties. Ultimately, it could lead to revocation of a provider's licence. The greatest damage is most likely to be to reputation, and the impact that has on patient choice and stakeholders' confidence in MFT as a provider of NHS services.
Recommendations	The Board of Directors is asked to approve NHSI (Monitor) FT Self-Certifications for Condition G6(3), G6(4) & CoS7(3) and note progress with Self-Certificate FT4(8)
Contact	Name: Alwyn Hughes, Director of Corporate Services / Trust Secretary Tel: 0161 276 6262

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

NHSI FT Self-Certification Requirements (2021)

1. Background

On 1st April 2013, Monitor's healthcare licensing regime was implemented for all NHS Foundation Trusts (The Health and Social Care Act 2012). It replaced the Terms of Authorisation for Foundation Trusts and is the main tool NHSI (Monitor) uses for regulating providers of NHS services.

All NHS Foundation Trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence, have the required resources available if providing commissioner requested services, and, have complied with governance requirements.

The Manchester University NHS Foundation Trust has an NHS Provider Licence (**No. 130164**) and in the past, the previous Legacy FTs (UHSM & CMFT) were required to submit six self-certifications, on an annual basis, to meet NHSI's (Monitor) Provider License conditions for NHS services, along with a declaration of risks against healthcare targets and indicators. This year (2021), and in keeping with guidance previously received from NHSE/I over the past four years, the Trust will self-certify the following three Licence Conditions after the financial year-end:

- The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution - **Condition G6(3)** & **Condition G6(4)**
- The provider has complied with required governance arrangements - **Condition FT4(8)**
- If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service - **Condition CoS7(3)**

2. NHSI Foundation Trusts Self-Certification

2.1 Self-Certification - Condition G6(3) & Condition G6(4)

Not later than two months from the end of the Financial Year, the MFT Board of Directors ('the Licensee') is required to self-certificate to the effect that it "Confirms" or "Does not confirm" that it had well established and effective processes and systems to identify risks and guard against their occurrence in 2020/21, and, that these are still in place and their implementation and effectiveness is regularly reviewed going forward.

Recommendation: Based on the evidence highlighted in Appendix A, it is recommended to the Board that the 'Condition G6(3)' Self-Certification is formally signed-off as **"Confirmed".**

Recommendation: In keeping with previous requirements of Condition G6(4), the Trust will publish its self-certification - **Condition G6(3)** - by 30th June 2021

2.2 Self-Certification - Condition FT4(8)

The Board of Directors is required to self-certificate "Confirmed" or "Not confirmed" to a number of governance-related statements (see Appendix B for summary of statement requirements) and set-out any risks and mitigating actions planned for each one within the NHSI self-declaration template. The Board has already received an electronic copy of the *draft* summary set of evidence to support this 'Condition FT4' Self-Certification with the aim of identifying any risks with compliance and any action taken, or, being taken to maintain future compliance.

Recommendation: The Board is recommended to review and comment (via the Board Secretary) on the draft governance statements during May and early June 2021.

Recommendation: The Board is recommended to delegate authority for 'sign-off' of the Self-Certification for 'Condition FT4(8)' to the Group Chairman & Group Chief Executive in order to meet the self-certification deadline of 30th June 2021; which is prior to the next Board of Directors meeting on 12th July 2021.

2.3 Self-Certification - Condition CoS7(3)

Not later than two months from the end of the Financial Year, the MFT Board of Directors ('the Licensee') is required to self-certificate to the effect that it "Confirms" one of the following three declarations about the resources required to provide 'Commissioner Requested Services' (CRS):

A. After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account of distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate;

B. After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below (Appendix C)**, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors** (as described in Appendix C) **which may cast doubt on the ability of the Licensee to provide Commissioner requested Services;**

C. In the opinion of the Directors of the Licensee, the Licensee will not have the required Resources available to it for the period of 12 months referred to in this certificate.

(Footnote: Providers do not need to state the other two are not confirmed)

Recommendation: Based on the statement of main factors taken into account in Appendix C, it is recommended to the Board that **Declaration B** within the Condition CoS7(3) Self-Certification is formally signed-off as **"Confirmed".**

APPENDIX A

Self-Certification Condition G6(3) – MFT Supporting Evidence of Compliance

- Throughout the 2020/21 COVID-19 National Emergency, the Trust has been meticulous in maintaining the integrity of Board and related governance arrangements and processes. This involved an assessment of existing arrangements to judge what should continue, what could be modified and what could be stood down to ensure compliance with infection prevention rules and government guidance on meetings. Attention was paid to the advice proffered by NHS E/I about Board governance and associated reporting;

- Board meetings were maintained, albeit 'virtually', and critical scrutiny committees continued unaffected. All decisions about the construct of meetings and business agenda were taken with the full endorsement of the Group Chairman. Moreover, weekly Group NED briefings were introduced at the outset of the Pandemic and has continued for the foreseeable future. These facilities have been complemented by frequent and regular briefings to the MFT Council of Governors;

- The Operations portfolio has led the MFT pandemic response from Wave 1 through to recovery. This has been driven through the use and development of MFT's Emergency Preparedness, Resilience & Response (EPRR) plans and protocols, with a clear regime of daily and weekly meetings, ensuring the Trust services were adapting in line with the pandemic response.

- Daily staff briefings complemented regular staff side meetings and special events. Additional staff-based groups were established including new staff networks and a safe working practices committee. A comprehensive COVID-19 Staff Survey was deployed and the results used to inform the response to staff need at the hight of the Pandemic. This was coupled by the extension of the Employee Health and Wellbeing Service across 7 days. A central attendance team was also introduced to support staff and managers with the management of the significant increase in staff absence rates, COVID testing demand and rapid access to staff welfare services;

- To help keep staff safe great attention was paid to risk assessments and the management of clinically extremely vulnerable staff.

- Outwith a National Emergency such as the one experienced throughout 2020/21, the MFT Board and supporting Committees (Audit Committee, Quality & Performance Scrutiny Committee, Human Resources Scrutiny Committee, Finance Scrutiny Committee, LCO Scrutiny Committee, EPR Scrutiny Committee, NMGH Scrutiny Committee and the Group Risk Oversight Committee) receive regular reports and supporting data analysis covering patient safety, clinical quality, patient experience, workforce, performance and finance.

  Examples include: Board Assurance Reports; Internal & External Audit Reports; Clinical Audit Reports; Patient Surveys; Staff Surveys; CQC Inspection Reports; Board Assurance Framework (BAF); Royal College Accreditation; H&S Executive Inspection Reports; Internal Quality Review Reports (and FU); Senior Leaderships Walk-rounds (stood down during the COVID-19 National Emergency); Ward / Department Accreditation; Clinical Pathology Accreditation; E&D Reports; General Medical Council Reports, and, Governor Hospital/MCS/LCO Visits Programme Feedback

- A programme of Board Seminars, Group NED Developments Sessions and Group Management Board Development Sessions provide an opportunity for 'deep dives' into specific topics/themes and these are identified through the governance structure, the BAF, the Group Risk Register and the Accountability Oversight Framework (AOF).

- The Group Risk Oversight Committee (GROC) is informed by the Governance structure as a whole and ensures that high level risks are overseen by the Board of Directors. The Committee is Chaired by the Group CEO, attended by the Group Executive Director Team, Hospital/MCS/LCO CE's and open to all Group Non-Executive Directors. The Committee reviews the management of risk and reports on organisational risk profile at each meeting supported by a schedule of reports across the year on:

  - New risks at level ≥15 – single report detailing management and oversight arrangements
  - Group wide risks at ≥15 – single report detailing management and oversight arrangements
  - Risks escalated for review/support by Hospitals/MCS/LCO where further mitigation is outside of the control of the Hospital/MCS/LCO (for example a national tariff issue) – single report detailing management and oversight arrangements

Self-Certification Condition G6(3) – MFT Supporting Evidence of Compliance

- The GROC may also identify risks that require more detailed scrutiny arising from the Group Board Assurance Report, Group Board Assurance Framework, regulatory issues, national reports, patient/service user feedback and public interest issues.

- The Trust's Single Operating Model is underpinned by the AOF which contributes to the overarching Board Governance Framework enabling the Group Board of Directors to fulfil its obligations and effectively run the organisation. The AOF is one of the key enabling processes to support the delivery of the MFT vision, strategic objectives, and operational plan, and incorporates the key elements below:

    - Fosters a culture of devolved decision making and accountability.
    - Sets out how the Group Board of Directors and Hospitals/MCS/LCO will interact.
    - The framework supports the principle of earned autonomy in high performing Hospitals/MCS/LCO and the support provided to challenged sites.
    - An annual performance agreement process will formally capture the contribution of each Hospital/MCS/LCO to Group corporate objectives and targets for the year.
    - The framework operates a process of performance review, led by the Group Executive Team, which assesses the performance and risk of each Hospital/ MCS/LCO in delivering its plans and objectives and meeting agreed KPIs.
    - Enables the corporate functions to identify potential support needs, by theme, as they emerge, allowing tailored support packages to the specific needs of each Hospital/ MCS, and drawing on expertise from across the corporate functions.

- The Trust AOF process incorporates 6 domains: Safety, Patient Experience, Operational Excellence, Finance, Workforce & Leadership, and, Strategy. The process provides a holistic and transparent process for the monitoring of Hospital/MCS performance, all domains are equally weighted with the exception of 'Safety' which is the override for monthly Hospital/MCS/LCO AOF scores

- To support the AOF, monthly cycle a performance dashboard for each Hospital/MCS has been developed which captures in one place the overarching Hospital/MCS/LCO AOF score, individual domain scores and performance against the KPIs which form each domain.

- A focused governance and accountability framework was maintained throughout the Group during 2020/21 in response to the rapidly escalating phases of the COVID-19 pandemic. A robust command and control (EPRR) framework was in place to provide the effective leadership and fast decision-making needed. Having said this, and whilst the AOF was temporarily suspended during the 'peaks' of the National Emergency, the Trust maintained performance management oversight through its adapted committee structure. Performance and quality reports continued to be produced and presented to the Board of Directors, Group Management Board and selected Board Sub-Committees.

- The Trust has an agreed document 'Responding to Recommendations and, Requirements of External Agency Visits, Inspections and Accreditation Policy' (October 2017). The policy sets out the processes to ensure that all recommendations made by external agency visits, inspections and accreditations are implemented within a specific time scale, that they are monitored following their implementation, and that there is a formal reporting and review process and that the Group Board of Directors are assured of the outcome.

- The Trust has an established Quality Review process in place since 2013/14 in response to the recommendations set out by the Francis, Keogh and Berwick reports earlier the same year (2013). Internal reviews are informed by extensive data packs which pull together key indicators reflecting the quality of care across each Hospital/MCS.

APPENDIX A (continued)

Self-Certification Condition G6(3) – MFT Supporting Evidence of Compliance

- The Trust has a well-established Improving Quality Programme (IQP) and Accreditation process in place which examines performance across four domains; leadership and culture of continuous improvement, environment of care, communication about and with patients and nursing processes: including medication management and the meals service. Findings are mapped against agreed criteria for each standard and clinical areas are scored as white, bronze, silver or gold. Areas that consistently achieve a Gold rating become eligible for an Excellence in Care Award providing a Gold rating is achieved in all domains. Patient experience survey data and quality of care data is used along with Accreditation outcomes to drive continuous improvement. The Board of Directors receives regular reports on accreditation outcomes and receive an Annual Accreditation Report. The full accreditation process was stood down in March 2020 to release capacity for the pandemic response, however, it was temporarily replaced by an assurance process in which quality and safety data was captured and triangulated for all clinical areas and each Director of Nursing/Midwifery/Healthcare Professionals undertook an assurance meeting with the Deputy Chief Nurse to identify any areas of best practice and improvement. Assurance meetings were underpinned by environmental visits by the Quality Improvement Team. The full accreditation programme will resume from May 2021.

- The Trust has in place a staffing escalation process to ensure the appropriate deployment of nursing and midwifery staff to support the needs of patient groups. An electronic e-rostering system is used to ensure that the planning and management of nursing and midwifery staffing across the Trust is effective and safe. During the pandemic response, this process was further enhanced by the implementation of Pandemic Safe Staffing Guidelines, which enabled close monitoring and escalation of the impact of the pandemic on nursing and midwifery staffing and a supported a Group-wide response where required.

- Governors hold Group Non-Executive Directors (individually and collectively) to account for the performance of our Board of Directors by ensuring that they act so that MFT does not breach the terms of authorisation. Governors receive details of meetings, agendas and approved minutes of each Board of Directors' Meeting. During non-COVID periods, private session between the MFT Governors and the full Board of Directors are held immediately following each bi-monthly Public Meeting of the Board of Directors. The aim of this regular session is to enable Governors to discuss with the full Board issues raised during the Public Meeting and/or any other issue(s) which may require further feedback, clarification, consideration and dialogue. During the COVID-19 National Emergency, the Group Chairman (supported by the Group NEDs) has held 'virtual' Chairman / Governor Surgeries a short time following the Board meetings (as an alternative to face-to-face meetings). This has also included *'Getting to know your NEDs'* sessions. Governors monitor the performance of MFT via the main Council of Governors meetings (which have all been held 'virtually' and have continued uninterrupted and on schedule throughout 2020/21 despite the ongoing COVID-19 National Emergency and UK Governments Social Distancing requirements), quarterly Performance Review Meetings (during non-COVID periods) to ensure high standards are maintained.

- **A further, comprehensive suite of evidence is available in support of this Self-Certification in the form of an Annual 'Well Led' Self-Assessment undertaken during Q4 2020/21 and reported to the MFT Board of Directors on 10th May 2020 (Agenda Item 9.1 – Private Agenda). The Board of Directors received the key findings of the 2020/21 Annual Well-Led Self-Assessment which mirrored the evidence sought to demonstrate compliance with 'Condition G6(3).**

APPENDIX B

Self-Certification Condition FT4(8) - Corporate Governance Statement Requirements

1. The Board is satisfied that Manchester University NHS Foundation Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

2. The Board has regard to such guidance on good corporate governance as may be issued by NHSI (Monitor) from time to time

3. The Board is satisfied that Manchester University NHS Foundation Trust implements:

a) Effective board and committee structures;
b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
c) Clear reporting lines and accountabilities throughout its organisation.

4. The Board is satisfied that Manchester University NHS Foundation Trust effectively implements systems and/or processes:

a) to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively;
b) for timely and effective scrutiny and oversight by the Board of the Licence holder's operations;
c) to ensure compliance with health care standards binding on the Licence holder including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions.
d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licence holder's ability to continue as a going concern);
e) to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
f) to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
h) to ensure compliance with all applicable legal requirements.

5. The Board is satisfied that the systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:

a) that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
b) that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations
c) the collection of accurate, comprehensive, timely and up to date information on quality of care;
d) that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
e) that Manchester University NHS Foundation Trust including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
f) that there is clear accountability for quality of care throughout Manchester University NHS Foundation Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to Board where appropriate.

6. The Board of Manchester University NHS Foundation Trust is satisfied that there are systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

Training of Governors

The Board is satisfied that during the financial year most recently ended, the Trust has provided, and continues to develop the necessary training to its new Governors as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

APPENDIX C

Self-Certification Condition CoS7(3) - Commissioner Requested Services (CRS) Requirements

CRS Definition: *Services that will be subject to regulation by NHSI (Monitor) in the course of a licensee's operations; and, Location Specific Services, which is a subset of CRS that, in the event of a provider failure, must be identified and kept in operation at that specific locality*.

- The current designation of MFT services as CRS continues to be a 'default' position (i.e. automatic full designation, across all services). Commissioners have again postponed a full and recurrent review of MFT services to make a proper and considered CRS designation.

- In effect, the current CRS designation remains inherited from the position in April 2013, when CRS principles were first established. At that point in time, the FT licence saw all NHS-funded services "grandfathered" into CRS status (pending service-line review) until 31st March 2016.

- In March 2016, the Manchester CCGs decided to extend that position through until at least October 2017. Since then (in October 2017 through to March 2019, again in April 2019 and now in April 2020 with effect for 2020/21) Manchester CCG has formally written to further extend this in light of the MFT merger, ongoing SHS and LCO developments. Given this it would not be meaningful for MFT in isolation to undertake self-certification work across all services

- As at April 2020 it remained the CCG's ultimate intention to work with MFT and the wider Manchester Health and Care Commissioning (MHCC) partnership to identify a revised list of CRS designated services. In the meantime, the CCG's view was that the current default designation provide stability and protection for services even though Commissioners remain able to re-procure or transfer services as has been the case for time to time during the period since April 2013 (e.g. outpatient Dermatology by CCGs, ACHD by NHS England).

- Since April 2020 there has been no formal requirement to sign off full contract documentation between providers and commissioners, due to the impact of COVID-19, and this remains the case for at least the first half of 2020/21. This has also meant that the CCG has not decided to progress any further work to review the list of CRS services.

- Given this position, MFT is unable to fully self-certify, across all services provided, that Option **A** or Option **C** are definitive.

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
Date of paper:	April 2021
Subject:	National Staff Survey Results 2020
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	The national NHS Staff Survey results are the primary method by which we measure how well we support the well-being of our workforce and enable each member of our staff to reach their full potential. This is essential to maintaining improved organisational performance.
Recommendations:	The Board of Directors is asked to: • Consider the strengths, improvements and areas for development following the 2020 Staff Survey Results. • Endorse the actions being taken in response to the survey results.
Contact:	Name: Peter Blythin, Group Executive Director of Workforce and Corporate Business Tel: 0161 701 0190

Summary of Key Highlights

- The Group staff engagement score is 7.0 (7.1 in 2019).
- MFT is within 0.1 of the average sector score for 9 of the 10 Key Themes (see appendix 1).
- Two themes show a statistically significant improvement on 2019: 'Health and Wellbeing' and 'Safe Environment – violence'.
- Five themes have recorded a statistically significant decline on 2019: 'Equality, Diversity and Inclusion', 'Immediate Managers', 'Morale', 'Staff Engagement' and Teamworking'.
- There have been statistically significant improvements in the scores for 8 of the 78 core questions, with a statistically significant decline for 32.
- Analysis suggests that for those staff working remotely during the Pandemic, including from home, scores were higher across all Key Themes, except for 'Quality of Care' and 'Safety Culture' where they were similar. Scores were generally lower for those staff who were working on a COVID ward and / or redeployed, especially for 'Health and Wellbeing' and 'Bullying and Harassment'.
- For questions contributing to the Workforce Race Equality Standard (WRES), all staff groups reported a decline in experience of harassment, bullying or abuse from patients, relatives, or the public in the past 12 months, with the decline greater for BAME staff. There was a general increase in staff experiencing discrimination and bullying and harassment from manager / colleagues and this was greatest for BAME staff.
- For questions contributing to the Workforce Disability Equality Standard (WDES), staff with and without a long-term condition or illness reported a decline in experience of harassment, bullying or abuse from patients, relatives, or the public in the past 12 months. There was also general increase in staff experiencing bullying and harassment from manager / colleagues. Across most of the contributory questions for the WDES, the experience of staff with a long-term condition of illness was more negative, although there was an improvement in staff believing that the organisation provides equal opportunities for career progression or promotion.
- Initial data indicates that staff at NMGH are much more likely to experience violence, bullying and harassment and discrimination from patients or members of the public, and to be less likely to be advocates of their organisation as a place to work or receive treatment.

1.0 Background

1.1 The 2020 NHS Staff Survey results are based on staff in post and organisational structures as at 1st September 2020. The 2020 Staff Survey results were published nationally by the Survey Co-ordination Centre (SCC) on 11th March 2021.

1.2 MFT received two reports: a national one issued by the SCC that will published and available for public scrutiny and includes national benchmark data, and a report issued by Quality Health which is not made public by the national team.

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

1.4 Survey questions for 2020 are categorised into 10 key themes (see Appendix A). These themes cover 49 of the questions included in the survey. The remaining questions are reported separately.

1.5 Three years of trend data is provided by the SCC at Group-level, although as a relatively new organisation, data for MFT only goes back to 2017.

1.6 In addition to the core survey questions that all participating organisations use, MFT included additional optional questions covering the MFT Values and Leadership and Career Development. These are excluded from national reporting but have been included at the survey at MFT since 2017.

1.7 As a change to the 2020 survey free text comments have been included as an option for staff to give feedback. Following analysis and theming the SCC are due to disclose feedback at the end of April 2021.

2.0 Response rate

2.1 MFT ran a census survey mode in 2020. There were 7421 completed surveys, giving a response rate of 33% (unchanged on 2019). The median response rate for our benchmark group was 45%.

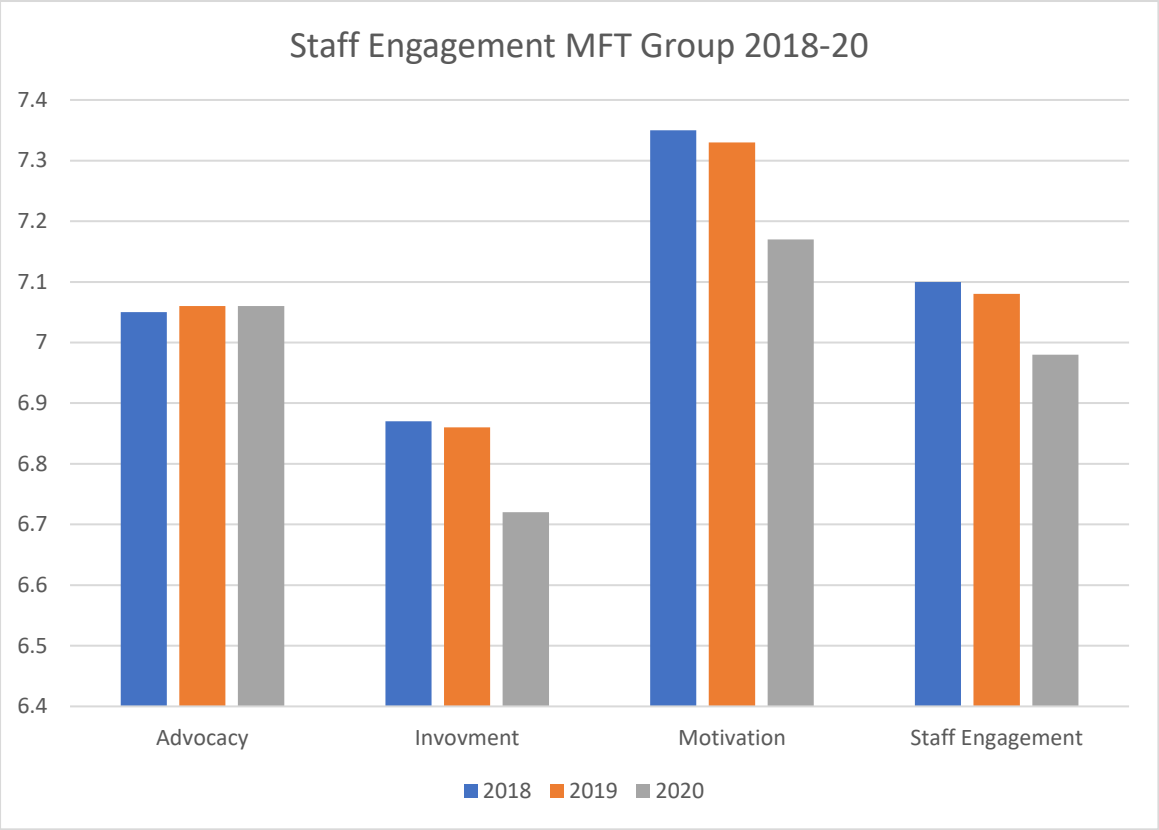
3.0 Group Results: Summary – overall staff engagement including national benchmarking

3.1 The staff engagement score is a composite of nine questions in the survey, with questions clustered into three sub-categories: 'advocacy', 'involvement' and 'motivation'.

3.2 The overall staff engagement score for MFT was 7.0 (7.1 in 2019), against a benchmark sector average of 7.0 (7.0 in 2019).

3.3 At MFT there was a statistically significant decline in scores for those questions linked to motivation, with no significant differences reported for involvement and advocacy.

3.4 The chart below compares staff engagement scores across the factors of advocacy, motivation, and involvement at MFT over the past three years.



3.5 *National Benchmarking – Shelford group*

3.5.1 The table below shows how the Trust compares to our peers in the Shelford Group for our staff engagement score. We are now ranked 7th equal for staff engagement (6th equal in 2019).

Trust	2018	2019	2020
Guy's and St. Thomas's	7.4	7.5	7.5
University College London Hospital	7.2	7.2	7.4
Newcastle Upon Tyne Hospitals	7.3	7.3	7.3
Cambridge University Hospitals	7.2	7.2	7.2
Oxford University Hospitals	6.9	7.1	7.2
Imperial College Healthcare	7.0	7.2	7.2
MFT	**7.1**	**7.1**	**7.0**
Sheffield Teaching Hospitals	7.0	7.1	7.0
University Hospitals Birmingham	7.0	6.9	6.8
King's College Hospital	6.8	6.8	6.8

3.6 *Regional Benchmarking- Greater Manchester Trusts*

3.6.1 The table below shows how the Trust compares to other NHS Trusts in Greater Manchester for the overall staff engagement score. We are ranked 4th equal (unchanged from 2019).

Trust	2018	2019	2020
Bolton	7.3	7.3	7.2
Wrightington, Wigan and Leigh	7.0	7.3	7.1
Salford Royal	7.1	7.1	7.1
East Cheshire	7.2	7.2	7.0
MFT	**7.1**	**7.1**	**7.0**
Pennine Acute Hospitals	6.8	7.0	6.9
Tameside and Glossop Integrated Care	7.1	7.0	6.8
Stockport	6.9	6.9	6.8

4.0 Group Results Summary – key themes

4.1 Survey questions for 2020 are categorised into 10 key themes. Questions not covered by these themes are reported individually. The table below shows the key themes results for 2020, compared with our benchmark group average and with the equivalent scores for 2019. Themes highlighted in green have improved on 2019 and those highlighted in amber have declined:

Theme	2020 MFT	2019 MFT	2020 sector Benchmark
Equality, Diversity and Inclusion	9.0	9.1	9.1
Health and Wellbeing	6.1	6.0	6.1
Immediate Managers	6.7	6.9	6.8
Morale	6.1	6.2	6.2
Quality of Care	7.5	7.4	7.5
Safe Environment – Bullying & Harassment	8.2	8.2	8.1
Safe Environment - Violence	9.6*	9.6	9.5
Safety Culture	6.8	6.8	6.8
Staff Engagement	7.0	7.1	7.0
Team-working	6.5	6.6	6.5

*Rounded score does not reflect improvement on 2019

4.2 Two themes show a statistically significant improvement on 2019: 'Health and Wellbeing' and 'Safe Environment – violence'.

4.3 Five themes have recorded a statistically significant decline on 2019: 'Equality, Diversity and Inclusion', 'Immediate Managers', 'Morale', 'Staff Engagement' and Teamworking'.

4.4 The SCC does not report on the statistical significance of differences between Trust and sector key theme scores. However, MFT is within 0. 1 of the sector average score for all 10 key themes.

4.5 Appendix 2 is a summary table provided by the SCC of MFT scores across the 10 key themes against the sector average, and the best and worst sector scores.

5.0 National summary and trends – Key Themes

5.1 Across the NHS in England, scores for both the health and wellbeing, and safety culture themes are the highest for five years, while the morale score is the highest since the theme was introduced three years ago.

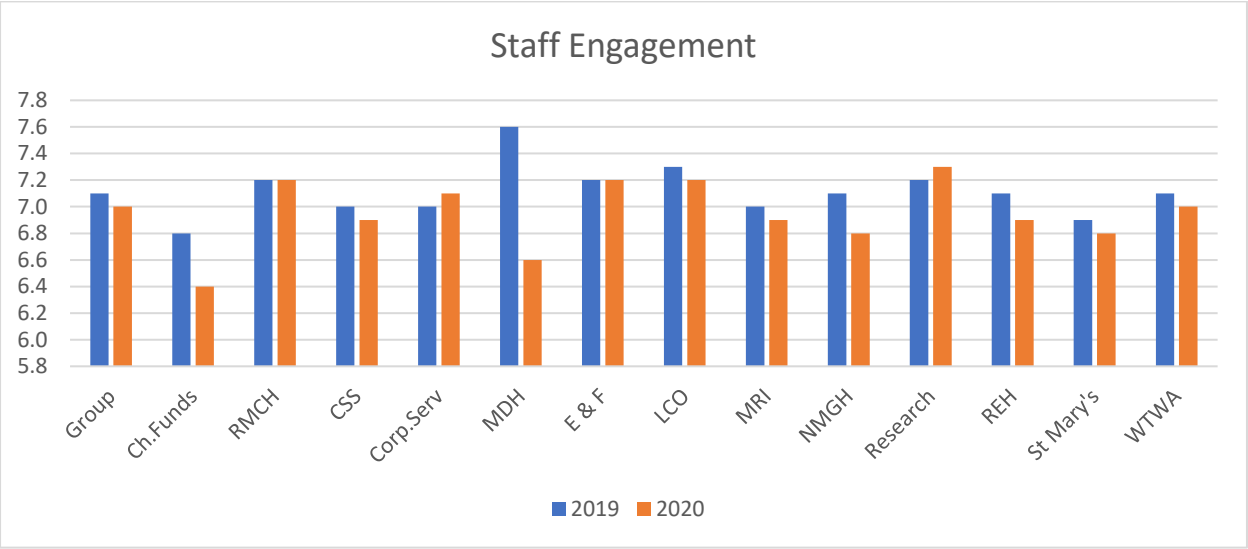
5.2 Compared to 2019, other themes, have shown improvement and consistency. Areas which have shown improvement are safe environment - bullying and harassment and violence.

5.3 Areas where consistency has been maintained are equality, diversity and inclusion and staff engagement.

5.4 Areas which have maintained a similar level are quality of care and immediate managers.

6.0 Hospital / MCS / LCO / Corporate summary – Staff Engagement & Key Themes

6.1 The chart below shows the overall staff engagement scores by Hospital / MCS / LCO / Corporate:



6.2 Appendix 3 shows the results for each key theme for 2020 by Hospital / MCS / LCO and Corporate, where this is available.

6.3 Appendix 4 shows the results for each key theme for 2020 in comparison with the 2019 score, where this is available.

7.0 Individual survey questions

7.1 The 2020 survey included 78 'scoring' questions, of which 49 are incorporated into the 10 key themes. These are referred to as 'core' questions. Statistically significant changes to our question-levels scores since 2019 is provided through our private report from Quality Health. Of these:

- 8 question scores have shown a statistically significant improvement
- 32 questions have shown a statistically significant decline
- 38 questions show no statistically significant change.

7.2 The core questions showing the greatest improvement are:

- In the last three months, have you ever come to work despite not feeling well enough to perform your duties? (*staff reporting 'yes'*) **(-9.72%)**
- There are enough staff in this organisation for me to do my job properly. **(+4.83%)**
- On average, how many paid hours do you work per week over and above your contracted hours (*staff reporting additional paid hours worked)* **(-3.66%).**

7.3 The core questions showing the greatest decline are:

- During the last 12 months have you felt unwell because of work-related stress? *(increase in staff responding 'yes')* **(+5.05%)**

- When feeling unwell, have you felt pressure from your manager to come to work? *(increase in staff responding 'yes')* **(+3.78%)**
- Satisfaction with level of pay **(-3.55%).**

7.4 Awareness of the Trust Values remained at 98**%**. However, there was a statistically significant decline (-3.16%) in positive responses to the question 'do managers demonstrate the values at work?' to 58%.

7.5 In summary, across all core and optional questions:

- 9 questions recorded a statistically significant improvement
- 42 questions recorded a statistically significant decline

7.6 A full list of questions showing statistically significant change is shown in Appendix 5.

8.0 New questions for 2020, including COVID-19

8.1 Two new general questions were included in the survey. For these questions there is no historical data. The questions were 'I feel safe in my work' (MFT = 80%) and 'I feel safe to speak up about anything that concerns me in this organisation' (64%). For the sector the response was 80% and 65% respectively. There is no significance data for these questions, but both were within 1% of the sector average.

8.2 For the COVID-themed questions, across MFT:

- 33% of respondents had worked on a COVID-specific ward or area (sector = 39%).
- 21% had experienced redeployment (20%).
- 33% had worked remotely / at home (26%).
- 11% had been shielding

8.3 The SCC provided data analysis on the impact of the four responses above on overall Key Theme scores. This indicates that for those staff working remotely, including from home, scores were higher across all Key Themes, except for 'Quality of Care' and 'Safety Culture' where they were similar. Staff who worked on a COVID ward and / or who were redeployed generally scored lower, for 'Health and Wellbeing' and 'Bullying and Harassment'.

8.4 Two free text question regarding the response to the Pandemic were included in the survey. Feedback on these questions will be issued to organisations when available and themed (anticipated end of April 2021).

9.0 National summary and trends – individual survey questions

9.1 Below is a summary of the key findings from national data on responses to individual questions, as supplied by NHS Providers.

9.2 Two-thirds of staff (66.3%) would recommend their organisation as a place to work. This is a strong increase from 2019 (63.3%) and over the past five years (59.9% in 2016). **MFT score for 2020 is 64.6 (+0.3))**

9.3 A higher proportion of staff in 2020 felt they had opportunities for flexible working (57%, up from 54% in 2019). **(MFT 53% (+2%))**

9.4 There has been a 4.1% increase this year in staff who reported that their trust takes positive action on health and wellbeing (33.4% in 2020, up from 29.3% last year). **(MFT 29.8% (+3.0%))**

9.5 The experience of Black, Asian and minority ethnic staff continues to fall far below that of white staff, with higher levels of discrimination, and bullying, harassment and abuse experienced and a lower proportion of Black, Asian and minority ethnic staff reporting equal opportunities for career progression and promotions**. (MFT see 8.3 above).**

9.6 During the COVID-19 pandemic a greater proportion of Black, Asian and ethnic minority staff worked on COVID-specific wards (49.4%, vs 40.4% for white staff) **(MFT 43.7% vs 30.1%**), and a lower proportion worked from home or remotely (29%, vs 37.7% for white staff) **(MFT 25.7% vs 34.7%).**

A full breakdown of the data is shown below:

Question	BAME staff	White staff
Worked on a COVID-19 specific ward or area	43.7%	30.1%
Redeployed	24.3%	20.4%
Working remotely / from home	25.7%	34.7%
Shielding	15.5%	8.9%

9.7 The proportion of staff who feel they are well paid has decreased this year for the first time since 2017, now at 36.7%. This is down from 38% in 2019, which was the highest level in five years **(MFT 38.7% (-3.4%)).**

9.8 44% of staff reported feeling unwell due to work-related stress in the past year, a substantial increase on 40.3% in 2019 **(MFT 43.6% (38.6% in 2019)).** Three-quarters of staff still regularly experience unrealistic time pressures at work; 74.9%, down from 77.1% in 2019 **(MFT 74% (76% in 2019)).**

9.9 There has been a 6% increase in the proportion of staff who report their organisations are adequately staffed: 38.4% in 2020, up from 32.4% in 2019 **(MFT 38.8% (33.6% in 2019)).**

9.10 18.2% are considering leaving the NHS; down from 19.6% in 2019 **(MFT 17% - unchanged).**

9.11 Therefore, trends in question-level data at MFT appear to be broadly in line with those at a national level.

10.0 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)

10.1 The table below summarises the scores for the questions that contribute to the Workforce Race Equality Standard. NMGH data is not included due to Staff Survey results being combined with Northern Care Alliance (NCA). Work is underway to extrapolate the NMGH data for inclusion in reporting and ongoing analysis with

MFT's overall position. Key themes from the NMGH data is presented in section 11 of this report, which has been undertaken by the NMGH Hospital Leadership Team.

Question	White		BME	
	2019	2020	2019	2020
Staff experiencing harassment, bullying or abuse from patients, relatives, or the public in the past 12 months	23.5%	21.2%	24.6%	20.6%
Staff experiencing harassment, bullying or abuse from staff in the past 12 months	21.0%	23.3%	25.6%	29.8%
Staff believing that the organisation provides equal opportunities for career progression or promotion	85.9%	85.9%	72.9%	67.0%
Staff experiencing discrimination at work for manager/team leader or other colleagues in past 12 months	5.9%	6.6%	13.6%	18.6%

10.2 The table below summarises the scores for the questions that contribute to the Workforce Disability Equality Standard.

Question	With LTC/Illness		Without LTC/Illness	
	2019	2020	2019	2020
Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the past 12 months	28.4%	25.7%	22.9%	20.0%
Staff experiencing harassment, bullying or abuse from manager in the past 12 months	18.5%	20.8%	9.5%	11.4%
Staff experiencing harassment, bullying or abuse from other colleagues in the past 12 months	24.9%	27.3%	15.5%	16.1%
Staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	47.9%	47.0%	46.2%	44.3%
Staff believing that the organisation provides equal opportunities for career progression or promotion	75.0%	76.8%	85.1%	84.0%
Staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	31.7%	34.9%	20.6%	23.5%
Staff satisfied with the extent to which their organisation values their work	40.5%	39.3%	51.6%	49.3%
Staff with a long-lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work	71.1%	70.7%		
Staff engagement score	6.6	6.5	7.2	7.1

11.0 North Manchester General Hospital Data

11.1 Extrapolating NMGH data from the NCA overall Staff Survey results, the NMGH senior leadership team have identified four key themes for focus which they will be aligning to their People Plan and recovery planning. These four themes are 'Raising Concerns', 'Senior Management Visibility and Engagement', 'Supporting our People through Recovery' and 'Staff Involvement'.

11.2 Outcomes have been shared by Division (i.e. Medicine, Survey, Women's & Children) focusing on areas for improvement.

11.3 NMGH comparison data for the last three years Staff Survey results can be found in Appendix 6.

12.0 Summary of performance against the key priority areas agreed following the 2019 Staff Survey

12.1 Following the analysis of the 2019 staff survey results, the following priority areas were agreed for 2019, these being the Key Themes that were below the sector average and / or had declined since the 2018 survey:

- Equality, Diversity and Inclusion
- Quality of Care
- Teamworking
- Safe Environment – Bullying and Harassment
- Safe Environment – Violence

12.2 *Equality, Diversity and Inclusion*

MFT score for this Key Theme reduced by 0.1 to 9.0, against a sector benchmark score of 9.1.

12.3 *Quality of Care*

MFT score improved 0.1 to 7.5, in line with the sector benchmark score and trend.

12.4 *Teamworking*

MFT score reduced by 0.1 to 6.5, which mirrored the sector benchmark and trend.

12.5 *Safe Environment – Bullying and Harassment*

MFT score remained unchanged at 8.2 compared to a sector benchmark score of 8.1.

12.6 *Safe Environment – Violence*

MFT rounded score was unchanged at 9.6, although there was a statistically significant improvement in this score which is not revealed due to rounding. The sector benchmark score was 9.5.

13.0 Action Plans

13.1 Staff experience of working the COVID-19 Pandemic and the related pressures have had a significant impact on their responses to the 2020 Staff Survey. Our results indicate that the experience of those staff who were redeployed during the Pandemic or working on a dedicated COVID-19 wards, generally led to lower scores in the staff survey across the key themes. Therefore, our priorities for 2021-22 will be focused on supporting staff recovery from the Pandemic, providing them with the opportunity to pause, rest, reflect and restart.

13.2 The 2020 results have been discussed at Group Management Board (29th March 2021) and will be included in Accountability Oversight Framework discussions being led by the Group Chief Operating Officer with the support of Group Executive Directors.

13.3 In addition, the results have been disseminated to Hospitals / MCSs / LCOs and Corporate Leadership Teams to consider, reflect and develop action plans. They have addressed the priority areas for improvement through an analysis of the results for their services across the 10 Key Themes in the survey. Actions plans are being aligned to localised versions of the emerging MFT People Plan, which itself is derived from priorities in the NHS People Plan publishing in 2020.

13.4 To support a consistent approach to action planning and goal setting, the Organisational Development Team has created a *'Staff Survey Action Plan Playbook'* which supports leaders and managers to work through a four-stage process in developing their plans. The *Playbook* includes how to lead staff engagement, the four enables of engagement, how to develop staff survey action plans, example actions and resources and action plan templates. This collection of resources enables local Hospitals / MCSs / LCO / Corporate to take ownership of their data and produce plans that are relevant and provide transparent actions for staff to recognise and contribute to.

13.5 Work is underway to extract local Equality, Diversity and Inclusion data for each Hospital / MCS / LCO / Corporate to understand the lived experience of staff with protected characteristics during the Pandemic. Discussions are ongoing at the Weekly HRD Network Meetings and regular meetings of the various staff networks to further understand the impact upon those staff groups focusing on using WRES and WDES data to support. This is particularly relevant given the recent publication of the NHS Workforce Race Equality Standard Report 2020.

13.6 The 2020 results are also informing several work streams that are being combined including *Putting People First, Civility Saves Lives,* Bullying and Harassment and Just Culture. These work streams focus on the lived experiences of staff, supporting policy, practice, and leadership to be more compassionate and inclusive, in turn improving environments and cultures across the Trust. The Staff Survey results, benchmarked against Regional and National contexts, have provided clear areas of strength and development to feed into this programme of work.

14.0 Next Steps

14.1 Free text comments from the 2020 survey, which are linked to specific questions relating to COVID-19, have yet to be received from the SCC. This is because of sentiment analysis and theming being undertaken by the SCC. This feedback will further inform the development and finalisation of actions plans.

15.0 Recommendations

15.1 The Board of Directors is requested to:

- Consider the strengths, improvements and areas for development following the 2020 Staff Survey Results and endorse the actions being taken in response to the survey results.

Appendix 1: Staff Survey 10 Key Themes

Equality, Diversity and Inclusion: The questions linked to this theme cover the fairness of career progression and promotion, experiencing a working environment that is free from discrimination, and the use of reasonable adjustments at work where these may be needed.

Health and Wellbeing: The questions linked to this theme cover work-related musculoskeletal problems and coming to work when feeling unwell; as well as how proactive the organisation is regarding staff health and wellbeing, including providing opportunities for flexible working.

Immediate Managers: This theme concerns the support provided by immediate line managers. This includes giving clear work expectations and feedback and valuing the work done by staff; getting the opinions of staff before making changes to their work; and taking a positive interest in the health and wellbeing of staff.

Morale: There are nine questions linked to this theme. These cover working relationships with colleagues and line manager; workload including choice at work and involvement with change; and intention to leave the organisation.

Quality of Care: The questions under this theme ask staff if they are satisfied with the quality of care that they give to patients or service users; are able to deliver the care they aspire to; and whether they feel that their role makes a difference to patients or service users.

Safe Environment (free from) Bullying and Harassment at Work: This theme is about the personal experience of bullying, harassment or abuse at work.

Safe Environment (free from) Violence at Work: This theme is about the personal experience of physical violence at work.

Safety Culture: This theme covers incidents and the raising of concerns, especially how the organisation responds to those incidents and concerns, including feedback to staff, fairness and acting to prevent recurrence.

Staff Engagement: There are nine questions linked to this theme. These cover whether staff are advocates for their organisation as a place to receive treatment and to work (advocacy); how positive staff are towards their work and their role (motivation); and whether they are able to show initiative at work, including their contribution to making improvements (involvement).

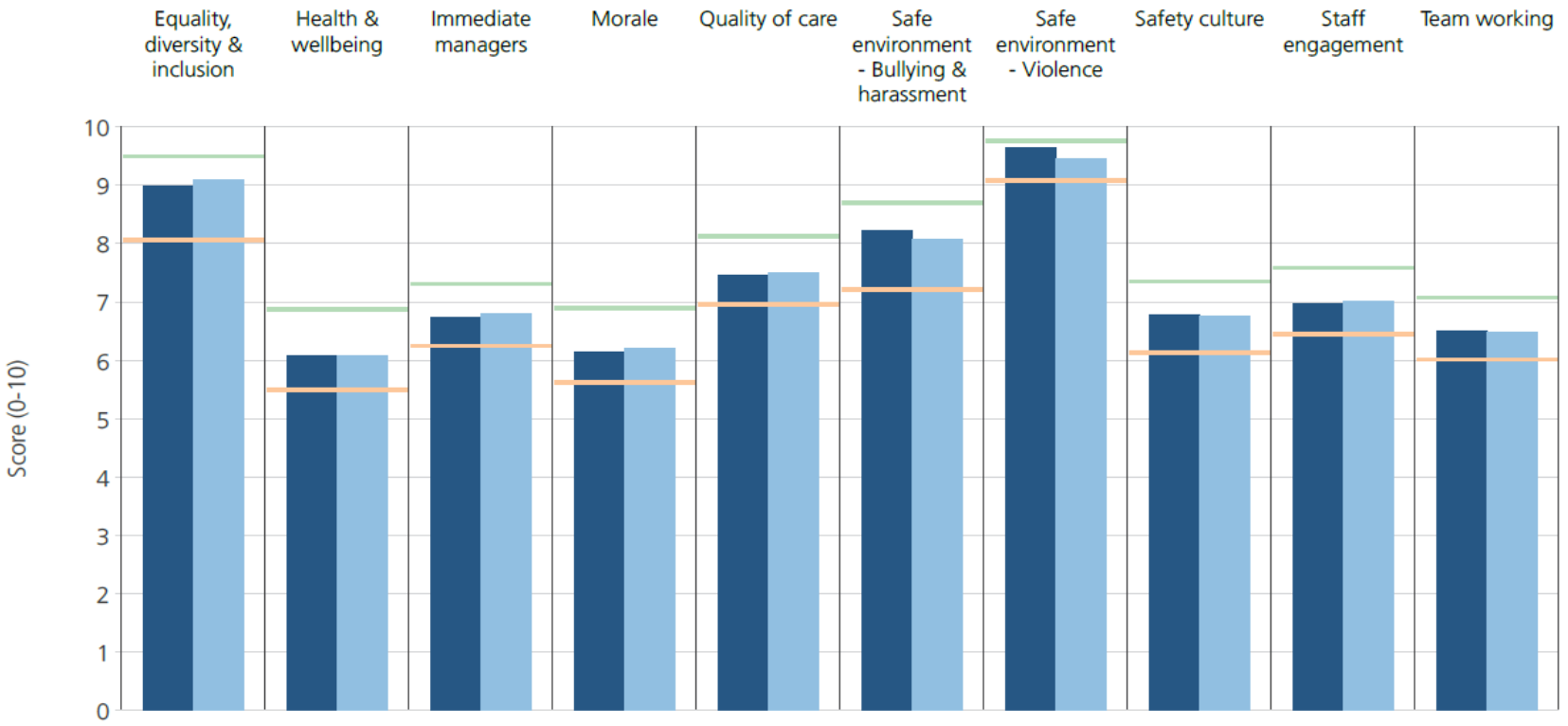
Teamworking: This theme is about shared team objectives and whether teams meet to review their effectiveness.

Appendix 2: MFT Key Theme score, compared to sector average and best and worst scores.

Survey Coordination Centre

2020 NHS Staff Survey Results > Theme results > Overview

NHS England



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.9	7.3	6.9	8.1	8.7	9.8	7.4	7.6	7.1
Your org	9.0	6.1	6.7	6.1	7.5	8.2	9.6	6.8	7.0	6.5
Average	9.1	6.1	6.8	6.2	7.5	8.1	9.5	6.8	7.0	6.5
Worst	8.1	5.5	6.2	5.6	7.0	7.2	9.1	6.1	6.4	6.0
Responses	7,339	7,379	7,396	7,390	6,275	7,354	7,360	7,386	7,407	7,247

Appendix 3: Group 2020 Staff Survey Results by Key Theme, including internal ESR L3 breakdown & sector comparison

	Equality, Diversity, and inclusion	Health and Wellbeing	Immediate managers	Morale	Quality of Care	Safe environment - Bullying and harassment	Safe environment - Violence	Safety culture	Staff engagement	Team-working
Group	**9.0**	**6.1**	**6.7**	**6.1**	**7.5**	**8.2**	**9.6**	**6.8**	**7.0**	**6.5**
Ch. Funds	**9.5**	**4.8**	**6.6**	**5.3**	**N/D**	**9.4**	**10.0**	**5.9**	**6.4**	**6.1**
Ch. Serv (RMCH)	**9.2**	**6.2**	**6.6**	**6.2**	**7.5**	**8.3**	**9.6**	**7.0**	**7.2**	**6.7**
CSS	**9.0**	**6.0**	**6.6**	**6.1**	**7.4**	**8.3**	**9.6**	**6.8**	**6.9**	**6.4**
Corporate	**9.1**	**6.5**	**7.1**	**6.3**	**7.2**	**9.0**	**10.0**	**6.6**	**7.1**	**6.7**
Dental	**8.6**	**5.8**	**6.2**	**6.0**	**7.6**	**7.8**	**9.8**	**6.8**	**6.6**	**6.3**
E & F	**9.3**	**7.3**	**6.9**	**6.8**	**7.1**	**9.1**	**9.8**	**6.8**	**7.2**	**6.5**
LCO	**9.2**	**6.3**	**7.1**	**6.5**	**7.7**	**8.4**	**9.8**	**6.9**	**7.2**	**7.0**
MRI	**8.6**	**5.8**	**6.7**	**5.9**	**7.5**	**7.7**	**9.3**	**6.6**	**6.9**	**6.3**
NMGH	**8.8**	**5.8**	**6.9**	**6.1**	**7.4**	**7.8**	**9.2**	**6.7**	**6.9**	**6.6**
Research	**9.2**	**6.7**	**7.4**	**6.4**	**7.8**	**9.0**	**9.9**	**6.9**	**7.3**	**7.4**
REH	**8.7**	**5.6**	**6.6**	**5.9**	**7.7**	**7.8**	**9.8**	**6.9**	**6.9**	**6.2**
St Mary's	**9.2**	**5.9**	**6.5**	**5.8**	**7.0**	**8.4**	**9.9**	**7.1**	**6.8**	**6.5**
WTWA	**9.0**	**5.9**	**6.5**	**6.1**	**7.6**	**7.9**	**9.4**	**6.7**	**7.0**	**6.3**
Sector	9.1	6.1	6.8	6.2	7.5	8.1	9.5	6.8	7.0	6.5

		0.3+ higher than Group
		Up to 0.2 higher than Group
		Up to 0.2 lower than Group
		0.3+ lower than Group

Appendix 4: 2020 Staff Survey Results by Key Theme – comparison with 2019 score

	Equality, Diversity, and inclusion	Health and Wellbeing	Immediate managers	Morale	Quality of Care	Safe environment - Bullying and harassment	Safe environment - Violence	Safety culture	Staff engagement	Team-working
Group	**9.0**	**6.1**	**6.7**	**6.1**	**7.5**	**8.2**	**9.6**	**6.8**	**7.0**	**6.5**
Ch. Funds	**9.5**	**4.8**	**6.6**	**5.3**	**N/D**	**9.4**	**10.0**	**5.9**	**6.4**	**6.1**
Ch. Serv (RMCH)	**9.2**	**6.2**	**6.6**	**6.2**	**7.5**	**8.3**	**9.6**	**7.0**	**7.2**	**6.7**
CSS	**9.0**	**6.0**	**6.6**	**6.1**	**7.4**	**8.3**	**9.6**	**6.8**	**6.9**	**6.4**
Corporate	**9.1**	**6.5**	**7.1**	**6.3**	**7.2**	**9.0**	**10.0**	**6.6**	**7.1**	**6.7**
Dental	**8.6**	**5.8**	**6.2**	**6.0**	**7.6**	**7.8**	**9.8**	**6.8**	**6.6**	**6.3**
E & F	**9.3**	**7.3**	**6.9**	**6.8**	**7.1**	**9.1**	**9.8**	**6.8**	**7.2**	**6.5**
LCO	**9.2**	**6.3**	**7.1**	**6.5**	**7.7**	**8.4**	**9.8**	**6.9**	**7.2**	**7.0**
MRI	**8.6**	**5.8**	**6.7**	**5.9**	**7.5**	**7.7**	**9.3**	**6.6**	**6.9**	**6.3**
NMGH	**8.8**	**5.8**	**6.9**	**6.1**	**7.4**	**7.8**	**9.2**	**6.7**	**6.9**	**6.6**
Research	**9.2**	**6.7**	**7.4**	**6.4**	**7.8**	**9.0**	**9.9**	**6.9**	**7.3**	**7.4**
REH	**8.7**	**5.6**	**6.6**	**5.9**	**7.7**	**7.8**	**9.8**	**6.9**	**6.9**	**6.2**
St Mary's	**9.2**	**5.9**	**6.5**	**5.8**	**7.0**	**8.4**	**9.9**	**7.1**	**6.8**	**6.5**
WTWA	**9.0**	**5.9**	**6.5**	**6.1**	**7.6**	**7.9**	**9.4**	**6.7**	**7.0**	**6.3**
Sector	9.1	6.1	6.8	6.2	7.5	8.1	9.5	6.8	7.0	6.5

	0.3+ higher than 2019
	Up to 0.2 higher than 2019
	Up to 0.2 lower than 2019
	0.3+ lower than 2019

Appendix 5: 2020 Staff Survey questions recording a statistically significant change 2019 (linked to survey Key Theme where appropriate)

Improvement:

In the last three months have you (not) ever come to work despite not feeling well enough to perform your duties? **Health and wellbeing**

Does your organisation take positive action on health and well-being? **Health and wellbeing**

Violence from patients / service users, their relatives or other members of the public (not experienced) **Safe environment – violence**

Bullying and harassment from patients / service users, their relatives or other members of the public (not experienced) Safe **environment – bullying and harassment**

If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation**. Staff engagement - advocacy**

There are enough staff at this organisation for me to do my job properly.

On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours? (staff reporting zero paid hours worked)

I have unrealistic time pressures

I take into account feedback from colleagues when making positive changes in my area of work.

Decline:

In the last 12 months have you personally experienced discrimination at work from a manager/team leader or other colleagues? (not experienced) – **Equality, Diversity and Inclusion**

In the last 12 months have you (not) experienced musculoskeletal problems (MSK) as a result of work activities? – **Health and wellbeing**

During the last 12 months have you (not) felt unwell as a result of work-related stress? **Health and wellbeing**

[How satisfied are you with] The support I get from my immediate manager – **Immediate managers**

My immediate manager gives me clear feedback on my work. **Immediate managers**

My immediate manager values my work. **Immediate managers**

My immediate manager encourages me at work. **Immediate managers**

My immediate manager asks for my opinion before making decisions that affect my work. **Immediate managers**

I am involved in deciding on changes introduced that affect my work area / team / department. - **Morale**

As soon as I can find another job, I will leave this organisation. **Morale**

In the last 12 months have you personally experienced bullying and harassment work from a manager/team leader or other colleagues? (not experienced**)- Safe environment – bullying and harassment**

My organisation acts on concerns raised by patients / service users. **Safety culture**

I look forward to going to work**. Staff engagement - motivation**

I am enthusiastic about my job. **Staff engagement - motivation**

Time passes quickly when I am working. **Staff engagement - motivation**

There are frequent opportunities for me to show initiative in my role. **Staff engagement – involvement**

I am able to make suggestions to improve the work of my team / department**. Staff engagement - involvement**

I am able to make improvements happen in my area of work. **Staff engagement – involvement**

The team I work in has a set of shared objectives.- **Teamworking**

The team I work in often meets to discuss the team's effectiveness. – **Teamworking**

I always know what my work responsibilities are.

I am trusted to do my job.

[How satisfied are you with] The opportunities I have to use my skills.

My immediate manager can be counted on to help me with a difficult task at work.

Senior managers here try to involve staff in important decisions.

[How satisfied are you with] The recognition I get for good work.

Communication between senior management and staff is effective.

Senior managers act on staff feedback.

Have you felt pressure from your manager to come to work (when feeling unwell)?

[How satisfied are you with] My level of pay?

Have you felt pressure from colleagues to come to work (when feeling unwell)?

[How satisfied are you with] the extent to which my organisation values my work?

Do managers demonstrate the trust's values at work?
There are opportunities for me to develop my career in this organisation.

Learning and development activities I have completed in the last 12 months have helped me to improve my chances of career progression.

I am encouraged to become a leader in my area of work.

The career conversation has made me more engaged in my role.

The career conversation helped me identify how I can achieve my full potential at work.

The career conversation led to an opportunity for my professional development.

My organisation has a clear vision for the future.

I feel like I am part of my organisation's vision for the future.

Appendix 6: NMGH Comparison Data

		Comparison Scores					
			2018	2019	2020	Comparison	% difference
Q2a	Often/always look forward to going to work	61%	61%	67%	61%	-6%	-8.96
Q2b	Often/always enthusiastic about my job	77%	77%	82%	75%	-7%	-8.54
Q2c	Time often/always passes quickly when I am working	82%	80%	82%	76%	-6%	-7.32
Q3a	Always know what work responsibilities are	91%	89%	91%	86%	-5%	-5.49
Q3b	Feel trusted to do my job	92%	92%	93%	91%	-2%	-2.15
Q3c	Able to do my job to a standard I am pleased with	80%	78%	83%	77%	-6%	-7.23
Q4a	Opportunities to show initiative frequently in my role	75%	75%	82%	76%	-6%	-7.32
Q4b	Able to make suggestions to improve the work of my team/dept	79%	76%	80%	76%	-4%	-5.00
Q4c	Involved in deciding changes that affect work	56%	53%	61%	53%	-8%	-13.11
Q4d	Able to make improvements happen in my area of work	59%	56%	63%	59%	-4%	-6.35
Q4e	Able to meet conflicting demands on my time at work	46%	43%	53%	46%	-7%	-13.21
Q4f	Have adequate materials, supplies and equipment to do my work	54%	53%	57%	52%	-5%	-8.77
Q4g	Enough staff at organisation to do my job properly	27%	30%	32%	31%	-1%	-3.13
Q4h	Team members have a set of shared objectives	75%	74%	77%	74%	-3%	-3.90
Q4i	Team members often meet to discuss the team's effectiveness	64%	62%	65%	56%	-9%	-13.85
Q4j	I receive the respect I deserve from my colleagues at work	79%	74%	78%	71%	-7%	-8.97
Q5a	Satisfied with recognition for good work	51%	57%	63%	57%	-6%	-9.52
Q5b	Satisfied with support from immediate manager	66%	68%	77%	68%	-9%	-11.69
Q5c	Satisfied with support from colleagues	83%	81%	84%	80%	-4%	-4.76
Q5d	Satisfied with amount of responsibility given	74%	77%	81%	74%	-7%	-8.64
Q5e	Satisfied with opportunities to use skills	74%	77%	80%	75%	-5%	-6.25

Q5f	Satisfied with extent organisation values my work	41%	46%	55%	46%	-9%	-16.36
Q5g	Satisfied with level of pay	33%	38%	42%	33%	-9%	-21.43
Q5h	Satisfied with opportunities for flexible working patterns	52%	56%	57%	53%	-4%	-7.02
Q6a	I have realistic time pressures		22%	24%	21%	-3%	-12.50
Q6b	I have a choice in deciding how to do my work		52%	57%	52%	-5%	-8.77
Q6c	Relationships at work are unstrained		42%	47%	43%	-4%	-8.51
Q7a	Satisfied with quality of care I give to patients/service users	83%	77%	85%	80%	-5%	-5.88
Q7b	Feel my role makes a difference to patients/service users	92%	92%	93%	91%	-2%	-2.15
Q7c	Able to provide the care I aspire to	71%	65%	73%	68%	-5%	-6.85
Q8a	My immediate manager encourages me at work	75%	67%	76%	71%	-5%	-6.58
Q8b	Immediate manager can be counted on to help with difficult tasks	68%	68%	77%	72%	-5%	-6.49
Q8c	Immediate manager gives clear feedback on my work	59%	59%	68%	62%	-6%	-8.82
Q8d	Immediate manager asks for my opinion before making decisions that affect my work	56%	52%	63%	56%	-7%	-11.11
Q8e	Immediate manager supportive in personal crisis	73%	71%	78%	78%	0%	0.00
Q8f	Immediate manager takes a positive interest in my health & well-being	65%	65%	71%	71%	0%	0.00
Q8g	Immediate manager values my work	68%	69%	78%	74%	-4%	-5.13
Q9a	I know who senior managers are	78%	79%	85%	77%	-8%	-9.41
Q9b	Communication between senior management and staff is effective	41%	44%	51%	38%	-13%	-25.49
Q9c	Senior managers try to involve staff in important decisions	34%	38%	43%	30%	-13%	-30.23
Q9d	Senior managers act on staff feedback	32%	34%	43%	31%	-12%	-27.91
Q10b	Don't work any additional paid hours per week for this organisation, over and above contracted hours	66%	64%	57%	57%	0%	0.00
Q10c	Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	34%	36%	39%	38%	-1%	-2.56
Q11a	Organisation definitely takes positive action on health and well-being	20%	21%	25%	22%	-3%	-12.00

Q11b	In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	73%	73%	72%	72%	0%	0.00
Q11c	Not felt unwell due to work related stress in last 12 months	61%	60%	61%	52%	-9%	-14.75
Q11d	In last 3 months, have not come to work when not feeling well enough to perform duties	35%	36%	37%	51%	14%	37.84
Q11e	Not felt pressure from manager to come to work when not feeling well enough	73%	77%	78%	75%	-3%	-3.85
Q11f	Not felt pressure from colleagues to come to work when not feeling well enough	78%	83%	83%	78%	-5%	-6.02
Q11g	Not put myself under pressure to come to work when not feeling well enough	6%	10%	10%	7%	-3%	-30.00
Q12a	Not experienced physical violence from patients/service users, their relatives or other members of the public	82%	80%	77%	77%	0%	0.00
Q12b	Not experienced physical violence from managers	99%	99%	99%	100%	1%	1.01
Q12c	Not experienced physical violence from other colleagues	98%	98%	97%	98%	1%	1.03
Q12d	Last experience of physical violence reported	60%	61%	80%	66%	-14%	-17.50
Q13a	Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	82%	64%	61%	66%	5%	8.20
Q13b	Not experienced harassment, bullying or abuse from managers	79%	83%	88%	90%	2%	2.27
Q13c	Not experienced harassment, bullying or abuse from other colleagues	78%	78%	81%	79%	-2%	-2.47
Q13d	Last experience of harassment/bullying/abuse reported	45%	45%	46%	50%	4%	8.70
Q14	Organisation acts fairly: career progression	85%	84%	88%	84%	-4%	-4.55
Q15a	Not experienced discrimination from patients/service users, their relatives or other members of the public	91%	94%	92%	88%	-4%	-4.35
Q15b	Not experienced discrimination from manager/team leader or other colleagues	91%	93%	92%	91%	-1%	-1.09
Q16a	In last month, have not seen errors/near misses/incidents that could hurt staff	80%	77%	76%	59%	-17%	-22.37

Q16b	In last month, have not seen errors/near misses/incidents that could hurt patients/service users	67%	64%	63%	89%	26%	41.27
Q16c	Last error/near miss/incident seen that could hurt staff and/or patients/service users reported	94%	96%	95%	70%	-25%	-26.32
Q18a	Know how to report unsafe clinical practice	99%	97%	96%	98%	2%	2.08
Q18b	Would feel secure raising concerns about unsafe clinical practice	70%	74%	76%	75%	-1%	-1.32
Q21a	Care of patients/service users is organisation's top priority	72%	75%	80%	75%	-5%	-6.25
Q21b	Organisation acts on concerns raised by patients/service users	70%	74%	80%	75%	-5%	-6.25
Q21c	Would recommend organisation as place to work	55%	55%	64%	57%	-7%	-10.94
Q21d	If friend/relative needed treatment would be happy with standard of care provided by organisation	57%	60%	64%	56%	-8%	-12.50
Q23a	I don't often think about leaving this organisation		45%	53%	41%	-12%	-22.64
Q23b	I am unlikely to look for a job at a new organisation in the next 12 months		54%	61%	51%	-10%	-16.39
Q23c	I am not planning on leaving this organisation.		59%	68%	60%	-8%	-11.76
Q28b	Disability: organisation made adequate adjustment(s) to enable me to carry out work	85%	74%	72%	75%	3%	4.17

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce and Corporate Business
Paper prepared by:	Alison Hughes, Head of Specialist HR Services
Date of paper:	April 2021
Subject:	Putting People First at MFT
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	In the absence of enough operational and strategic effort on workforce matters the sustainability of MFT would be compromised. Upholding Trust vision and values is imperative to ensuring a positive workplace experience and fair treatment for all.
Recommendations:	The Trust Board is asked to; • Review the contents of the report noting the developments to date and endorse actions planned for 2021/22.
Contact:	Name: Peter Blythin, Group Executive Director of Workforce and Corporate Business Tel: 0161 701 0190

Update Report on the
'Putting People First at MFT' Programme

1.0 Purpose

To provide the Board with an overview of the work being undertaken to improve Trust people practices in relation to employee relation matters.

2.0 Introduction

2.1 A tragic event occurred at a London NHS Trust in 2015 whereby a nurse, Amin Abdullah was subject to an investigation and disciplinary procedure. The protracted procedure culminated in Amin's summary dismissal on the grounds of gross misconduct.

2.2 Tragically in February 2016 just before an arranged appeal hearing, Amin sadly took his own life. The Trust commissioned an independent report which concluded that in addition to serious procedural errors having been made, throughout the investigation and disciplinary process, Amin was treated very poorly, to the extent that his mental health was severely impacted.

2.3 Subsequently NHS Improvement established a 'task and finish' advisory group to consider to what extent the failings identified were unique to that Trust or widespread across the NHS and what learning could be applied. It was established that Amin's experience was far from unique and the report acknowledged that there needed to be greater consistency in the demonstration of an inclusive, compassionate and person-centred approach, underpinned by an over-riding concern to safeguard people's health and wellbeing, whatever the circumstances.

2.4 Baroness Dido Harding wrote to all NHS Trusts in May 2019 requesting that they review the recommendations of the advisory group and implement the guidance to ensure the NHS treats people fairly and protect their wellbeing. This was discussed with HRD colleagues and in partnership with staff to review practices. A Board assurance report (BAF+) report was presented at HR Scrutiny Committee in June 2019 on policy development and in August 2019 the workforce report advised the establishment of the Employee Relations (ER) Oversight Group to provide Executive oversight of ER policy and practices.

2.5 In December 2020 Prerana Issar, NHS Chief of People Officer shared the Disciplinary Policy from the Imperial College Healthcare NHS Trust, as an example of good practice. She asked Trusts to review disciplinary procedures on a yearly basis and that these be formally discussed/minuted at a Public Board or equivalent.

3.0 Putting People First

3.1 A programme of work has commenced titled *'Putting People First at MFT'.* This programme is the overarching term at MFT which incorporates several initiatives identified below.

Initiative	Description
Putting People First	Learning lessons to improve our people practices following the tragic death of Amin Abdullah.
A Fair experience for all	Closing the ethnicity gap in rates of disciplinary action across NHS workforce.
Personal Responsibility Framework	Providing an open and transparent approach to enable effective and efficient management of cases to a speedier conclusion (where appropriate) where an investigation finding merit a sanction and the employee has admitted the allegations.
Just Culture in patient safety incidents	Recognition that individual practitioner should not be held accountable for system failings over which they have no control.

3.2 In addition, following the release of the National 2020 Staff Survey results, work is underway to also bring together work streams such as bullying and harassment work being led by Equality, Diversity and Inclusion and the Civility Saves Lives Programme, previously on hold due to the COVID-19 Pandemic.

3.3 This overarching work will allow a level of consistency across the different work streams, maintained a joint working, collaborative approach to ensure employee experience is fair and equitable.

3.4 Work commenced on the Putting People First Programme with two workshops which were held late 2019 / early 2020 with a wide range of managers, HR / OD staff, Employee Health & Wellbeing experts, and staff side representatives. Due to the COVID-19 Pandemic response the progress paused until February 2021 when it was revisited. A further four workshops have taken place during March and April 2021.

4.0 Putting People First at MFT Programme Review

4.1 The table below outlines the points of guidance and recommendations devised by the NHS E/I Advisory group, which provided a framework to review and assess MFT procedures and processes in line with best practice. These have been reviewed again and further workshops are planned with HRDs, staff side colleagues and key clinical stakeholders to further review and improve our current practice.

4.2 Further discussing the below with the HRD Network will also enable seamless integration with the other identified work streams previously mentioned.

Guidance relating to the oversight of local investigation and disciplinary procedures	MFT review and action 19/20 and 20/21	Action Planned 21/22
Adhering to best practice.	Review of disciplinary policy. Drafted aligned to best practice ACAS code of practice.	Further review of policy in line with GMC 'principles of a good investigation' and updated ACAS guidance. Consultation with staff side colleagues to achieve reviewed policy ratification by end of Quarter 1. Review and implementation of revised Maintaining High Professional Standards (MHPS) policy by end of Quarter 1.
Applying a rigorous decision-making methodology	Workshops held discussed the 'just culture' principles and approach recognising not always necessary or appropriate to invoke formal management action and comprehensive and consistent decision-making methodology should be applied. Employee Relations Oversight Group established with Executive oversight and HRD, Associate Medical Director membership.	Aligned to new policy implementation, new guidance, and documentation to be developed by end of Quarter 2 including: • Investigations • Checklist for management actions – comprehensive and clear steps for decision making Continue to develop ER dashboard for the ER Oversight Group.
Ensuring people are fully trained and competent to carry out their role.	Commissioned training packages for case managers; investigators and panel members with law firms.	Develop training schedule to be completed by end of Quarter 4 (2021/22) with updated training packages to include relevant updated best practice, principles of natural justice, compassionate leadership and appreciation of race and cultural considerations.

Assigning sufficient resources.	Workshops outlined the need to work differently. Barrier identified of capacity to undertake investigations in a timely way due to workload pressures at same time as undertaking investigations.	Review and consideration of COVID-19 lessons learned e.g. virtual investigation meetings and hearing to free capacity. Review and consideration of Investigator bank by end of Quarter 4 of named and trained individuals who would be afforded time to support with complex investigations. Allocation of disciplinary panel membership to be cross Hospital / MCS / LCO /Corporate to ensure independence.
Decisions relating to the implementation of suspensions/exclusions.	ER Oversight Group established with monitoring of suspension/exclusion activity.	Continued monitoring and further development of dashboard and analysis.
Safeguarding people's health and wellbeing.	Employee Health and Wellbeing referral pathways established. ER Oversight Group monitoring any 'never event' cases if raised for an independent investigation for any individual subject to an investigation or disciplinary procedure who has encountered serious harm, physical or mental. Reporting process to Board if applicable.	Communication plan template for individuals subject to an investigation or an employee relations procedure developed by end of Quarter 2. Review, define and embed reporting process for 'never event'.
Board level oversight	Employee Relations Oversight Group established August 2019	Annual review and update at HR Scrutiny Committee and MFT Board.

5.0 Employee Relations Oversight

5.1 During 2020/21 the ER Oversight Group developed monitoring and reporting practices which provide operational oversight and escalation to Executive level members whilst also ensuring that current policy and processes are fit for purpose and supportive of all staff who may be involved in any investigatory and / or disciplinary procedures.

It has been reported to date in 2020/2021 that there are no reported 'never events' relating to any staff member who is involved in an investigatory or disciplinary procedure.

6.0 Recommendations

6.1 The Board of Directors is asked to:

- Review the contents of the report noting the developments to date and endorse actions planned for 2021/22.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Sue Ward, Group Deputy Chief Nurse Lynne Birchall, Head of Nursing (Patient Experience) Claire Horsefield, Head of Customer Services
Date of paper:	April 2021
Subject:	Quarter 4 Complaints Report 2020/21
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Patient and Staff Experience
Recommendations:	The Board of Directors is asked to receive this report and note the: • Complaints and PALS service activity during Q4 2020/21 • Brief analysis of identified themes
Contact:	Name: Lynne Birchall, Head of Nursing (Patient Experience) Tel: 0161 701 7679

Manchester University NHS Foundation Trust (MFT)
Complaints Report 1st January 2021 – 31st March 2021

1. Executive Summary

1.1 This report relates to complaints and PALS activity across MFT in Q4 2020/21. The report provides:

- A brief summary of activity: Complaints and Patient Advice & Liaison Service (PALS)
- Q4 in context: Increase in outpatient related complaints, recommencement of local resolution meetings and The Parliamentary and Health Service Ombudsman (PHSO) position
- Overview of Complaints and PALS contacts including a brief analysis of themes
- Care Opinion and NHS Website feedback
- Improvements made and planned to ensure learning from complaints is embedded in practice
- Results of the Complaint Handling internal audit, and
- Appendix 1: Supporting information presented in tables and graphs.

2. A brief summary of activity Q4 2020/21

- 1,449 PALS concerns were received compared to 1,424 in the previous quarter

- 303 new complaints were received compared to 290 in the previous quarter

- 100% of complaints were acknowledged within 3 working days; the position was maintained throughout all the previous quarters of 2020/21

- 301 complaints were closed compared to 341 in the previous quarter

- 93.7% of complaints were closed within the agreed timescale compared to 94.4% in the previous quarter. This is the third quarter the Trust has achieved or exceeded the 90% target

- 69 (23%) complaints investigated were not upheld and 191 (63.4%) were partially upheld

- 9 cases were being investigated by the Parliamentary Health Service Ombudsman (PHSO), the same number that were reported in Q2 and Q3, 2020/21

- North Manchester General Hospital (NMGH) Complaints and PALS activity continues to be reported separately through the NMGH quality assurance process and will be included in the MFT report from 1st April 2021.

3. Q4 2020/21 in context

Q4, 2020/21 continued to see an increase in complaints relating to outpatient services across the Trust.

During this quarter, the Trust resumed face to face local resolution meetings that had been paused in response to the Covid-19 pandemic.

During this quarter, the PHSO did not close any cases and the same 9 cases from the previous 2 quarters remained under investigation. Detail of the on-going PHSO investigations is set out in **Table 1**, Appendix 1.

3.1. During Q4 the PALS and Complaints team have continued to:

- Maintain existing PALS and Complaints provisions.
- Support Hospital/MCS/LCOs to continue to investigate and respond to complaints.
- Support Hospital/MCS/LCOs to continue to hold local complaint resolution meetings, virtually and face to face.
- Support the PALS Volunteer role during the on-going period of restricted visiting.
- Prepare for implementation of the delivery of a Corporate PALS and Complaints service at NMGH.

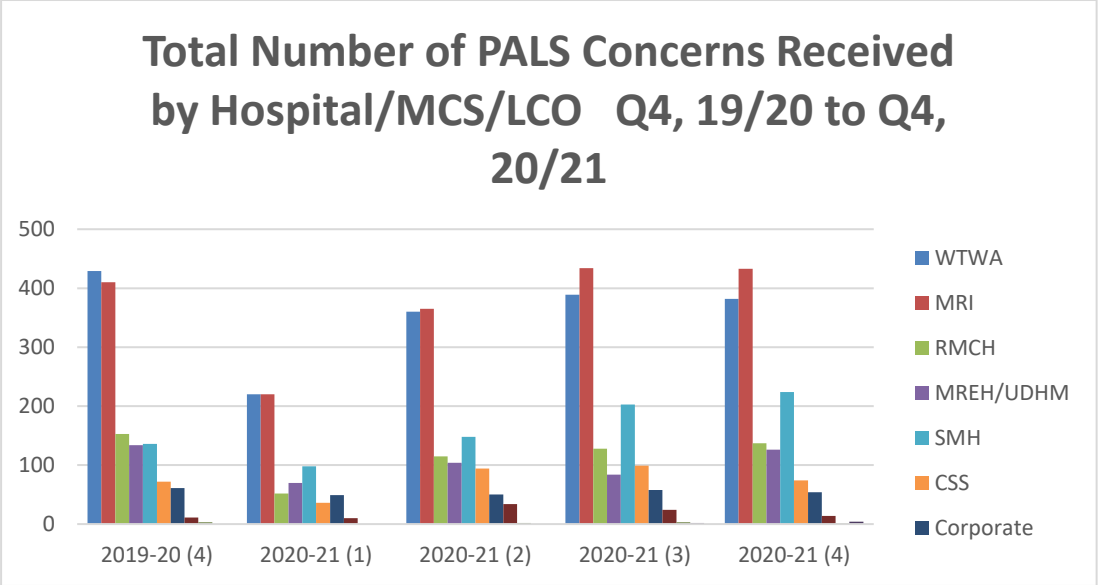
3.2 The Complaints Review and Scrutiny Group, chaired by a Non-Executive Director met once during Q4, 2020/21. The Management Teams from WTWA presented two cases in March 2021. The learning identified from these cases is detailed in Section 6 of this report.

4. Overview of Quarter 4, 2020/21

Patient Advice and Liaison Service (PALS) activity

4.1 During Q4, the PALS team responded to 1,449 concerns, representing a slight increase in comparison to the previous quarters. **Graph 1** below shows the number of PALS concerns received by each Hospital/MCS/LCO over the previous 5 quarters. Further detail is provided in **Table 2**, Appendix 1 of this report.

Graph 1: Total number of PALS Concerns Received by Hospital/MCS/LCO by Quarter

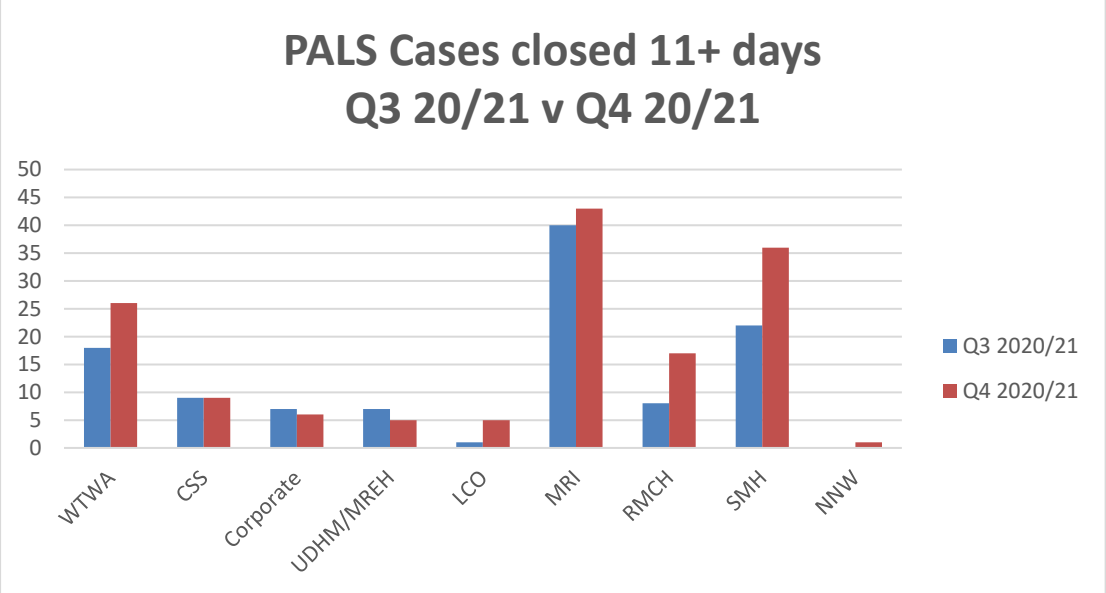


4.2 The Trust aims to quickly resolve PALS concerns. During this quarter, 90.0% of PALS concerns were resolved within 10 working days, which is a slight decrease from the previous quarter. **Table 3**, Appendix 1 shows the timeframes in which PALS concerns have been resolved during the last five quarters. These data show that resolution of PALS concerns within 10 days has remained at or above 90% for all 4 quarters of 2020/21.

4.3 Delays in resolving PALS concerns are monitored by the Corporate PALS team and are reported to the relevant Hospital/MCS/LCO senior management teams via weekly reports detailing unresolved PALS concerns. PALS cases, which remain open at 8 days are escalated to the PALS Manager. **Graph 2** shows that as in the previous quarter, MRI had the highest number of PALS concerns overall and highest number of PALS concerns open longer than 10 days. The data also illustrate that in this quarter SMH has seen the greatest increase in PALS concerns. The increase coincides with waiting times having increased significantly. Work focusing on improving accessibility in Gynaecology is expected to result in a reduction in PALS concerns in Q1.

4.4 At the request of the WTWA and MRI senior management teams, monthly and quarterly reports continue to be produced by the Corporate Data Analyst. These reports identify the specific areas where the delays are encountered and drive ongoing improvement.

Graph 2: Number of PALS concerns taking longer than 10 days to close by Hospital / MCS/ LCO, Quarter 3, 2020/21 to Quarter 4, 2020/21



4.5 The number of PALS concerns taking longer than 10 days to close by Hospital/MCS/LCO Quarter 4, 2019/20 to Quarter 4, 2020/21 can be found in **Table 4** (Appendix 1).

4.6 There are occasions when in agreement with the complainant, PALS concerns are escalated to complaints. During Q4, ten PALS cases were escalated to formal investigation. This represents the same number received in the previous quarter. **Table 5**, Appendix 1 shows the number of PALS cases escalated to formal investigation during the last five quarters.

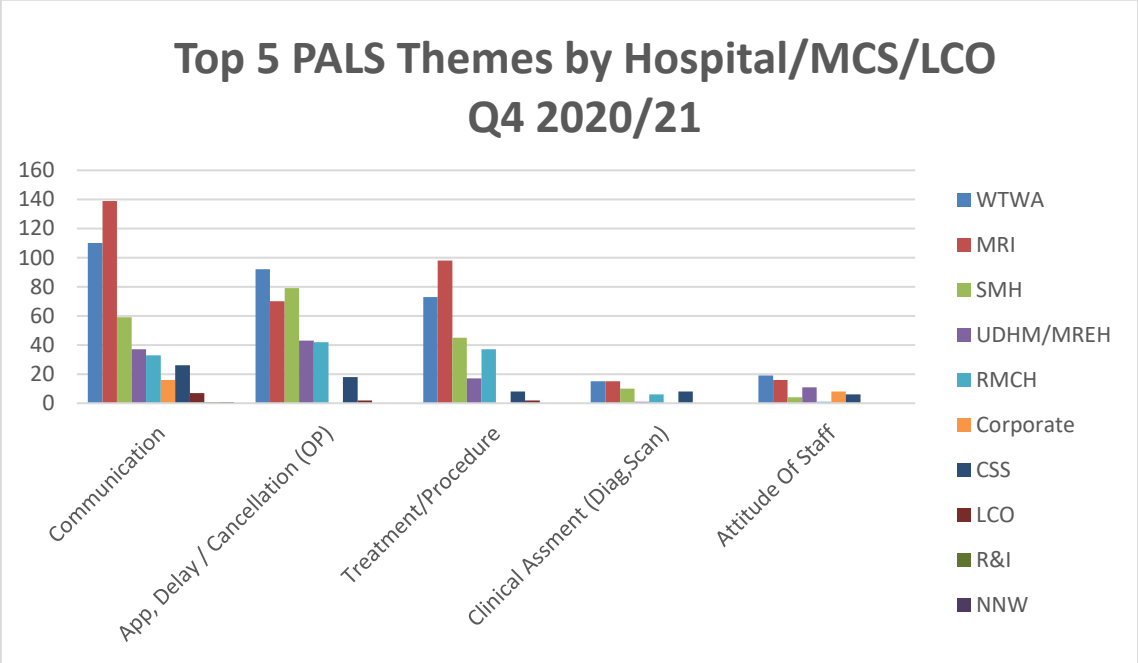
Themes from PALS concerns

4.7 Of the 1,449 PALS concerns received in Q4, 1,080 (74.5%) related to Outpatient areas, compared to 1043 (73.2%) in the previous quarter. Trust-wide, the top 3 category themes for PALS concerns from this quarter remain unchanged and are:

- Communication
- Treatment/Procedure
- Appointment, Delay / Cancellation (OP)

Key themes are shown at Hospital/MCS/LCO-level in **Graph 3,** below.

Graph 3: Number of Top PALS themes by Hospital/ MCS / LCO, Quarter 4, 2020/21



4.8 Examples of PALS concerns include:

- poor communication regarding the results of a patient's blood test
- a patient requesting support in gaining an outpatient appointment
- a patient requesting support to access urgent investigations

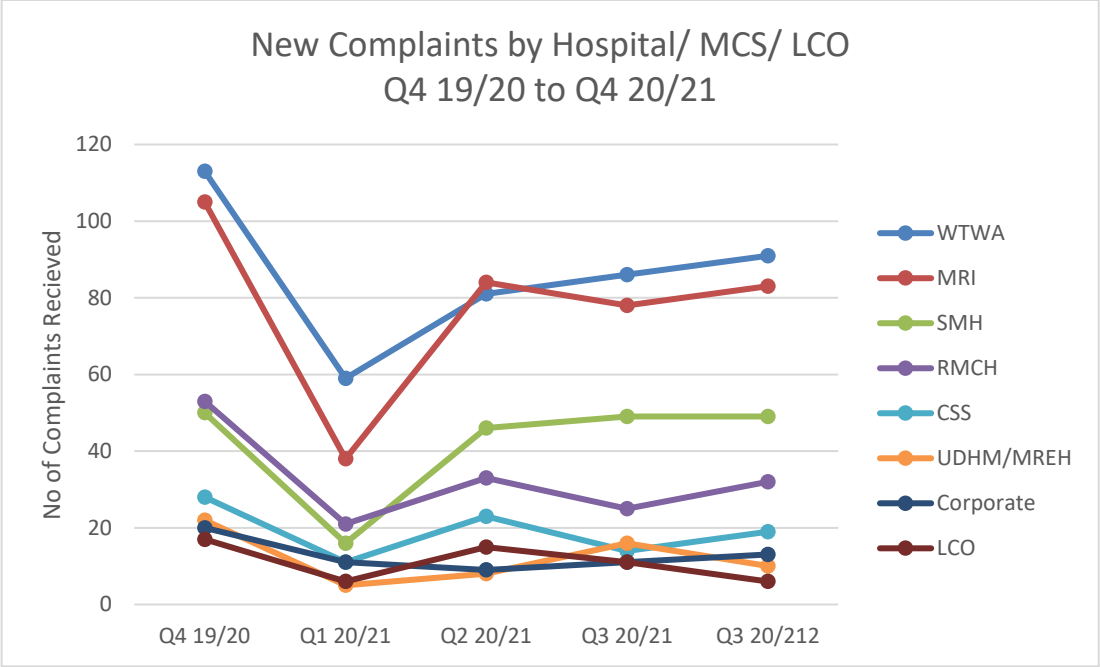
Complaints activity

4.9 Effective complaints handling is a cornerstone of patient experience. At all times the Trust aims to provide local resolutions to complaints; taking all complaints seriously. By listening and responding to complaints the Trust aims to remedy the situation as quickly as possible and to ensure that the individual is satisfied with the response they receive. The learning acquired from complaints is used to improve services for the people who use them, as well as for the staff working in them.

New Complaints received in Q4

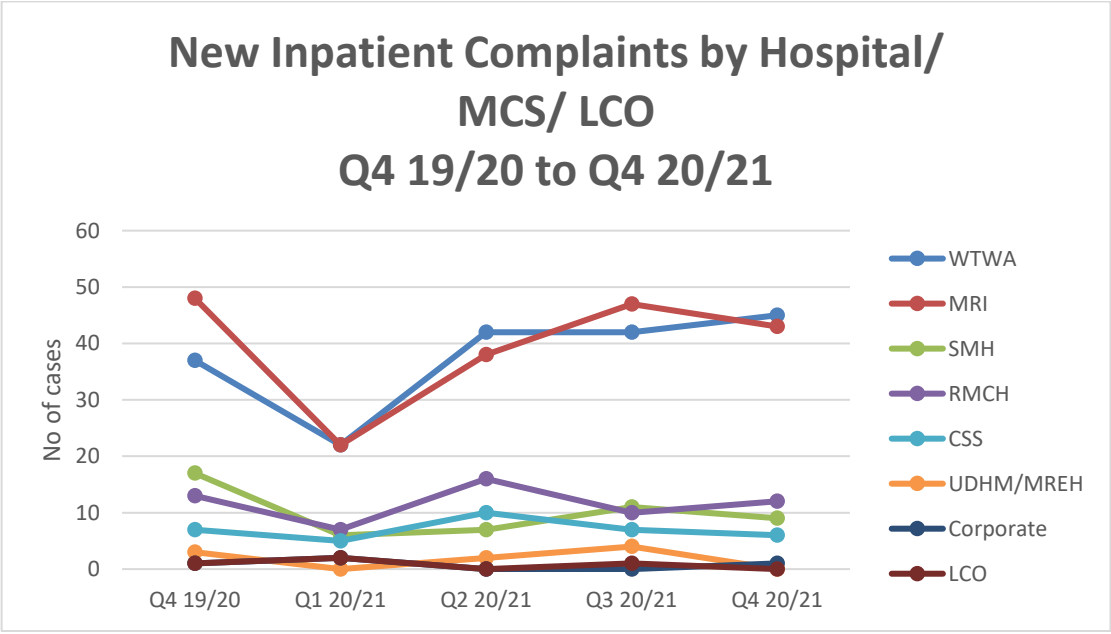
4.10 The Trust received 303 new complaints this quarter, which is a slight increase compared to the last quarter. **Graph 4** shows the number of complaints received by each Hospital/MCS/LCO each quarter. Due to their size, it is expected that MRI and WTWA receive the greatest number of complaints. Further detail is provided in **Table 6**, **Appendix 1**.

Graph 4: Total number of New Complaints Received by Hospital/MCS/LCO

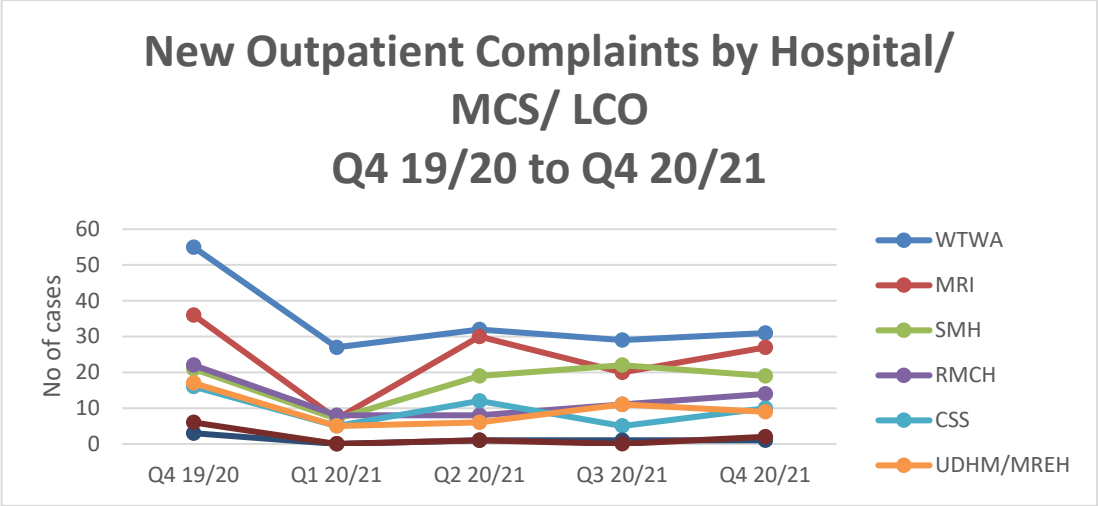


4.11 **Graphs 5 and 6** below illustrate the number of new complaints relating to inpatient and outpatient services for Quarter 4, 2019/20 to Quarter 4, 2020/21. As noted above, overall, the greatest increase in complaints relates to outpatients, with a slight reduction in complaints relating to in-patient services being noted. The increase in complaints relating to outpatient services coincides with waiting times having increased significantly for care and treatment as a result of the impact of the Covid-19 pandemic on service provision and the need to divert resources to inpatient and critical care services.

Graph 5: Number of new complaints relating to inpatient services by Hospital/ MCS/ LCO



Graph 6: Number of new complaints relating to outpatient services by Hospital/ MCS/LCO



4.12 Under the NHS Complaints Regulations (2009) all new complaints are required to be acknowledged within 3 working days of receipt of the complaint. The Trust has a performance indicator that all complaints are to be acknowledged within 3 working days in 100% of cases. This quarter, as in all previous quarters, the Trust met this indicator. **Table 7**, Appendix 1 demonstrates the complaints acknowledgment performance.

Resolved Complaints

4.13 During Q4, 93.7% of complaints were closed within the agreed timescale, which, although good performance, is a 0.7% decrease (negative) compared to the previous quarter. This is the third quarter that the Trust has achieved above its 90% target, demonstrating the work undertaken within hospitals/MCS/LCOs to improve complaints management processes. **Table 8**, Appendix 1, provides the comparison of complaints resolved within agreed timeframe during the last 5 quarters.

4.14 The oldest complaint case closed during Q4 was registered within the Manchester Royal Infirmary on 4th November 2020 and was 96 days old when closed on 23rd March 2021. The complaint also involved another NHS organisation, in which delays were experienced in receiving the outcome of their investigation and a local resolution meeting which impacted the response time. The complainant was kept updated and was fully supported throughout this process.

Outcomes from Complaint Investigations

4.15 Whilst all complaints provide an opportunity to review and improve services, the NHS Complaints Regulations (2009) require the Trust to report the volume of complaints which are well-founded. This information is provided on a quarterly basis through the KO41a submission to NHS Digital and the information obtained from the KO41a collection monitors written hospital and community health service complaints received by the NHS. It also supports the NHS commitment to improve the patient's experience by listening to the public voice.

4.16 Often complaints relate to more than one issue. In conjunction with the Hospital/ MCS/LCO investigating team, the Corporate Complaints Case Managers review each of the issues raised to determine what happened. If failings are found in all the issues complained about, and substantive evidence 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.** It is important to note that there will not be outcomes for all registered complaints, for example where complaints have been withdrawn, or consent has not been received.

4.17 During Q4, 26 (8.63%) of the complaints investigated were fully upheld (well-founded), which is a significant decrease from the previous quarter, whilst 191 (63.45%) were partially upheld. **Table 9,** Appendix 1 demonstrates the outcome status.

Further Complaint Correspondence

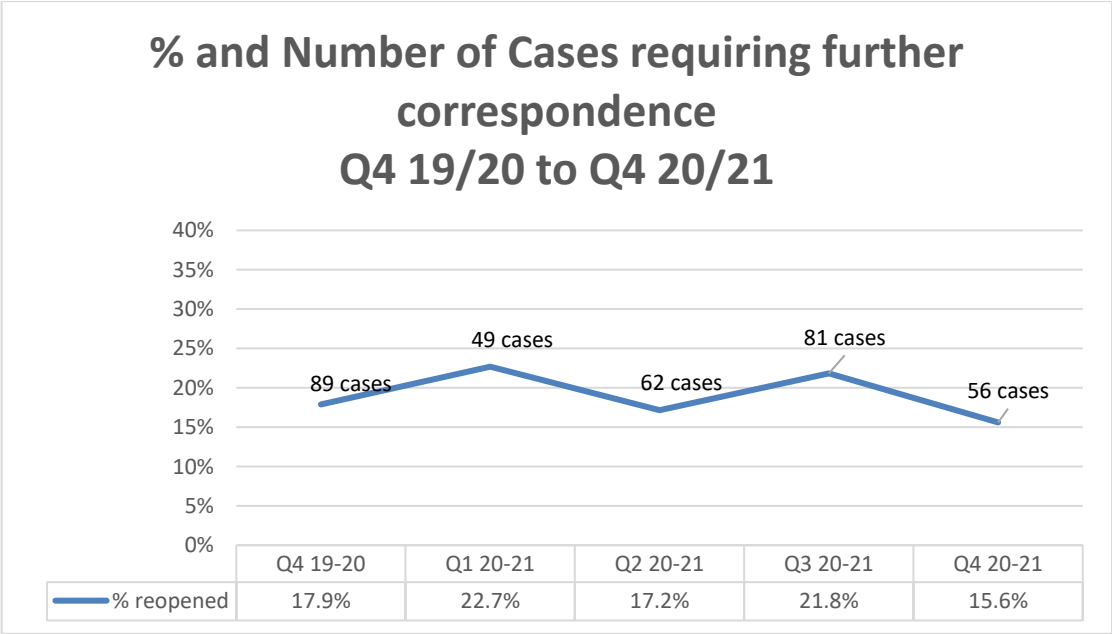
4.18 Further complaint correspondence is used as a proxy indicator to measure the quality of the initial response. A tolerance threshold of 20% has been agreed by the MFT Chief Nurse. The Trust received further correspondence for 56 complaint cases during this quarter; representing a 15.6% further correspondence rate, compared to 21.8% the previous quarter.

4.19 The Trust categorises further complaint correspondence from the complainant as:

- Request for a local resolution meeting
- New questions raised as a result of the information provided
- Response did not address all issues
- Dissatisfied with response

4.20 **Graph 7** demonstrates the numbers of further complaint correspondence received from Q4, 2019/20 to Q4, 2020/21. **Table 10**, **Appendix 1** provides an overview of the predominant reasons for the further correspondence by Hospital/MCS/LCO during Q4.

Graph 7: Total further complaint correspondence received Quarter 4, 2019/20 to Quarter 4, 2020/21



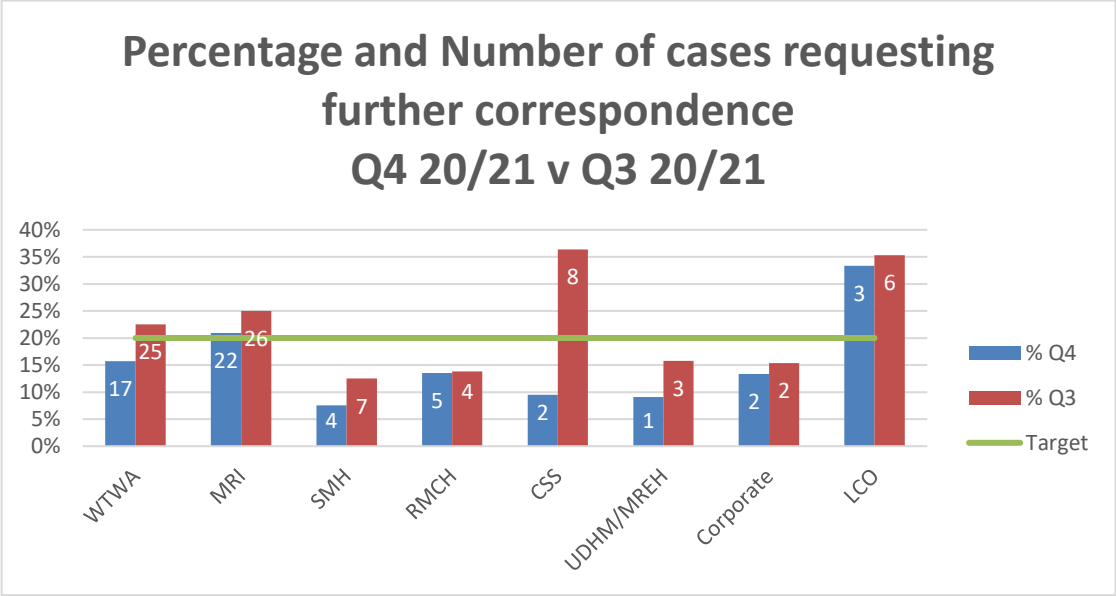
4.21 Further complaint correspondence was received for 15.6% of complaints this quarter compared to 21.8% in Q3 and 17.2% in Q2. In 34 of the 56 cases requiring further correspondence, the predominant reason for further correspondence was due to the 'response not addressing all issues', with WTWA and MRI receiving the greatest number.

4.23 Hospital/MCS/LCO performance against the 20% further correspondence threshold in Q4, where the threshold was exceeded is as follows:

- MRI (21.0%)
- LCOs (33.3%)

4.24 Further complaint correspondence received by WTWA, SMH, RMCH, CSS, UDHM/MREH and Corporate fell below the 20% threshold. This position is demonstrated in **Graph 8** below. It should be noted, however, that small fluctuations in the total number of complaints received in a Hospital/MCS/LCO or Corporate Services can result in large percentage changes for those areas where the overall number of complaints is low, which is the case for the LCOs. The Corporate Complaints Team letter writing training programme continues to support improvements in the content and quality of responses with a review to ensuring that the complainant's concerns are fully answered in the first response.

Graph 8: Percentage of further correspondence Complaints, Quarter 4, 2020/21



Themes from Complaints

4.25 Complaints are viewed as a learning opportunity to support the Hospital/MCS/LCOs to improve patient care and experience. By applying categorisation and theming to the complaints received, the Trust works to improve the quality of care where themes emerge, or practice is identified as requiring improvement.

4.26 During Q4, 3 of the 5 top categories remained unchanged with 'Treatment/ Procedure' remaining the top category; however, in Q4 'Attitude of Staff' was the fourth category replacing 'Discharge/Transfer' and 'Appointment, Delay/Cancellation (Outpatient)' was the fifth category replacing 'Access'. 'Appointment, Delay/Cancellation (Outpatient)' has not been in the top 5 categories in the previous 3 quarters and reflects the current challenges in the provision of services during the response to the Covid-19 pandemic.

The top themes in Q4 from complaints are shown in **Table 11** below. Also included are themes from previous quarters to enable comparison.

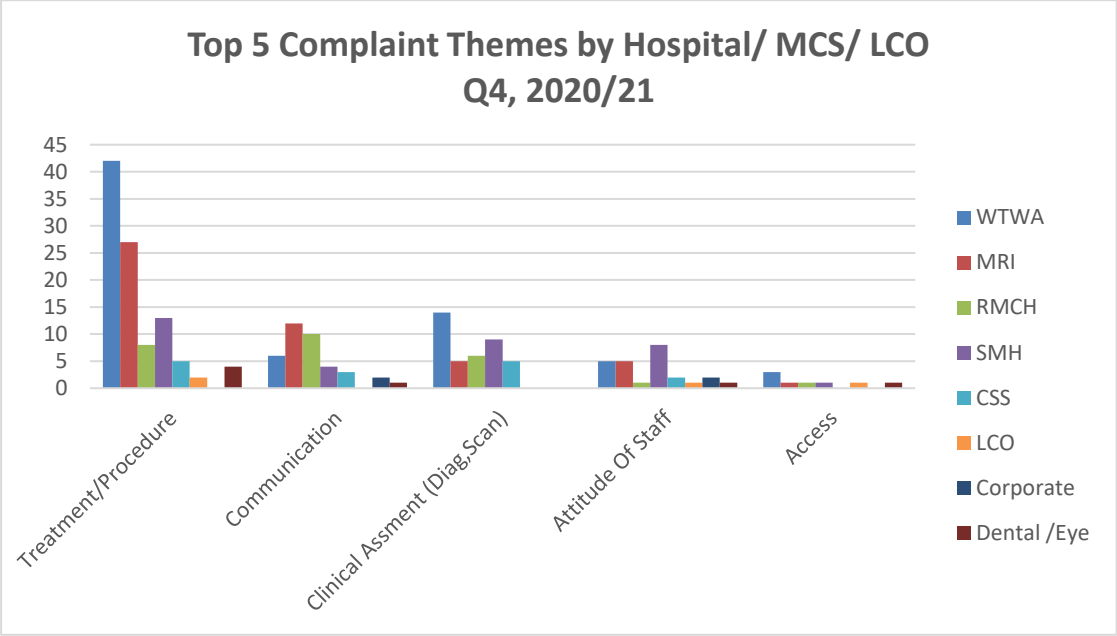
Table 11: Top Complaint Themes Quarter 4, 2019/20 to Quarter 4, 2020/21

	Q4,19/20	Q1,20/21	Q2,20/21	Q3,20/21	Q4,20/21
1	Treatment/ Procedure	Treatment/ Procedure	Treatment/ Procedure	Treatment/ Procedure	Treatment/ Procedure
2	Communication	Clinical Assessment (Diag,Scan)	Communication	Clinical Assessment (Diag,Scan)	Clinical Assessment (Diag,Scan)
3	Clinical Assessment (Diag,Scan)	Communication	Clinical Assessment (Diag,Scan)	Communication	Communication
4	Attitude of Staff	Attitude of Staff	Attitude of Staff	Discharge/ Transfer	Attitude of Staff
5	App, Delay / Cancellation (OP)	Discharge/ Transfer	Access	Access	App, Delay / Cancellation (OP)

4.27 **Graph 9** below shows the distribution of the top 5 themes by Hospital/MCS/LCO in Q4, 2020/21. As in the previous quarter, WTWA received the most complaints relating to 'treatment/procedure'. The majority of new complaints relate to inpatient and outpatient services. Some examples include:

- a patient experiencing his operation being cancelled on the day of the planned surgery.
- a patient experiencing an unexpected clinical outcome following orthopaedic surgery.

Graph 9: Total number of Top 5 Complaint Themes by Hospital/MCO/LCO, Q4, 2020/21



4.28 Work continued during this quarter to theme the concerns raised in complaints against the MFT *What Matters to Me* (WMTM) categories.

4.29 The themes identified from Q4, 2019/20 to Q4, 2020/21 are shown in **Table 12** below, with Professional Excellence and Positive Communication being illustrated as the top

2 WMTM themes. Some examples of complaints received relating to Positive Communication and Professional Excellence include:

- a complaint was received regarding poor communication in relation to a patient's treatment plan.
- a complaint was received about a patient's condition not being monitored appropriately by nursing staff on the ward.

Table 12: Theming of complaints to MFT WMTM cateogories, Q4, 2019/20 to Q4, 2020/21

WMTM themes	Q4,19/20	Q1,20/21	Q2,20/21	Q3,20/21	Q4,20/21
Environment	3	11	17	6	7
Leadership	0	18	8	11	10
Organisational Culture	7	85	78	24	37
Positive Communication	10	84	104	45	82
Professional Excellence	17	65	61	47	62
Employee Wellbeing	0	1	3	0	1
Grand Total	**37**	**270**	**256**	**133**	**199**

5. Care Opinion and NHS Website feedback

5.1. The Care Opinion and NHS Website are independent healthcare feedback websites whose objective is to promote honest and meaningful conversations about patient experience between patients and health services.

5.2. This quarter a total of 31 comments were received, of which 64.5% (20) of the overall total number received were positive. Negative comments equated to 19.4% (6) of the overall total received this quarter. The number of Care Opinion and NHS Website comments by category; positive, negative and mixed, are detailed in **Table 13**, Appendix 1.

5.3. All NHS Website and Care Opinion comments are received by the Patient Experience Team (PET) and shared with the relevant Hospital/MCS/LCO. Responses are required for publication within 5 working days. Within each Hospital/MCS/LCO designated staff support the provision of a response to the PET. The PET ensures that responses are quality assured prior to on-line posting. **Table 14** below provides two examples of the feedback received and the subsequent responses posted on Care Opinion and NHS Website during Q4.

Table 14: Examples of Care Opinion/ NHS Website Postings and Reponses Quarter 4, 2020/21

Quarter 4, 2020/21
Wythenshawe Hospital
"Professional, Methodical Care" The Asthma team (nurses, doctors, reception staff, support workers) have been absolutely excellent with my care over the last 12 months - life changing. The professional, methodical, structured, timely and caring manner has been a delight. I have been to two other hospitals on the route to being fixed - both very good - but Wythenshawe have been on a different level. In my view, they should be the blueprint / benchmark on how healthcare is administered. Thank you very much.

Response

Thank you for your positive comment posted on the NHS website regarding the care you received by the Asthma Team 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 their hard work, professionalism and caring approach. It was wonderful to read the excellent care you received from all the nurses, doctors, reception staff and support workers throughout your experience. I can assure you that we have passed on your feedback to the Director of Nursing who will share this with the staff in the department.

University Dental Hospital of Manchester

"Change of procedure"
Visited the hospital with my elderly mother. Staff/service excellent as always. I was informed at the hospital that I could not go in with her due to new procedure to allow patient only to enter regarding Covid rates increasing. Fully understand and accept this but disappointed not to be told of this earlier and to be told that hospital not putting this new restriction on letters/emails being sent to patients. Spent a cold hour outside waiting for her as nowhere to go for coffee etc.

Response

We are very sorry to receive your comments and concerns via the NHS Website about your experiences in January 2021. Unfortunately, due to the Covid pandemic we have had to implement additional safety measures to keep both our patients and staff safe. The limited waiting space within the hospital and the requirement of social distancing measures, this has resulted in the Dental Hospital being unable to accommodate relatives/escorts accompanying patients to their appointments. We do have a Covid information leaflet for patients which is sent out with all appointment letters. However, we have been made aware that since we have transferred to a Central Trust printing resource, the information leaflet has not been sent out with the appointment letters. We would like to sincerely apologise for this and for the inconvenience this caused you when attending the hospital with your mother. We are in the process of getting this issue resolved to ensure that our patients are fully aware of the current restrictions we have in place.
If you would like to discuss your experience with us in more detail, please do not hesitate to contact our Patient Advice and Liaison Service (PALS) on 0161 276 8686 or by e-mailing pals@mft.nhs.uk

Manchester Royal Infirmary

"Very good treatment at Manchester Royal Infirmary Acute Cardiac Centre"
In March 2021 I woke up with chest pains. Having had a previous suspected heart attack, and with a history of cardiovascular disease in my family I was worried. I called 111 and they summoned an ambulance. From there my care was quick, seamless, caring and very efficient. I was through Accident and Emergency speedily and soon having a cardiogram before even the blood tests had been analysed.
I was transferred in the early evening to a bed in the Acute Cardiac Centre. The nurses were excellent. Next morning the consultant and his team came around. They listened carefully to me. They thought it might be the less serious condition of pericarditis and ordered further tests and examinations such as an echocardiogram and an X-ray.
By late afternoon they had made the difficult differential diagnosis of pericarditis, and I was soon discharged. Congratulations to all concerned!

Response
Thank you for your positive comments posted on the NHS website regarding the care you received at the Acute Cardiac Centre, Manchester Royal Infirmary. We are pleased to read that you were treated seamlessly and with care by our staff, and the nurses were excellent throughout your experience. It is important to us that you had been listened to carefully. We are sincerely grateful for you taking the time to share this feedback and we can assure you that we have passed on your thoughts to the Head of Nursing who will share your comments with the staff involved at the Acute Cardiac Centre. We wish you all the best in your recovery.
Saint Mary's Hospital
"Excellent from start to finish" I arrived at 7am to have my surgery and I was greeted by a lovely nurse and taken to a room. Here I met the surgeon and the anaesthetist who explained everything and put my mind at ease. I was put on a ward at 9.30 then was taken down to surgery at 10.30. All the staff I met were lovely and really helped put my mind at ease, as this was my first time being put to sleep. I went into theatre where they put me to sleep and the next thing, I knew I was waking up in the recovery room. The only thing I would like to suggest is that when a patient has just come round from surgery, the surgeon should tell the nurse or write down what they did as they told me when I woke up and I can't remember what they said due to just coming round. Overall service was outstanding and very professional. I would recommend this hospital/ward to everyone.
Response
Thank you for your positive comments posted on the NHS Website regarding your care in the Gynaecology Services at Saint Mary's Hospital. It was very kind of you to take the time to write and compliment the staff as it is good to receive positive feedback which reflects the hard work and dedication of our staff. The Trust has introduced a behavioural framework within which all members of the nursing and medical teams' practice, so it was reassuring to read that you found both medical, nursing and support staff caring, supportive and professional and that your experience has been a positive one. I can assure you that we have passed on your feedback to the Clinical Head of Division for Gynaecology and Head of Nursing who will be delighted to share your feedback with the staff involved. We would like to take this opportunity to wish you well for the future.

6. Learning from Complaints: Service Improvements

6.1 The Trust is committed to continuous learning from complaints, which is reflected in service improvements. This section of the report provides examples of improvements made in response to feedback via complaints.

6.2 **The Complaints Scrutiny Group**, which is chaired by a Non-Executive Director, met once during Q4, 2020/21. The management teams from WTWA presented two cases at the meeting in March 2021. As a result of the 3rd wave of the Covid-19 pandemic a decision was made to stand down January's meeting to release time to support the pandemic response. The learning identified from the two cases that were presented in March 2021 along with the actions discussed and agreed at the meetings is outlined in **Table 15**. Transferable learning from complaints is identified and shared through this group.

Table 15: Actions identified at the Trust Complaints Scrutiny Group during Q4, 2020/21.

Hospital/MCS /LCO	Learning	Actions
WTWA (Medicine)	Communication breakdown with the medical team when the patient is re-admitted	• Develop process of reviewing discharge checklist
	Timely administration of time specific medications	• Undertaking of audit monitoring and education
	Multiple ward moves - impact moves had on patient's care	• A review and improvement of communication standards between the Bed Managers and Clinicians to be undertaken
	Discharge Planning - patient re-admitted 1/52 following discharge – failed discharge	• Staff on Ward A2 to undertake pre-discharge blood glucose monitoring training • With the support of Clinical Governance explore patients bringing in their own blood glucose equipment to hospital
	Junior staff in attendance at a complaint local resolution meeting (CLRM - Unknown CLRM) procedure/expectations - Senior support not sought as part of CLRM	• Explore stress inoculation therapy (SIT) for staff attending CLRM's • Explore mediators chairing the CLRM's • Explore and develop Complaints Meeting Training - 'Effective Complaint Local Resolution Meetings – Expectations and best practice for staff'
WTWA (Heart & Lung)	Disjointed communications between the family, Hospital Complaints Investigating team and the MCS High Level Investigating (HLI) team	• Explore and develop process for undertaking combined complaint investigations and HLI's across multi Hospital/MCS/LCO boundaries • In-conjunction with developing triangulation process for complaint investigations and HLI's, review and develop clear processes for the role of the Family Liaison Officer (FLO) where there is multi hospital/MCS/LCO involvement • Review of how the HLI findings are shared with families

6.3 Detailed below, in **Table 16** are some examples of how learning from complaints has led to changes and been applied in practice.

Table 16: Examples of the application of learning from complaints to improve services, Q4, 2020/21

Hospital/ MCS/LCO	Reason for complaint	Action Taken
RMCH	Concerns regarding whether surgery was necessary and could have been avoided.	Change in practice ensuring all patients are reviewed prior to listing for surgery by an ophthalmologist and physiotherapist. Concern shared and discussed with consultant colleagues.
MREH	Patient details communicated to incorrect GP.	Concern shared and discussed with staff emphasising the importance of correct patient identification being gained and held on the hospital patient administration system.
UDHM	Patient discharged before completion of course of treatment.	The importance of reviewing the patient's treatment plan prior to discharging patients back to their General Dental Practitioner (GDP) discussed with the clinicians. Clinicians to be reminded of the importance of clear communication with patient at all time during the patient's journey.
CSS **(Critical Care)**	Poor communication, breach of patient's data and dignity following death	Concerns shared and Consultant supported staff in reflecting on the events leading to the complaint and discussed how communication could have been improved when delivering sensitive information. Learning Review undertaken to identify area to enable confidential handovers to take place. Enhance process of documentation handover to the medical team emphasising the responsibility and safe keeping of sensitive information. Nursing staff supported in reflecting on the delivery of difficult and sensitive information being provided. Staff to attend the Trust's Customer Care study day.

		All staff reminded of the importance of ensuring annual mandatory Information Governance training is kept up to date.
CSS **(Imaging)**	Appointment delay and patient's wellbeing affected due to non-compliance of Covid measures in the waiting room centre	Compliance monitoring process developed and implemented in the waiting areas. Review undertaken of 'Computer Downtime' Policy and amendments introduced regarding 'issues that may cause a delay in patients being seen'.
MRI **(In-Patient Medical Services)**	Attitude of nursing staff on the ward, communication and lack of privacy and dignity	A programme of Malnutrition Universal Screening Tool (MUST) Audits implemented to check appropriate nursing care is being provided. MUST Audit results to be shared at the Trust's Quality and Safety meeting. Concerns shared anonymously with nursing and medical staff at the ward team meeting. In order to enhance patient experience a 'Discharge Improvement' project is being developed and undertaken. Lessons learned from the project will be shared and integrated across all services within MRI. Nursing Staff to undertake Caring for Patients on Palliative Care and at End of Life training.
WTWA	Disempowerment of an 'expert patient' upon hospital admission	Nursing Staff to undertake self-administration of medication and diabetes management training. Additional one to one clinical educator provision to support communication, managing changing priorities and other identified competencies. Concerns shared anonymously with staff.

		Nursing staff to undertake training in the Management of Sliding Scales and Management of Diabetes. A ketone meter (small device which can be used in-conjunction with a blood glucose monitoring meter to detect deterioration) now available on the ward for patients with diabetes to use as required. Pharmacy Review to be undertaken of self-administration of medication on the unit.

Quality Improvements

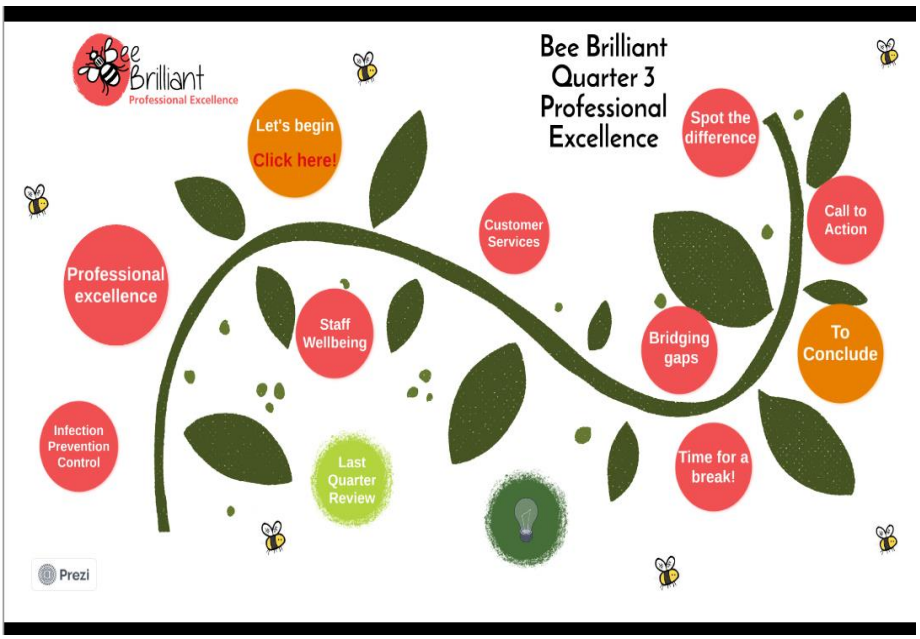
6.4 Improvement activities during Q4, 2020/21 included:

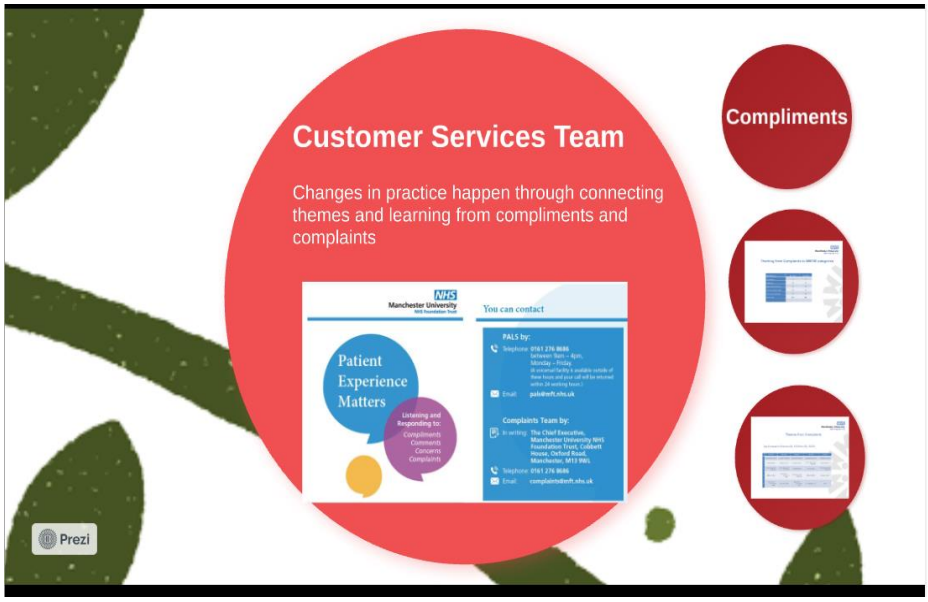
- **In-house E-Learning Customer Service – PALS and Complaints package:**

  Completion and initial quality assurance checks of Module 1 were undertaken in Q4. Launch of the e-learning education package on the MFT learning hub is planned for Q1, 2021/22.

- **Listening to complainant feedback: Enhancing how MFT demonstrates learning across the Hospitals/MCS/LCO:**

  During this quarter an aspect of the Trust's Bee Brilliant event: 'Professional Excellence' focused on Customer Services with themes and changes in practice from complaints being showcased to provide staff with the understanding that:
  - Complaints are a learning opportunity to support the Hospitals/MCS/LCOs to improve patient experience;
  - By applying categorisation and theming to a complaint, the Trust can improve the quality of care where themes emerge and practice is identified as requiring improvement.





- **Internal Audit 2020/21: Complaints Handling**

  Following an internal audit to provide assurance that the Trust's policies and processes for responding to patient complaints are appropriately designed in Q3, the findings and improvement plan were presented to the Quality and Safety Committee in Q4.

  The audit involved a review of a sample of 25 patient complaints received between 1st October 2019 and 30th September 2020 (5 complaints each from MRI and WTWA to reflect the higher volume of patients and complaints they receive overall. The remaining 15 complaints were split evenly between the remaining Hospitals/MCSs/LCO).

For each complaint in the sample the audit tested:

- The design of the local complaints process and how they linked in to the overall Trust Complaints Policy.
- Whether the complaint had been handled in line with both, including meeting all relevant timescales for acknowledgements and responses;
- Whether each Hospital/MCS/LCO could demonstrate throught its response that it acted in line with the Patients Associations Guidelines for Complaints Handling (namely the response was open and transparent, evidence-based, logical and rational, timely and expeditious);
- How Hospitals/MCSs/LCO work with the Corporate Complaints team to manage complaints responses, including the setting up of local resolution meetings; and
- How lessons learned from complaints were collated and shared throughout the Trust.

Audit findings:

- Positive Assurance rating of "Significant assurance with minor improvement opportunities".
- 8 low priority (good practice that would achieve better outcomes) recommendations.
- Appropriate design controls are place in relation to complaints handling for the areas tested.
- Respones were of a high quality and written in an appropriate tone.
- Lessons learned from complaints were sufficiently circulated.
- Processes and controls operate effectively with some minor exceptions
  - responses to complaints not being sent within the timesframes agreed in the Trust Policy
  - complainants not being made fully aware of the support available to them
  - complaint satisfaction surveys not being sent out to complainants once the case closed.

Next Steps:

- In order to improve the existing standards and reach the given targets, in Q4 a Complaints Audit Action Plan was developed and implemented. The action plan will be undertaken during the next 3 months and will involve the Corporate Complaints team and each Hospital/MCS/LCO taking steps to implement the 8 low priority recommendations.

- **PHSO Research: Frontline Complaint Handling – 'Complaints Standards Framework for NHS Staff'**

  In Q4 the PHSO announced the pilot launch of the NHS Complaint Standards with the Complaints Standards being made live on their website https://www.ombudsman.org.uk/complaint-standards

  The next phase for the PHSO will be the testing of the Standards within NHS pilot sites over the next year. The PHSO anticipates upon completion of this phase, that introduction of the Standards will happen across the NHS in 2022.

- **Standard Operating Procedures (SOPs):**

  In response to a formal restructure of the Trust's Corporate PALS and Complaints Service, which is due to be implemented in Q1, 2021/22, as planned during this quarter, a full review of standard operating procedures (SOP) and letter templates commenced in Q4 and will be completed in Q1.

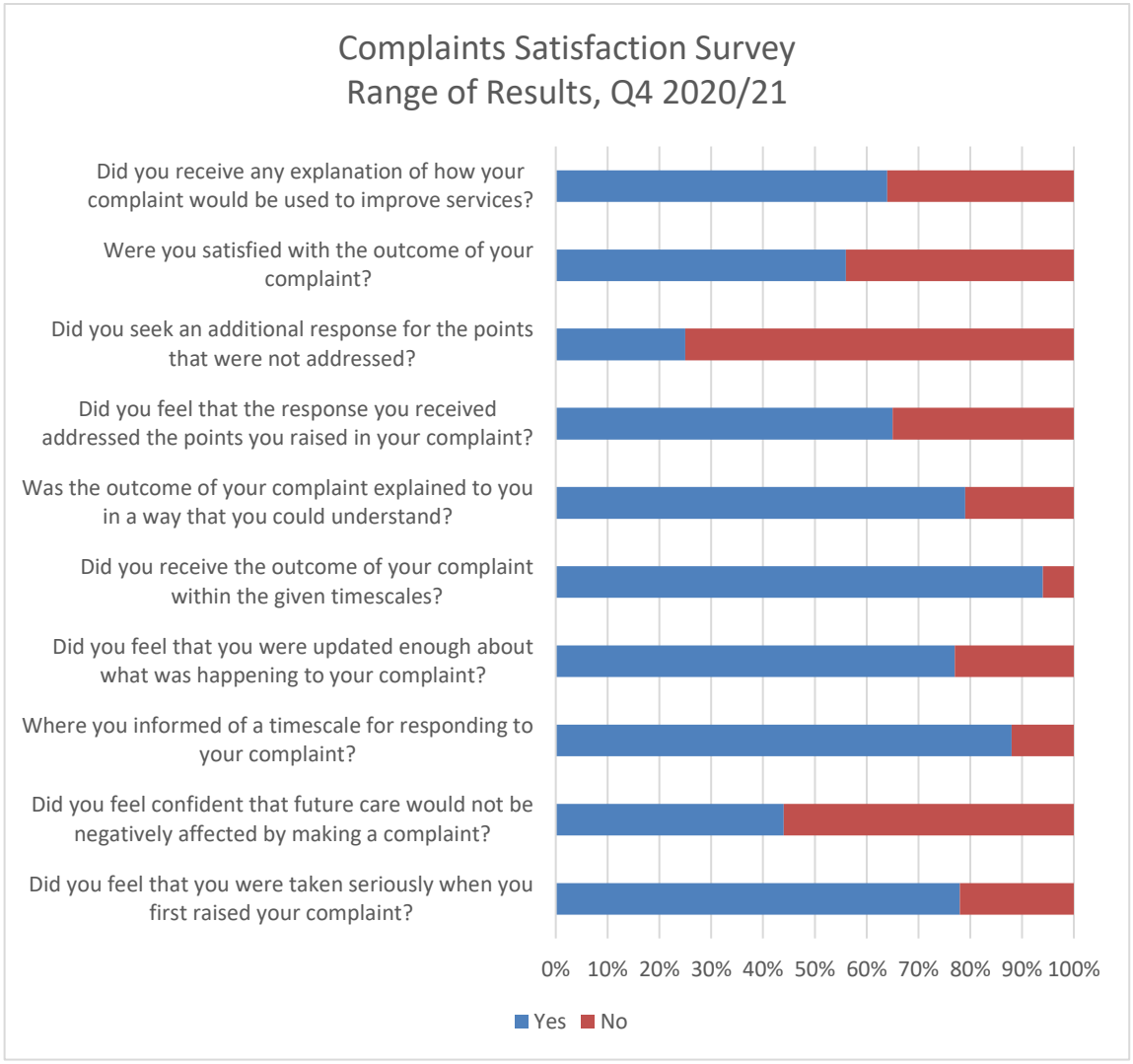
  Existing SOPs and letter templates will be used to support the ongoing work in developing a 'Complaint Handling Procedure and Template Implementation Plan', which will in turn provide the Customer Services team with a clear operating framework.

Complainant's Satisfaction Survey

6.5 Based on the ***'My Expectations'***[1] paper, the Trust complaint's satisfaction survey has been developed by the Picker Institute. It is sent to complainants across all MFT Hospitals/MCS/LCOs. During this quarter 253 surveys were sent to complainants. 18 questionnaires were completed this quarter and the range of results from completed questionnaires in Q4, 2020/21 are shown in **Graph 10.** These results identify an increase in complainants receiving the outcome of their complaint within the given timescales.

Graph 10: Range of complaints satisfaction survey results for Q4, 2020/21

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


Complaints Satisfaction Survey
Range of Results, Q4 2020/21
Did you receive any explanation of how your complaint would be used to improve services?
Were you satisfied with the outcome of your complaint?
Did you seek an additional response for the points that were not addressed?
Did you feel that the response you received addressed the points you raised in your complaint?
Was the outcome of your complaint explained to you in a way that you could understand?
Did you receive the outcome of your complaint within the given timescales?
Did you feel that you were updated enough about what was happening to your complaint?
Where you informed of a timescale for responding to your complaint?
Did you feel confident that future care would not be negatively affected by making a complaint?
Did you feel that you were taken seriously when you first raised your complaint?
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Yes
No

6.6 Listening to complainant feedback allows MFT staff to use the feedback to improve the standard of care and service provided. As detailed above in Section 6.2, a focus on complainant feedback and learning will be integral to planned improvements over the coming year. Comments received during Quarter 4, 2020/21 include the following:

Planned Improvements

6.7 Improvement priorities for Q1 include the following activities:

- Implementation of the new Corporate Complaints and PALS structure and patterns of working to deliver an enhanced, responsive and compliant PALS and Complaints Service across MFT.
- Review and update of PALS and Complaints content on internal and external website. Standard Operational Procedures (SOPs): On-going development and review of SOPs.
- Commencement of the delivery of a North Manchester General Hospital Corporate PALS and Complaints service.
- Continuation of enhancement of the demonstration of learning in practice.
- Review of Complaints and Incidents pathways to continuously improve services, ensuring a person-centred approach.
- Continuation of Quality Control of the complaint 'acknowledgement' process; including development of complaint questions and the outcomes sought by the complainant.
- Development of Module 2 of the specifically tailored e-learning Customer Service package and finalisation of Module 1.
- Continue to encourage all Hospitals/MCS/LCOs to participate in the Complaint Response Letter Quality Standards Audit.

7. Equality and Diversity Monitoring Information

7.1 The collection of equality and diversity data is shown in **Table 17,** Appendix 1. As in previous quarters it is evident that the collection of this information has remained inconsistent.

7.2 This quarter, as in the previous quarter, good compliance was found with regard to 'gender' data (99%) and 'ethnicity' data (77.2%); however, the need to improve 'disability' and 'religion' remained evident with only 3.3% and 20.7% being received respectively.

7.3 A departmental Equality and Diversity Checklist has been developed and introduced in Q4, which will be completed upon complainants making contact with the Corporate PALS and Complaints teams. This will ensure that complainants have been informed of their right to support with their 'religion' and/or 'disability' status and in addition provides staff with a valuable tool in obtaining this important information.

Information required when registering a PALS case

Information Required	Tick Yes or No	Related Information
Name of Complainant and/or Patient	Yes ☐ No ☐	
Demographics of Complainant and/or Patient	Yes ☐ No ☐	
Patient Date of Birth	Yes ☐ No ☐	
Patient Hospital Number/NHS Number	Yes ☐ No ☐	
Complainant and/or Person Type	Yes ☐ No ☐	
Complainant and/or patient Telephone Number	Yes ☐ No ☐	
Complainant and/or Email address (if applicable)	Yes ☐ No ☐	
Complainant relationship to patient, if applicable. This information to be placed in the 'previous surname' field	Yes ☐ No ☐	
If patient deceased, date of death to be inputted	Yes ☐ No ☐	
Equality Monitoring data collection to include: • Ethnicity • Gender • Religion/belief • Disability • If yes, type of disability • Special requirements – such as large font	Yes ☐ No ☐	

A further audit to measure the outcome of the checklist will be undertaken during Q1, 2021/22.

8. Conclusion and recommendations

8.1 This report provides a concise review of matters relating to Complaints and PALS during Q4. Opportunities for learning and service improvement have continued to be identified, and this report has provided highlights of where this has and will take place.

8.2 In conclusion, the Trust will:

- Continue to monitor complaint response timescales against expected response timescales, providing support to Hospitals/MCS/LCOs when required.
- Continue to review and embed recommendations from National Guidance within MFT's policies.
- Continue to learn from complaints and concerns raised.
- Continue to progress the improvements outlined in this report.

8.3 Members of the Board of Directors are asked to note the content of this Q4 Complaints Report and the on-going work of the Corporate and Hospital/MCS/LCO teams to ensure that the Trust is responsive to concerns raised and learns from patient feedback in order to continuously improve the patient's experience.

Appendix 1 – Supporting information

Table 1: Overview of PHSO Cases open as at 31st March 2021

Hospital/ MCS/ LCO	Cases/s	PHSO Investigation Progress
CSS (1)	1	Awaiting Provisional Report
MRI (3)		
Cardiovascular Specialty	1	Awaiting Final Report
Cardiovascular Specialty	1	Awaiting Provisional Report
GI Medicine & Surgical Specialty	1	Awaiting Provisional Report
WTWA (5)		
Surgery (Orthopaedics)	1	Awaiting Provisional Report
Surgery (Orthopaedics)	1	Awaiting Provisional Report
Heart & Lung (Cardiology)	1	Awaiting Provisional Report
Surgery	1	Awaiting Provisional Report
Surgery (Lung Cancer &Thoracic)	1	Awaiting Provisional Report
TOTAL	9	

Table 2: Number of PALS concerns received by Hospital/ MCS/ LCO Quarter 4, 2019/20 to Quarter 4, 2020/21

	Q4,19/20	**Q1,20/21**	**Q2,20/21**	**Q3,20/21**	**Q4,20/21**
WTWA	429	221	360	389	382
MRI	410	219	365	434	433
RMCH	153	52	115	128	137
UDHM/MREH	134	70	104	84	126
SMH	136	98	148	203	224
CSS	72	37	94	99	74
Corporate	61	48	50	58	54
LCO	11	10	34	24	14
R&I	3	0	2	3	1
Nightingale NW (NNW)	n/a	0	0	2	4
Grand Total	**1409**	**755**	**1272**	**1424**	**1449**

Table 3: Closure of PALS concerns within timeframe Quarter 4, 2019/20 to Quarter 4, 2020/21

	Q4,19/20	**Q1,20/21**	**Q2,20/21**	**Q3,20/21**	**Q4,20/21**
Resolved in 0-10 days	1227	697	1095	1346	1336
Resolved in 11+ days	214	52	96	112	148
% Resolved in 10 working days	**85.1%**	**93.1%**	**91.9%**	**93.0%**	**90.0%**

Table 4: Number of PALS concerns taking longer than 10 days to close by Hospital/MCS/LCO Quarter 4, 2019/20 to Quarter 4, 2020/21

	Q4, 19/20	Q1,20/21	Q2,20/21	Q3,20/21	Q4,20/21
WTWA	53	18	25	18	26
MRI	53	15	29	40	43
RMCH	26	0	4	8	17
UDHM/MREH	15	2	4	7	5
SMH	23	9	16	22	36
CSS	6	3	3	9	9
Corporate	21	2	5	7	6
LCO	1	0	6	1	5
R&I	0	0	0	0	0
NNW	0	0	0	0	1
Grand Total	**198**	**49**	**92**	**112**	**148**

Table 5: Number of PALS concerns escalated to formal investigation Quarter 4, 2019/20 to Quarter 4, 2020/21

	Q4,19/20	Q1,19/20	Q2,20/21	Q3,20/21	Q4,20/21
No of cases escalated	11	3	8	10	10

Table 6: Number of Complaints received by Hospital/ MCS / LCO Quarter 4, 2019/20 to Quarter 4, 2020/21

	Q4,19/20	Q1,19/20	Q2,20/21	Q3,20/21	Q4,20/21
WTWA	113	59	81	86	91
MRI	105	37	83	78	83
SMH	50	16	46	49	49
RMCH	53	21	33	25	32
CSS	28	11	23	14	19
UDHM/MREH	22	5	8	16	10
Corporate	20	11	9	11	13
LCO	17	6	15	11	6
NNW	0	0	0	0	0
Grand Total	**408**	**166**	**298**	**290**	**303**

Table 7: Complaints Acknowledgement Performance

3 Day Target	Q4, 19/20	Q1, 20/21	Q2, 20/21	Q3, 20/21	Q4, 20/21
100% acknowledgement	100%	100%	100%	100%	100%

Table 8: Comparison of complaints resolved by timeframe: Quarter 4, 2019/20 to Quarter 4, 2020/21

	Q4, 19/20	Q1,20/21	Q2,20/21	Q3,20/21	Q4,20/21
Resolved in 0-25 days	296	120	178	270	244
Resolved in 26-40 days	56	49	20	22	17
Resolved in 41+ days	76	77	51	49	40
Total resolved	**428**	**246**	**249**	**341**	**301**
Total resolved in timescale	363	171	227	322	282
% Resolved in agreed timescale	**84.8%**	**69.5%**	**91.2%**	**95.3%**	**93.7%**

Table 9: Outcome of Complaints, Quarter 4, 2019/20 to Quarter 4, 2020/21

Number of Closed Complaints		Upheld	Partially Upheld	Not Upheld	Information Request	Consent Not Received	Complaint Withdrawn	Out of Time
Q4,20/21	301	26	191	69	4	9	2	0
Q3,20/21	340	56	189	79	7	7	1	2
Q2,20/21	249	37	146	56	6	3	1	0
Q1,20/21	246	26	157	55	8	0	0	0
Q4,19/20	428	79	245	88	16	0	0	0

Table 10: Further Complaint Correspondence by Hospital/MCS/LCO Quarter 4, 2020/21

	Request for local resolution meeting	New questions raised as a result of information provided	Response did not address all issues	Dissatisfied with response	TOTAL
WTWA	1	0	12	4	17
MRI	0	1	12	9	22
SMH	0	0	1	3	4
CSS	0	0	5	0	5
RMCH	0	1	1	0	2
UDHM/MREH	0	1	0	0	1
Corporate	0	0	1	1	2
LCO	0	0	2	1	3
NNW	0	0	0	0	0
Grand Total	**1**	**3**	**34**	**18**	**56**

Table 13: Care Opinion/NHS website postings by Hospital/ MCS / LCO in Q4, 2020/21

Number of Postings received by Hospital/MCS/LCO/Corporate Service Q4 20/21			
Hospital/ MCS /LCO	**Positive**	**Negative**	**Mixed**
MRI	**6**	**2**	**2**
WTWA	**9**	**1**	**1**
CSS	**0**	**0**	**0**
Corporate	**0**	**0**	**0**
UHDM/MREH	**2**	**0**	**1**
LCO	**0**	**0**	**0**
RMCH	**0**	**1**	**0**
SMH	**3**	**2**	**1**
Grand Total	**20 (64.5%)**	**6 (19.4%)**	**5 (16.1%)**

Table 17: Equality and Diversity Monitoring Information

	Q4,19/20	Q1,20/21	Q2,20/21	Q3,20/21	Q4,20/21
Disability					
Yes	33	12	21	12	6
No	52	18	6	8	4
Not Disclosed	323	137	272	270	293
Total	**408**	**167**	**299**	**290**	**303**
Disability Type					
Learning Difficulty/Disability	3	0	1	0	1
Long-Standing Illness or Health Condition	17	7	10	15	8
Mental Health Condition	2	0	0	5	2
No Disability	0	0	0	0	0
Other Disability	1	0	2	0	3
Physical Disability	9	3	4	3	2
Sensory Impairment	1	1	1	2	1
Not Disclosed	375	156	281	265	286
Total	**408**	**167**	**299**	**290**	**303**
Gender					
Man (Inc Trans Man)	180	73	123	115	124
Woman (Inc Trans Woman)	225	90	172	167	176
Non-Binary	0	0	0	0	0
Other Gender	0	0	0	1	0
Not Specified	2	3	4	7	3
Not Disclosed	1	0	0	0	0
Total	**408**	**166**	**299**	**290**	**303**

Sexual Orientation					
Heterosexual	82	28	65	64	56
Lesbian / Gay/Bi-sexual	4	0	2	2	2
Other	2	0	0	0	3
Do not wish to answer	0	0	2	0	0
Not disclosed	320	139	230	224	242
Total	**408**	**167**	**299**	**290**	**303**
Religion/Belief					
Buddhist	0	0	0	0	1
Christianity (All Denominations)	52	17	39	36	40
Do Not Wish to Answer	0	0	3	3	1
Muslim	5	1	1	3	6
No Religion	24	10	24	18	13
Other	7	2	1	2	0
Sikh	1	0	1	0	0
Jewish	0	1	0	2	0
Hindu	0	0	0	1	1
Not disclosed	319	136	228	234	240
Humanism	0	0	1	1	1
Paganism	0	0	1	0	0
Total	**408**	**167**	**299**	**290**	**303**
Ethnic Group					
Asian Or Asian British - Bangladeshi	1	0	0	1	1
Asian Or Asian British - Indian	4	1	4	4	5
Asian Or Asian British - Other Asian	2	1	2	2	0
Asian Or Asian British - Pakistani	9	3	9	6	15
Black or Black British – Black African	7	6	2	4	6
Black or Black British – Black Caribbean	7	3	5	2	2
Black or Black British – other Black	0	1	0	1	1
Chinese Or Other Ethnic Group - Chinese	1	0	1	1	0
Mixed - Other Mixed	0	0	0	5	2
Mixed - White & Asian	2	1	1	2	1
Mixed - White and Black African	0	0	1	0	1
Mixed - White and Black Caribbean	1	2	2	1	2
Not Stated	101	28	48	54	65
Other Ethnic Category - Other Ethnic	3	1	2	2	4
White - British	181	75	121	116	122
White - Irish	4	4	3	7	3
White - Other White	9	4	11	5	4
Not disclosed	76	37	87	77	69
Total	**408**	**167**	**299**	**290**	**303**

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Anne-Marie Varney, Acting Corporate Director of Nursing Jenny Halse, Acting Assistant Chief Nurse (workforce and education) Karen Sutcliffe, Lead Nurse Post-Registration Education & Development
Date of paper:	April 2021
Subject:	Nursing and Midwifery Revalidation Annual Report 2020/21
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust Vision &Values and Key Strategic Aims:	1. Patient safety 2. Patient experience 3. Productivity and efficiency
Recommendations:	The board are asked to note the content of this paper and actions taken to support Nurses, Midwives and Nursing Associates across the Trust to meet the Nursing & Midwifery Council statutory revalidation requirement.
Contact:	Name: Anne-Marie Varney, Acting Corporate Director of Nursing Tel: 0161 276 8862

BOARD OF DIRECTORS

1. Introduction

1.1 This paper provides an annual overview of Nursing and Midwifery Revalidation at MFT, describing the current practice and assurance systems in place to support Nurses, Midwives and Nursing Associate meet the Nursing and midwifery Council's (NMC) revalidation requirements.

1.2 This paper reports in activity from 1st April 2020 to 31st March 2021 for MFT.

2. Background

2.1 Since April 2016, Nurses and Midwives have been required to undergo a three-yearly process of revalidation to demonstrate that their practice is in line with the Nursing and Midwifery Council (NMC) professional standards of practice for nurses, midwives and nursing associates[1].

2.2 All registrants receive formal notification from the NMC 60 days before their revalidation submission deadline. This enables the registrant to collate their portfolio of evidence which demonstrates they have met the requirements for revalidation. Confirmation that a registrant has met the required standard occurs through a standardised confirmation process set by the NMC by another NMC registrant.

2.2 It is the individual nurse, midwife and nursing associate's professional responsibility to ensure that they meet the revalidation standards. However, the Trust has a responsibility to support registrants in meeting revalidation requirements, thereby assuring that their practice is safe and effective.

3. Current Situation

3.1 Revalidation has been an essential requirement of nurses and midwives to meet their professional registration requirement since April 2016, it is now seen as "business as usual" in relation to the maintenance of professional registrations for this group of staff.

3.2 Each hospital/MCS have developed Revalidation Champions who work with the Professional Education and Development Team to ensure nurses and midwives are supported to complete their revalidation.

3.3 A monthly workforce report is generated from the NMC register for MFT staff; this is utilised to inform the assurance process in place. Revalidation champions are provided with data at key points throughout the month informing them of who is required to revalidate that month and progress to-date. The champions monitor and support at a local level, ensuring confirmation meeting are arranged and completed.

3.4 Corporately revalidation is monitored by the Professional Education and Development Team who escalate to the relevant Hospital/MCS Director of Nursing in a timely manner when non-completion of revalidation is pending.

3.5 If a member of staff fails to meet the revalidation requirement, their registration remains active for one month, prior to their registration expiring. In this situation the Trusts Professional Registration Policy would come into effect.

[1] Nursing and Midwifery Council (NMC), 2018, The Code: professional standards of practice for nurses, midwives and nursing associates

3.6 The first Nursing Associates qualified and registered with the NMC in January 2019; these members of the workforce will be subject to their first revalidation in January 2022. Support for this group is highlighted in the work programme for 2021/2022.

4. Revalidation Changes due to Covid-19

4.1 In view of the Covid-19 pandemic the NMC acknowledged that the pandemic could make it more difficult for registrants to meet revalidation requirements.

4.2 To support registrants during this period the NMC applied temporary changes to the revalidation process. These changes came into effect from March 2020. Nurses, midwives and nursing associates due to revalidate between this timeframe were automatically given a twelve-week extension. These changes remained in effect until March 2021.

4.2 For staff due to revalidate from April 2021 onwards, if they require an extension, they must individually apply to the NMC.

4.3 The Trust has put in place temporary assurance measures to monitor where extensions have been granted to ensure that revalidation compliance is maintained. Monitoring and escalation process remain unaffected.

5. Revalidation figures 1st April 2020 - 31st March 2021

5.1 The total number of the Trust's nursing and midwifery workforce who have revalidated with the NMC between the 1st of April 2020 -31st of March 2021 is **2128** out of a total number of 2136 staff. Of the staff who have not revalidated:-

- 6 staff members have resigned from the Trust
- 1staff member has retired from the Trust
- 1 staff member has remained within the Trust in a role that does not require NMC registration

6. 2021/22 Revalidation work programme

6.1 To support revalidation across MFT, the following priorities have been identified for 2021/2022:

- Provision for the Trust nursing associate workforce in preparation for their first revalidation, including provision of revalidation workshops, educational material and line manager support.
- Raising awareness to managers and confirmers regarding the requirement for nursing associates to revalidate from January 2022.
- Development of the Learning Hub to enable staff and managers to monitor continuing profession development (CPD) hours, upload learning activity and complete reflective learning logs. This will support staff with the CPD and reflective aspects of their revalidation.
- Work with leads at NMGH to align revalidation processes.

7. Conclusion

7.1 The Board of Directors are asked to acknowledge the content of this report and the identified actions for 21/22 to support revalidation for nurses, midwives and nursing associates across MFT.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Dr Sarah Vause, Medical Director, SMH MCS Mrs Kathy Murphy, Director of Nursing and Midwifery, SMH MCS Mary Hynes, Divisional Director, Obstetrics, SMH MCS Kathryn Chamberlain, Directorate Manager, Obstetrics, SMH MCS Daniel Davies, Innovation and Improvement Manager, SMH MCS
Date of paper:	April 2021
Subject:	NHS Resolution Maternity Incentive Scheme
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 improve patient safety, clinical quality and outcome • Improve the experience of patients, carers and families
Recommendations:	The Board is requested to accept the report and approve signing of the Board declaration by the Chief Executive
Contact:	Name: Mary Hynes, Divisional Director, Obstetrics Tel: 0161 701 0429

Board report:
Assurance against the standards for the Maternity Incentive Scheme Year 3 for Trusts

Purpose

This paper provides an update to the Board of Directors in relation the compliance with the third year of the Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme for Maternity Safety Actions. The scheme offers a financial rebate of up to 10% of the maternity premium for Trusts that are able to demonstrate progress against a list of ten safety actions.

This paper provides an assurance report for the Board of Directors that NHS Resolution (NHSR) Maternity Incentive Scheme (MIS) year 3 standards have been met.

It was agreed by NHSR that separate CNST submissions would be made for Saint Mary's Managed Clinical Service (SMH MCS) and North Manchester General Hospital (NMGH) to reflect the separation of the two organisations for much of the MIS year three reporting period. Two separate reports for Saint Mary's MCS and for NMGH have been provided to the Board of Directors to provide assurance for each submission to NHSR.

Background

Obstetric incidents can be catastrophic and life-changing, with related claims representing the scheme's biggest area of spend. Of the clinical negligence claims notified to CNST in 2019/20, obstetrics claims represented nine per cent (1,015) of clinical claims by number but accounted for 50 per cent of the total value of new claims; almost £2.4 billion.

The Maternity Safety Strategy sets out the Department of Health and Social Care's ambition to reward those who have taken action to improve maternity safety. This work is supported through the maternity incentive scheme. NHS Resolution (NHSR) manages the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to support the delivery of safer maternity care. The scheme for 2020/21 builds on previous years to evidence both sustainability and ongoing quality improvements. The safety actions described are considered to be a contributory factor to achieving the national ambition of reducing stillbirths, neonatal deaths, perinatal morbidity and maternal deaths by 50 % by 2025. As in previous years Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund (which is 10% of their premium) and will also receive a share of any unallocated funds.

There are 10 safety actions to be achieved with a total of 128 standards which need to be evidenced in order to be fully compliant. It is anticipated that a number of the actions will be subjected to external validation as they involve electronic submission to national databases such as PMRT, MBRRACE, NHS Resolution and the Maternity Services Dataset.

Pause and Re-launch and Revised Guidance from NHSR

The ten safety actions for year three of the scheme were first published by NHSR on 23rd December 2019 but were subject to change as a direct result of the Covid-19 pandemic. Safety remained paramount however, after a pause on the scheme during the first wave of the pandemic, NHSR relaunched the Scheme on the 1st October 2020. There were updates to the scheme with the final version in March 2021 and a submission deadline of 15th July 2021. This relaunched Scheme included the addition of elements aiming to ensure key learning from important emerging Covid-19 themes were considered and implemented.

Ockenden Report

Following the publication of Donna Ockenden's first report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust on 11th December 2020, NHS England and Improvement (NHSE & I) mandated that all Trusts providing maternity services should proceed to implement the full set of the Ockenden Immediate and Essential Actions (IEAs).

The Board of Directors received assurance reports from Saint Mary's MCS in January 2021 and March 2021 in response to the Ockenden IEAs. Saint Mary's have cross referenced the MIS year 3 safety actions which inform and support the Trust response to the seven Ockenden IEAs

North Manchester General Hospital (NMGH)

As part of the ambition to provide a Single Hospital Service for the City of Manchester and Trafford, North Manchester General Hospital (NMGH) joined MFT on 1st April 2021. In 2019/20 North Manchester General Hospital reported as a combined organisation with Pennine Acute Hospital Trust. The service demonstrated full compliance against all 10 of the safety actions. It was agreed by NHSR that separate CNST submissions would be made for Saint Mary's MCS and NMGH to reflect the separation of the two organisations for much of the MIS year three reporting period.

Conclusion

The declaration form for NHSR must state that the Board of Directors is satisfied that the evidence provided demonstrates compliance with the ten MIS safety actions. Saint Mary's MCS have provided two full assurance reports to the Board of Directors with the evidence and compliance against the ten safety actions for Saint Mary's MCS and for NMGH

MIS year 3 Safety Action	SMH MCS	NMGH
Safety Action 1	Achieved	Achieved
Safety Action 2	Achieved	Achieved
Safety Action 3	Achieved	Achieved
Safety Acton 4	Achieved	Achieved
Safety Action 5	Achieved	Achieved
Safety Action 6	Achieved to date. Still in reporting period	Achieved to date. Still in reporting period
Safety Action 7	Achieved	Achieved
Safety Action 8	Achieved	Achieved
Safety Action 9	Achieved	Achieved
Safety Action 10	Achieved	Achieved

The maternity service can demonstrate full compliance against all ten safety actions and has included the relevant and appropriate evidence.

Recommendation

The Board is requested to accept the report and approve signing of the Board declaration by the Chief Executive.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce and Corporate Business
Paper prepared by:	Alwyn Hughes, Trust Board Secretary
Date of paper:	April 2021
Subject:	MFT Board of Directors' Register of Interests (April 2021)
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Assurance • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	The MFT *'Constitution'* and *'Standing Orders for the Practice & Procedure of the Board of Directors'* requires the Board of Directors to provide a Register of Interests.
Recommendations	The Board is asked to note the MFT Board of Directors' Register of Interests (April 2021)
Contact	Name: Alwyn Hughes, Trust Board Secretary Tel: 0161 276 4841

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS

Board of Directors' Register of Interests

April 2021

1. Introduction

The Board of Directors, in line with the MFT constitution and standing orders, is required to make a declaration of its register of interests.

The register has to include details of all directorships and other relevant and material interests which have been declared by both Executive and Non-Executive members.

The Register is available to the public on the MFT Public Website:

https://mft.nhs.uk/the-trust/the-board/register-of-directors-interests/

2. Recommendation

The Board is asked to note the MFT Board of Directors' Register of Interests (April 2021).

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS

REGISTER OF DIRECTORS' INTERESTS

(April 2021)

BOARD OF DIRECTORS

REGISTER OF INTERESTS – April 2021

NAME	POSITION	INTERESTS DECLARED
Kathy Cowell OBE DL	Group Chairman	• Chair of the Manchester Health Academy Trust Board • Non-Executive Director PAHT • Member Manchester Academic Health Science Centre • Vice Chair Cheshire Young Carers • Mentor on the Aspirant Chairs Programme (NHSI) • Member of the QVA's mentoring panel (Cheshire) • Chairman of Totally Local Company • Deputy Lieutenant for Cheshire • Chairman of the Hammond School (Chester) • People Ambassador for Active Cheshire
Barry Clare	Group Deputy Chairman	• Partner (Clarat Partners LLP) • Partner (Clarat Healthcare LLP) • Chairman (Vantage Diagnostics Ltd) • Non-Executive Director (Ingenion Medical Ltd) • Chairman (Crescent OPS Ltd) • Chairman (FLOBACK Ltd) • Chairman Evgen Pharma PLC • Non-Executive Chairman of Porton Biopharma Ltd • Non-Executive Chairman (Ori Biotech) • Non-Executive Director (Arterius Ltd)

NAME	POSITION	INTERESTS DECLARED
Dr Ivan Benett	Group Non-Executive Director	• Standing member of a NICE Quality Standards Committee and Topic Specific Guideline Update Committee • Director of the Primary Care Cardiology Society • Salaried GP with Heart Network (Manchester) • Trustee to the Hideaway Youth Project
John Amaechi OBE	Group Non-Executive Director	• Founder, APS Intelligence (APS Intelligence Ltd, London) • Non-Executive Director, KPMG UK LLP Inclusive Leadership Board (ILB) • Non-Executive Director, Greencore Group PLC • Senior Fellow, Applied Centre for Emotional Literacy, Learning and Research (ACELLR), USA • Professional Member, European Mentoring & Coaching Council • Member, BPS Division of Occupational Psychology • Member, BPS Psychological Testing Centre (PTS) • Research Fellow, University of East London • Fellow, Royal Society for Public Health
Professor Dame Susan Bailey OBE DBE	Group Non-Executive Director	• Independent Chair of New Roles in Mental Health Chairs Group to Health Education England (HEE) • Chair Autistica Research Network • NED – Department of Health & Social Care (ends 31st October 2020) • President of Child & Adolescent Section of European Medical Training Body (UEMS) • Chair of Centre for Mental Health • Bevan Commissioner • Council Member of Salford University • Independent NED KOOTH plc – Mental Health Online Platform

NAME	POSITION	INTERESTS DECLARED
Professor Luke Georghiou	Group Non-Executive Director	• Deputy President and Deputy Vice-Chancellor, University of Manchester • Non-Executive Director of Manchester Science Partnerships Ltd • Non-Executive Director, Manchester Innovation Factory • Member of Manchester Graphene Company, Shadow Board • Member of NWBLT (North West Business Leadership Team) • Member GESL (Graphene Enabled Systems Board) • Chair of Steering Group, EUA (European Universities Association / CDE (Council for Doctoral Education)
Nic Gower	Group Non-Executive Director	• Director Furness Building Society [NED]
Chris McLoughlin	Group Non-Executive Director & Senior Independent Director (SID)	• Director of Children's Services, Stockport Metropolitan Borough council • Member of Association of Director of Children's Services Ltd • Chair of Greater Manchester Social Work Academy Board • Member of Greater Manchester Mental Health Partnership • Chair of Greater Manchester Start Well & School Readiness Board • Chair of Greater Manchester Children and Young People Health and Wellbeing Executive
Trevor Rees	Group Non-Executive Director	• Treasurer/Trustee (Manchester Literary and Philosophical Society) • Independent Co-opted member (Audit Committee at University of Manchester (not a Board Member) • Non-Executive Director of Totally Local Company, Stockport (3-year Term) • Chair of the Audit Committee of GB Taekwondo

BOARD OF DIRECTORS

REGISTER OF INTERESTS – April 2021

NAME	POSITION	INTERESTS DECLARED
Sir Mike Deegan CBE	Group Chief Executive Officer	• Board Member, The Corridor, Manchester • Board Member, Health Innovation Manchester
Darren Banks	Group Executive Director of Strategy	• Nominated Director for Manchester LCO Partnership Board • Spouse - Finance Director of Rochdale Infirmary, PAT • Board Member, The Corridor, Manchester
Peter Blythin	Group Executive Director of Workforce & Corporate Business	• No interests to declare
Julia Bridgewater	Group Chief Operating Officer	• Foundation Director of Multi Academy, All Saints Catholic Collegiate
Professor Jane Eddleston	Joint Group Medical Director	• Chair of Adult Critical Care CRG [NHSE] • Clinical lead for Healthier Together Programme • GM Partnership Joint Medical Executive lead for Acute Care
Jenny Ehrhardt	Group Chief Finance Officer	• Trustee and Treasurer – Faculty of Medical Leadership & Management • Personal Financial Advice sought and paid personally from Mazars (External Auditors for the Trust) • Chair of Sub-Committee of the National Finance Leadership Council
Gill Heaton OBE	Group Deputy Chief Executive	• Chair of the Manchester LCO Partnership Board
Professor Cheryl Lenney OBE	Group Chief Nurse	• Spouse – Director of Workforce & Organisational Development, Manchester Local Care Organisation
Miss Toli Onon	Joint Group Medical Director	• No interests to declare

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Sarah Corcoran, Group Director of Governance Dympna Ebah, Associate Director of Clinical Governance and Patient Safety
Date of paper:	March 2021
Subject:	CQC Regulatory Regulation 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:	Patient safety and clinical quality
Recommendations:	The Board of Directors are asked to note the de-registration of Nightingale North West Hospital from MFT's CQC registration
Contact:	Name: Dympna Ebah, Associate Director of Clinical Governance and Patient Safety Tel: 0161 701 8114

1. Introduction

1.1. MFT is required to register all new locations and de-register any decommissioned locations with the Care Quality Commission (CQC) as per the CQC regulations.

1.2. The purpose of this paper is to inform the Board of Directors of the de-registration of the Nightingale North West Hospital and removal from MFT's CQC registration, as nationally the Nightingale Hospitals have been decommissioned.

1.3. MFT is required to update its statement of purpose document to reflect the removed location.

1.4. There is no change to function or purpose but the Nightingale North West Hospital has been removed from the statement of purpose.

1.5. The amended statement of purpose is included for information at Appendix A.

2. Recommendation

The Board of Directors are asked to note the de-registration of Nightingale North West Hospital from MFT's CQC registration

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Appendix A

Statement of purpose

Health and Social Care Act 2008

Part 2

Aims and objectives

Please read the guidance document *Statement of purpose: Guidance for providers*.

Aims and objectives
What are your aims and objectives in providing the regulated activities and locations shown in part 3 of this statement of purpose

The vision for Manchester University NHS Foundation Trust (MFT) is to improve the health and quality of life for our diverse population by building an organisation that:

- Excels in quality, safety, patient experience, research, innovation and teaching
- Attracts, develops and retains great staff
- Is recognised internationally as a leading healthcare provider

The agreed strategic objectives are defined as follows:

- To improve patient safety, clinical quality and outcomes.
- To improve the experience of patients, carers and their families.
- To achieve financial sustainability.
- To develop single services that build on the best from across all our hospitals.
- To develop our research portfolio and deliver cutting edge care to patients.
- To develop our workforce enabling each member of staff to reach their full potential.

Manchester University NHS Foundation Trust was formed on October 1st 2017. It has a turnover of circa £2.3 billion and employs over 27,000 people. It operates clinical services in nine hospitals across nine discrete locations and provides a comprehensive range of functions ranging from local district general hospital services through to highly specialised regional and national specialities. It is the principal provider of hospital care to a local population of approximately 750,000 in Manchester and Trafford and is available to a much larger population providing regional and supra regional tertiary care.

The organisational form is based around ten Hospitals and a number of community sites.

The following Hospitals:

- Manchester Royal Infirmary
- Wythenshawe Hospital
- Royal Manchester Children's Hospital
- Saint Mary's Hospital
- Manchester Royal Eye Hospital
- Trafford General Hospital
- Withington Community Hospital
- Altrincham Hospital
- University Dental Hospital of Manchester
- North Manchester General Hospital

Other regulated activities are provided at the following sites:

- Buccleuch Lodge
- Dermot Murphy Centre
- Tameside Hospital MFT Renal Satellite
- North Manchester General Hospital MFT Renal Satellite
- Hexagon House MFT Renal Satellite

- Octagon House MFT Renal Satellite
- Harpurhey Health Centre
- Longsight Health Centre
- Moss Side Health Centre
- Newton Heath Health Centre
- Plant Hill Clinic
- Withington Community Clinic
- 144 Wythenshawe Road Short Break Service
- Gorton Parks
- Brownley Green Health Centre
- Wythenshawe Forum
- Cornerstone Centre
- Crumpsall Vale Intermediate Care Facility
- The Spire Hospital Manchester
- Transform Hospital Group Pines Hospital
- BMI The Alexandra Hospital, Manchester
- HCA Wilmslow Hospital
- Royal Oldham Hospital
- Fairfield General Hospital
- Rochdale Infirmary

A number of other bases and sites are registered under the Trust Headquarters at Cobbett House, Oxford Road as they do not meet the criteria for standalone registration with the CQC. These are:

- Burnage Health Centre
- Northenden Health Centre
- Higher Openshaw Primary care Centre
- Vallance Health Centre
- Chorlton Health Centre
- Maddison Place
- Stratus House
- The Power House
- Pendleton Gateway
- Abbey Hey Clinic
- Starlac Centre
- Alexandra Park Health Centre
- Charleston Road Health Centre
- Cheetham Hill Primary Care Centre
- Clayton Health Centre
- The Longmire Centre
- Gorton Health Centre
- Levenshulme Health Centre
- Platt Lane Surgery
- Specialised Ability Centre
- Newton House

Full details of services provided and their location can be found on the Trust web pages at www.mft.nhs.uk