NHS
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NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS' MEETING

Meeting Date: 12th July 2021

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

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

88/21 Board of Directors' (Public) Meetings

At the outset, the Group Chairman reported 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 Group Chairman also explained that all Governors had been sent a link to today's meeting (12/07/21) so they had the opportunity to attend and observe the meeting. A notice was also placed MFT's public website explaining how the meeting would be conducted and inviting people to request a link to the meeting should they wish to attend. The agenda and supporting documents had also been posted on the MFT Public Website (https://mft.nhs.uk/board-meetings/board-of-directors-meeting) beforehand and members of the public invited to submit any questions and/or observations on the content of the reports presented/discussed to the following e-mail address: Trust.Secretary@mft.nhs.uk.

The Chairman noted that this was the final Board of Directors' meeting for Alwyn Hughes, the Trust Board Secretary. The Chairman paid tribute to Alwyn's work and thanked him for his valuable contribution to the work of MFT over the years. The Chairman also introduced Nick Gomm who will be replacing Alwyn from the end of August 2021.

89/21 Apologies for Absence

Apologies were received from:

Miss Toli Onon

90/21 Declarations of Interest

There were no declarations of interest received for this meeting.

91/21 Minutes of the 'virtual' Board of Directors' Meeting held on 12th May 2021

The minutes of the Board of Directors' meeting of 10 May 2021 were approved.

Board decision	Action	Responsible officer	Completion date
The Board approved the minutes.	None	N/A	N/A

92/21 Matters Arising

There were no matters arising.

93/21 Group Chairman Report

The Chairman presented a summary of recent events of note.
The following had received honours in the recent Queen's Birthday Honours list:

- Julia Bridgewater, Group Chief Operating Officer received an MBE for services to the NHS, particularly during the COVID-19 pandemic.
- Chris McLoughlin, Group Non-executive Director, received an OBE for her services to children and families in her role as Director for Children Services at Stockport Metropolitan Borough Council.

- Jemma Haines, Consultant Speech and Language Therapist, was awarded an MBE in recognition of Jemma's leadership within the field of upper airway respiratory disorders in speech and language therapy, in addition to her significant contribution and response during the COVID-19 pandemic.

Monday July 5 2021 was the NHS's 73rd Birthday and staff across MFT celebrated by taking part in the NHS 'Big Tea' event. It was an opportunity to join with colleagues and to thank each other and our volunteers for everything they have all done over the past year. Emma Davies, Senior Clinical Scientist in Virology from MFT, was invited to the NHS National Service of Thanksgiving, which took place on the anniversary at St Paul's Cathedral in London. The event recognised the dedication and commitment of all those who played their part in combating Covid-19 across the NHS, care sector, and beyond.

Celebrations for Volunteers Week took place in June providing an opportunity to appreciate the fantastic work MFT's volunteers do every day and to recognise their dedication to their role. In line with this year's theme 'A Time to Say Thanks', the Trust paid tribute to, and thanked, all MFT Volunteers for their time, dedication, commitment and effort, during what has been a really challenging year.

MFT has been nominated for the Employer Award Category in the 2021 Manchester Adult Education and Skills (MAES) Awards because of the successful collaborative working between MFT's Apprenticeship Team and MAES which has enriched Maths and English skills within MFT's workforce. This has enabled staff to develop and thrive both in work and in their personal lives, gain more confidence and grasp future opportunities.

On Armed Forces Day, on 26th June, MFT showed support for the men and women who make up the Armed Forces community: from currently serving troops to service families, veterans and cadets. Unfortunately, the planned events had to be postponed due to the ongoing Covid-19 pandemic, but they will be rescheduled as soon as they can be safely delivered.

Board decision	Action	Responsible officer	Completion date
The Board noted the report.	None	N/A	N/A

Group Chief Executive's Report

The Group Chief Executive echoed the Chairman's recognition of Alwyn Hughes' contribution and dedication to MFT, and public service in general, and welcomed Nick Gomm to his new role.

MFT continues to deliver a significant operational response to the COVID-19 (Covid) National Emergency while being faced with ongoing challenges around urgent and emergency care. This is described in further detail within the report of the Chief Operating Officer (item 7.2.1).

MFT has been selected by the Health Foundation, an independent charity, to be part of its new programme supporting providers of healthcare to create the conditions that will enable faster and more effective uptake of innovations and improvements. The Adopting Innovation programme is supporting four 'Innovation Hubs' with funding of up to £475,000 each, for two and a half years.

Professor Bill Newman, Consultant Clinical Geneticist, has been appointed as Medical Director of the North West Genomic Medicine Service (NWGMS) Alliance, which is hosted by MFT, from 1 April 2021.

Professor Newman will lead the NW GMS Alliance as one of seven regional Alliances forming a national network established to deliver the benefits of Genomics across the NHS. The NW GMS Alliance is leading the national group transforming use of genomic data to improve management of chemotherapy pathways for cancer patients.

To support delivery of the MFT People Plan, and to recognise the work of all MFT staff during the past year, July has been designated as our staff recognition month, beginning with the NHS Birthday on July 5th. During the month Hospitals, Managed Clinical Services (MCS), the Local Care Organisations (LCO), and Corporate Services teams are being encouraged to recognise their staff locally with the month culminating in artwork, an ebook and a film to tell 'our MFT story'.

Work on the development of our Rare Conditions Centre within MFT is progressing well. MFT's size and long-held record of providing patient-centred care for people with rare conditions puts MFT in a unique position to establish this new Centre. Existing rare conditions care, work and research extends across all areas of MFT and the Rare Conditions Centre brings this widespread work together**.** In June, Dr Siddharth Banka was appointed Clinical Director to the Rare Conditions Centre, where he will be responsible for setting the strategic direction and leading all aspects of the Centre's development.

Board decision	Action	Responsible officer	Completion date
The Board noted the report.	To schedule an update on MFT's Genomics service for a Board Development session.	Trust Board Secretary	October 2021

94/21 Board Assurance Report

The Board Assurance Report is produced every two months to inform the Board of compliance against key local and national indicators as well as commentating on key issues within the Trust. The report also highlights key actions and progress in addressing any shortfalls.

The report is divided into the following five key priority areas: Safety; Patient Experience; Operational Excellence; Workforce & Leadership; and Finance. The lead Group Executive Director for each priority area summarised the contents of their section.

The Joint Group Medical Director presented the 'Safety' section.

There are two core priorities which are not currently being met: 'Monthly Reviews' and 'Never Events'.

In February 2019 the Trust implemented a group-wide safety management system which enables the timely contextualisation of multi-source information about the safety of the care provided to patients. This approach ensures a smart approach to identifying opportunities for high impact and transferable learning, accelerated improvement and smart assurance through:

- the capture of 'safety II' data (ensuring learning from the majority of patient outcomes that are at, or exceed, expectations);
- the use of SPC analysis to understand our data about harm, this has enabled us to identify, explore and understand the risk associated with any special cause variation;
- the consideration of multiple sources of intelligence in relation to patient safety (qualitative and quantitative); and
  a daily Trust-wide patient safety huddle- a weekly Trust-wide Patient Safety Oversight Panel.

MFT has reported 3 Never Events (YTD April 21 to May 21). The recently reported Never Events are currently under investigation. The Trust-wide Never Event risk has been reviewed and reframed in light of this and the need to focus on human/system interaction in the way we approach improvement.

Dr Ivan Benett, Group Non-executive Director, noted that the mortality data for Wythenshawe Hospital was higher than the other hospitals and asked whether this had been investigated.

The Group Joint Medical Director confirmed that the matter had been looked into and nothing of concern had been found.

The Group Chief Nurse presented the Patient Experience section.

In May 2021 the percentage of formal complaints that were resolved in the agreed timeframe was 94.4%, an increase of 4.1% from the previous month. MFT have consistently exceeded the 90% target since September 2020. The number of new complaints received across the Trust during May 2021 was 126, which is a decrease of 6 when compared to 132 in April 2021. Performance is monitored and managed through the Accountability Oversight Framework (AOF).

The Friends and Family Test (FFT) was paused nationally between March and December 2020 in order to release capacity to support the response to the COVID-19 pandemic. The Trust overall satisfaction rate for FFT (including data from the North Manchester General Hospital (NMGH) acquisition on 1st April 2021) is 94.3% in May 2021 which is a slight increase from the 93.7% that was achieved in April 2021. There is a continued focus for all areas of the Trust to use both the positive and negative FFT feedback to improve the experience of our patients.

Infection prevention and control remains a priority for the Trust. Trust performance for the last financial year was above trajectory for Methicillin-resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (CDi). When comparing MFT's 2020/2021 position to that of 2019/2020, CDi rates have increased from 19 to 34 per 100,000 overnight beds and MRSA bacteraemia rates have increased from 1 to 3 cases per 100,000 overnight beds. Gram negative blood stream infections (GNBSI) rates have increased from 35 to 55 cases per 100,000 overnight beds.

No national targets have been set for CDi, so a 10% reduction target on last year's position (179 cases) has been agreed. There have been 23 trust-attributable CDi cases reported so far this year, against a threshold of 26. There is a zero-tolerance approach to MRSA bacteraemia, and a 15% reduction objective applied to E. coli bacteraemia. There have been 3 trust-attributable MRSA bacteraemia and 14 E. coli bacteraemia so far, this financial year.

The Group Chief Operating Officer presented the Operational Excellence section and explained that the detail with regard to the Trust's ongoing response to, and recovery from, Covid would be covered in item 7.2.1.

The Group Executive Director of Workforce and Corporate Business presented the Workforce and Leadership section.

Following the successful acquisition of NMGH, work continues to fully embed the MFT Workforce & Organisational Development (OD) service delivery model. The full transition to MFT workforce systems has commenced which will provide better visibility of workforce issues and ultimately improve workforce management and support across NMGH.

MFT's COVID-19 Workforce Recovery Programme is underway, putting staff health and wellbeing, inclusion, compassion, and new ways of working at the forefront of MFT's approach. This programme will deliver increased psychological support for staff; accelerated/over recruitment initiatives in key areas; enhanced support and development for managers/ teams; and additional support for workforce transformation.

The MFT People Plan has also now been launched. A governance structure and performance monitoring dashboards are currently being embedded to oversee delivery.

Dr Ivan Benett, Group Non-executive Director, noted that the figures for Medical Appraisals at NMGH were lower than for the other hospitals and asked if there was an underlying problem.

The Group Executive Director of Workforce and Corporate Business explained that the figures were lower due to the number of vacancies at NMGH and their current reliance on locum staff. The figures will improve once permanent staff are in place.

The Group Chief Finance Officer explained that the discussion on financial matters will take place within item 7.3 on this meeting's agenda. The monthly update on Operational Financial Performance is provided through regular papers provided to the Finance and Scrutiny committee as well as the Board of Directors meeting.

Board decision	Action	Responsible officer	Completion date
The Board noted the content of the report.	Item on 'Learning from Covid deaths' to be presented to the next Board of Directors meeting.	Trust Board Secretary	13 September 2021

95/21 Update on the Trust's ongoing response to the COVID-19 National Emergency

General Update, Performance Standards & Recovery Programme

The Group Chief Operating Officer (COO) presented this report which provides the Board of Directors with an overview of MFT's ongoing response to the Covid pandemic.

The Covid pandemic has had a significant detrimental impact on MFT performance against constitutional standards, particularly those related to elective access. Following the April 2020 Covid peak of demand for inpatient and Critical Care beds (487 inpatients and 104 critical care patients), MFT experienced high Covid attendances during January and February 2021. Inpatient Covid numbers of 453 in January were 93% of the wave 1 inpatient Covid peak, and Critical Care occupancy was at 64 (62% of wave 1 peak). Each of these peaks required the redeployment of nursing, medical and other operational staff for extended periods of time in order to support Critical Care demand.

MFT Strategic Group (Strategic Group) took the decision to again reduce routine elective activity from the start of November 2020 to release bed and staff capacity to support Critical Care. Individual Hospital / MCS escalation plans, approved via the Strategic Group in October 2020, continued in place through the remainder of the year and into Quarter 1 of 2021.

Between February and May there has been a slow decline in Covid inpatient and Critical Care patient numbers. As a result, a staged approach to reconfiguration and de-escalation has been agreed through the Strategic Group. The overarching aim being to safely increase non-Covid capacity, and de-escalate away from non-Critical Care (surge) areas, as the incidence of Covid activity declined. Following careful consideration by the Strategic Group a cautious restart was made to the Trust's elective and outpatient activities.

Activities aimed at planning for, and delivering resumption, of MFT services began in April and May. Examples include:

- Utilisation of available elective capacity being undertaken through the Clinical and Operational leadership of the Managed Elective Surgical Hub (MESH);
- The managed release of clinical staff from Covid wards, including Critical Care allowing Outpatient activity to increase; and
- Specific Committee and programme governance meetings being re-introduced or returned to pre-Covid formats.

MFT's recovery programme continues to be managed through a Recovery and Resilience Board, incorporating operational workstreams such as Outpatients, Elective Care, Urgent Care and Cancer. Each workstream has a designated Group Executive Director or Hospital Chief Executive lead to oversee the programme of work. The bi-weekly Recovery and Resilience Board meeting is overseen by the Chief Transformation Officer and reports into the Strategic Group chaired by the Group Chief Operating Officer.

The report provided a summary of performance against a number of key metrics up to May 2021 including the following:

- There had been some improvement in diagnostic performance, including NMGH performance post-merger.
- MFT's waiting list size has continued to grow throughout 2020 and Q1 of 2021. At the end of May 2021 there were 137,393 patients on the waiting list compared to 113,552 (including NMGH) at April 2020.
- There were 15,755 patients who have waited longer than 52 weeks at the end of May2021, compared to 515 (including NMGH) at April 2020.
- The Trust is under-achieving 5 cancer standards, only performing against the 31-day subsequent surgery standard. The 62-day position is improving as at the end of May 2021. Performance is slightly above trajectory to reduce the 104-day backlog to pre-Covid levels by end of June 2021, and 62-day backlog by the end of September.
- MFT 4-hour performance was ranked 6th in GM for the month of May 2021 and 5th across April and May 2021. This reflects high levels of attends across MFT Emergency Departments and ongoing challenges to meet the demand whilst maintaining screening, and separation, of patients who are possible Covid-positive.

The Group Medical Director provided some wider context and explained that across Greater Manchester, at its peak, there had been approximately 375,000 people waiting for an elective procedure and that, as of June 2021, that number was now approximately 325,000. The number of 52-week waiters was also falling.

Mr Nic Gower, Group Non-executive Director, asked if the increased acuity of patients presenting at MFT's hospitals had been expected as part of recovery planning.

The Joint Group Medical Director, confirmed that it had been. This included anticipating the required segregation of patients in Critical Care departments to prevent transmission of Covid or Flu.

The Chief Operating Officer confirmed that the pressure at the 'front door' of services was higher than anticipated with the numbers of Category 1 and Category 2 patients presenting already at 110% of pre-Covid levels. This position is reflected across the country. Cancer referral rates are at 120% of pre-Covid levels.

The Group Executive Director of Strategy highlighted the impact of Covid on workforce with outbreaks in specific teams and services causing issues with the capacity to maintain service provision.

Mr Trevor Rees, Group Non-executive Director, stated it is understandable that MFT are finding it difficult to meet pre-Covid performance measures. He asked how the Board of Directors can be assured that progress is being made whilst ensuring the workforce remain motivated by realistic performance measures and expectations.

The Group Chief Operating Officer explained that within the Accountability Oversight Framework (AOF) there are specific local targets but it was also necessary to ensure everything is being done to meet the national targets as well.

The Group Deputy Chairman asked how communications with patients was being handled bearing in mind the ever-changing circumstances being faced.

The Group Chief Operating Officer explained that MFT is reliant on the individual hospitals and MCS to handle communications with patients.

The Group Deputy Chief Executive Officer added that MFT was also in regular communication with the local Clinical Commissioning Groups (CCGs) and GP practices to ensure they were aware of the current circumstances and could support communication with local people and patients.

Board decision	Action	Responsible officer	Completion date
The Board noted the content of the report.	None	N/A	N/A

<u>Update on the COVID-19 Vaccination Programme</u>

The Group Chief Nurse presented the report which provided an update on MFT's Covid Vaccination programme.

The MFT vaccination programme commenced in December 2020, delivering both AstraZeneca and Pfizer vaccines across the four clinics at Wythenshawe Hospital, the Oxford Road Campus, North Manchester General Hospital and Trafford General Hospital. It has delivered over 129,000 vaccines through the four clinics.

Through the MFT staff vaccination programme:

- 92.2% have received their first vaccine
- 87% of BAME staff have been vaccinated
- 88.9% 2nd dose vaccines have either been administered or booked
- 93.8% of staff have either had or booked their 1st dose
- 100% of MFT staff have been offered the vaccination.

MFT work in partnership with Manchester Health and Care Commissioning (MHCC), supporting delivery of the wider Manchester vaccine programme, by providing:

- Walk-in clinics targeted at particular communities.
- 'Your Household' offers targeting family members aged 18 years and over who either live locally, and/or within family bubbles to ensure our staff and therefore patients have the best level of protection.

- Offers of vaccination to pregnant women of all ages, including staff, who are booked for care at St Mary's.
- Support to vaccination programmes for staff from The Christie, National Blood and Transplant, Greater Manchester Mental Health NHS Foundation Trust (GMMH), and care homes across the city.
- Opportunistic in-patient vaccination, including paediatric in-patients and particularly vulnerable groups, for example patients with cystic fibrosis and parents/guardians of babies in neonatal units.

Vaccination Programme Meetings are held weekly, focusing on the strategic planning of the vaccine programme. A vaccination dashboard, which summarises progress to date, is issued daily and a Reporting Working Group is in place to ensure that consistent and timely returns are made, and to monitor, and improve, data quality.

Situation reports (Sitreps), providing a range of information including projections of vaccine requirements and vaccination uptake in various staff groups, are submitted regularly in line with local, regional, and national requirements. 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.

Staff COVID-19 vaccination reports are distributed to line managers on a weekly basis in order to facilitate targeted wellbeing conversations.

Professor Luke Georghiou, Group Non-executive Director, asked if there had been any cases of staff refusing to have the vaccine.

The Group Chief Nurse confirmed that there had been and noted that a national consultation was currently underway to consider mandatory vaccination for healthcare staff.

Mr John Amaechi, Group Non-executive Director, confirmed that the Group Chief Nurse and the Group Director of Workforce and Corporate Business had worked with others to ensure that the vaccination programme was as responsive as possible to the needs of the diverse communities serviced by the vaccination programme. He thanked everyone for their contribution to this work.

Board decision	Action	Responsible officer	Completion date
The Board noted the content of the report.	None	N/A	N/A

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

The Group Chief Nurse presented the report and explained that prevention of all transmissible infections, both viruses and bacteria, are paramount to patient safety. Prevention starts with adherence to good IPC practice by all staff. There is evidence that the number of new cases of Covid amongst in-patients is starting to increase due to the Delta Variant of Concern. It is therefore essential that all staff continue to be vigilant.

Evidence of MFT's commitment to the prevention and management of Nosocomial Infections can be found in the continuing actions and improvement programmes set out in the IPC Board Assurance framework (BAF), appended to the report.

In addition to the update on the IPC BAF, the report describes the current position with nosocomial transmissions of Covid and provides an overview of the updated guidance on FFP3 Resilience in the Acute Setting. The prevention and management of Covid nosocomial Infections is multifaceted, and practice has been evolving throughout the pandemic as more is learnt about the Covid virus and how it is transmitted.

Board decision	Action	Responsible officer	Completion date
The Board noted the actions and progress to reduce the risk of transmission of COVID-19 across all MFT services.	None	N/A	N/A

96/21 Group Chief Finance Officer's Report

The Group Chief Finance Officer presented the report which provided detail of MFT's financial performance across 5 areas: delivery of financial control total; run rate; remedial action to manage risk; cash and liquidity; and capital expenditure.

The financial regime for 2021/22 has been split into 2 halves (H1 and H2) with the first half of 2021/22 representing a period of recovery and potentially stabilisation as the intensity of the activity directly related to Covid reduces but the implications of reduced activity over the previous period manifest themselves across almost all areas of clinical activity.

MFT is required to deliver a surplus of £23.1m for H1 and has developed the H1 plan to reflect this requirement. The underpinning budget profiles are largely flat across the full financial year however there are three key exceptions to this:

- actual delivery of the full year Waste Reduction Programme (WRP) where an element of backloading is to be expected;
- a higher level of GM system funding is shown in the H1 than is assumed for H2 (H2 values are to be determined as part of the H2 planning process) which adds a degree of uncertainty to the annual plan across the full financial year; and
- elements of expenditure relating to activity recovery step-up across H1 reflecting the expected increase in activity e.g., clinical supplies, diagnostic testing etc

The Trust will also need to maintain tight financial control across the balance sheet, and management of technical items during the forthcoming months, in the context of the challenging environment and the several significant provisions at the end of 2020/21 which include annual leave and the Healthcare Support Worker (HCSW) pay banding review.

Hospitals continue to report each month against their projected forecasts, alongside reporting their forecast year-end position against the control totals which have been formally issued to each Chief Executive. The controls over additional investment linked to activity recovery have been established. In the short term these may be supported by additional income from the Elective Recovery Fund (ERF) however the Trust must maintain a strong grip of the recurrent level of spend as elements may prove unaffordable in a revised financial regime.

Through the governance structures, there has been a consistent message that maintaining control of expenditure is key even during the pandemic. Formal notification has been received that the previous financial regime will largely remain in place at least for H1 of 2021/22 and the control totals implemented at Hospital level have been reviewed and refined in light of this guidance. The Finance Accountability Framework has been updated and clarified, and is now being implemented, as part of the overall Accountability Oversight Framework.

As at 31st May 2021, the Trust had a cash balance of £278.4m a small decrease from the April balance of £280.2m. This balance is in part due to the ongoing level of accruals and provisions with key items including the annual leave provision at the end of 2020/21 and the Healthcare Support Worker pay review.

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. The plan value for 2021/22 is £199,169k with potential outturn of £208,495k which reflects a degree of pressure, in particular around backlog maintenance. It is envisaged that there will be a degree of slippage across the programme during the year which will bring the actual spend back in line with the agreed envelope.

The position across GM is that additional funding streams identified through the year will also be applied to assist in closing the gap, where appropriate, as opposed to being entirely new spend. Up to May 2021 £14.1m has been incurred against a plan of £18.8m i.e. underspent against profile by £4.7m with the majority of the slippage (£3.1m) relating to HIP2, due to delays in the approval of the Park House scheme and associated enabling works.

Board decision	Action	Responsible officer	Completion date
The Board noted the content of the report.	Scrutiny of cash position to continue to be undertaken at the Finance Scrutiny Committee.	Group Chief Finance Officer	26 October 2021 and ongoing

Mr Trevor Rees, Group Non-executive Director, recognised the difficulties in financial planning this year due to the remaining uncertainty over national spending plans.

97/21 Update on Strategic Developments

The Group Executive Director of Strategy presented the report which gave an overview of current strategic developments.

NHS E/I have now published the Integrated Care System (ICS) design framework which provides further detail on the proposed structure and functions of ICSs.

Formal designated ICS chairs and chief executives must in place by end of September 2021 and the other executive board roles must be confirmed by the end of 2021.

The NHS System Oversight Framework 2021/22 was published on 24 June 2021. It describes NHS England and NHS Improvement's approach to oversight of Integrated Care Systems (ICSs), CCGs and Trusts for 2021/22.

The Royal Manchester Children's Hospital has successfully bid for just under £3m of funding as part of NHS England's 'elective accelerator' initiative. The bid was made in conjunction with other specialist Children's hospitals, as part of the Children's Hospital Alliance, and will support an increase in elective activity to reduce the time children and young people wait for their treatment.

A business case has been submitted to NHS England covering plans to develop Community Diagnostic Hubs (CDHs) for Manchester and Trafford. Year 1 plans would see a CDH established at Withington Community Hospital, with services also being delivered from a number of 'spoke' sites across Manchester and Trafford. A decision is expected in August with implementation due to start this financial year, dependent on funding.

The Chairman highlighted that there will be briefing on ICSs for Group Non-executive Directors on 2 August 2021.

Board decision	Action	Responsible officer	Completion date
The Board noted the updates in relation to strategic developments nationally, regionally and within MFT.	None	N/A	N/A

98/21 Approve the MFT Annual Plan (2021/22)

The Group Executive Director of Strategy presented MFT's Annual Plan for 2021/22. The Annual Plan sets out what MFT intends to do in the coming year in order to achieve its short-term targets (such as performance and financial targets) as well as making progress towards its longer-term aims. Each Hospital, MCS, LCO and corporate team within MFT develop their own annual plan; deciding what their priorities for the coming year should be based on their own individual circumstances, aligned to the overall MFT vision and strategic aims

The financial envelope and control total for MFT, as part of GM, is fixed now for the first six months of 21/22, but there is no indication of the level of funding for the second half of the year. In developing these plans, which cover the full 12-month period from April 21 to March 22, an assumption has been made about the level of funding that we will receive for the second half of the year.

Draft Hospital / MCS / LCO priorities were presented to the Council of Governors (CoG) in an Annual Planning session on 25 May where the Governors had an opportunity to input their views and comments. A draft MFT Annual Plan document, drawing together plans from across the Hospital / MCS / LCO and corporate teams, was then produced. and circulated to members of the CoG for comment. Any further Governor feedback has now been considered and included in the Plan.

The objectives described in the Annual Plan will be monitored in various ways; some through the Board Assurance Report, others through less formal mechanisms.

Board decision	Action	Responsible officer	Completion date
The Board approved the MFT Annual Plan 2021/22. The Board noted that further work will be brought back to the Board to show how progress will be monitored.	None	N/A	N/A

99/21 Update on the Ockenden Review of Maternity Services

The Group Chief Nurse presented the report which describes progress against the Ockenden Report Immediate and Essential Actions (IEAs) and proposed an extended governance process to ensure compliance with the actions within a group model like MFT.

Donna Ockenden's first report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust was published on 11th December 2020 and MFT's immediate response was reported to the Board of Directors in March and May 2021. The response of the Immediate and Essential Actions (IEA's) for Saint Mary's Managed Clinical Service (SM MCS) demonstrated no major non-compliance.

Subsequently, SM MCS completed the more detailed National Assurance Assessment tool which was reported through the GMEC Local Maternity System (LMS) and shared with the NHS North West Regional Office on the 15th February 2021. This demonstrated the level of compliance with all 7 IEAs with no high-level patient safety risks being identified.

The report outlines the Saint Mary's MCS proposal to deliver an enhanced governance model for maternity services that not only supports the recommendations of the Ockenden report but also adapts and adopts the perinatal quality surveillance model provided by the GM LMS and supported nationally. The model identifies roles and responsibilities, including for the Board of Directors and the Executive Board Safety Champions, it also details the key quality and safety metrics which will be regularly reviewed at relevant committees as part of the oversight element. This includes monitoring of perinatal support for vulnerable women including Black, Asian and ethnic minority populations and those from areas of deprivation. The effectiveness of the proposed model will be reviewed every 6 months by the Saint Mary's MCS Quality and Safety Committee.

Chris McLoughlin, Group Non-executive Director, commended staff for the culture and attitude within teams and noted their focus on seeking out opportunities to improve the care they provide, and the momentum in place early on to address the recommendations.

Professor Luke Georghiou, Group Non-Executive Director, asked whether the challenges in recruiting staff form different ethnic communities could be affecting the experience of women from those communities.

The Group Chief Nurse agreed that it may be the case and confirmed that the issue was being addressed and there is now a more diverse workforce, including at more senior levels.

Board decision	Action	Responsible officer	Completion date
The Board approved the extended governance infrastructure which is aligned to the perinatal quality surveillance model being adopted in Saint Mary's MCS.	None	N/A	N/A

100/21 Clinical Research Network (CRN) – GM annual report (2020/21) and annual plan (2021/22)

The Joint Group Medical Director presented the report which provides a summary assessment of the CRN's delivery against the areas of national priority in Urgent Public Health, Vaccines, and the managed recovery of research. The report offers the assurance that the LCRN and Host Organisation have been fully compliant in discharging the requirements of the Department of Health and Social Care contract and have delivered initiatives, activities and projects which have contributed to the National NIHR objectives.

The Chairman commended the breadth and success of the research programme covered in the report and offered sincere congratulations and gratitude to all those involved.

Board decision	Action	Responsible officer	Completion date
The Board acknowledged and approved the CRN GM Annual report.	None	N/A	N/A

101/21 Annual Complaints report

The Group Chief Nurse presented the report which covers all complaints and concerns made by (or on behalf of) patients of the current and legacy Trusts, received between 1st April 2020 and 31st March 2021.

The impact of the Covid-19 pandemic across the NHS initially led to fewer patients being admitted or attending for treatment and as a result the number of complaints and PALS concerns were reduced compared to 2019/20.

The total number of PALS concerns received in 2020/21 was 4,900. This is a decrease of 997 (16.91%) when compared with the 5,897 received in 2019/20. The total number of complaints received in 2020/21 at MFT was 1,059. This is a decrease of 569 (34.95%) when compared to the 1,628 complaints received, in 2019/20.

MFT is committed to the delivery of continuous improvement in all aspects of the complaints process with the following implemented over the year:

- Launch of an in-house Complaints Letter Writing Training Package
- Development of an in-house Customer Service e-learning package
- Connecting hospital patients with their families – Launch of Trust's Family Liaison Team and long-term Virtual Visiting Service

- Enhancement in the quality and accuracy of equality monitoring and complaint themes reporting
- Digital Access/Technology – Implementation of virtual complaint local resolution meetings

The report details examples of learning and change as a direct result of feedback received from complaints and concerns. Examples of learning from complaints have been published in each Quarter during 2020/21 as part of the Quarterly Complaints Report presented to the Board of Directors.

Dr Ivan Benett, Group Non-executive Director and Chairman of the Complaints Review Scrutiny Group (CRSG), explained that now NMGH was part of MFT, the same complaints process would be adopted there. He also commended the members of staff who had presented complaints they had handled at the CRSG and noted their openness and eagerness to learn lessons and improve their services.

Board decision	Action	Responsible officer	Completion date
The Board noted the report and, in line with statutory requirements, approved the report for publication on the MFT's website	None	N/A	N/A

102/21 Annual Infection Prevention Control report (2020/21)

The Group Chief Nurse presented the report which details Infection Prevention and Control (IPC) activity from April 2020 to March 2021 and outlines key achievements in a year where IPC has been key in combatting Covid.

There were 115 Covid outbreaks across the Oxford Road Campus (ORC), Wythenshawe, Trafford and North Manchester General (NMGH) Hospitals and the Local Care Organisations (LCO) from June 2020 – March 2021 with peaks occurring between October 2020 and January 2021. The escalation in numbers between October 2020 and January 2021 can be attributed in part to the rising local community prevalence rate.

There was continuous surveillance of all Covid positive cases undertaken by the IPC surveillance team. The daily Covid data was circulated at all levels across the Group. Each case was reviewed by the IPC nursing team to ensure that all aspects of IPC standards were being followed and any further necessary actions put in place.

Achievements over the year include:

- The Trust Infection Prevention and Control/Tissue Viability (IPC/TV Team) provided IPC advice and guidance to St Ann's Hospice across their three North West Hospice sites: the Neil Cliffe Centre (based at Wythenshawe Hospital); Heald Green, and Little Hulton.
- The IPC/TV Team serviced the Nightingale North West (NNW) including planning and training on the principles of IPC, based on the Trust existing policies and procedures. The team maintained a service there throughout the year.
- An overall IPC Strategy called 'Keeping Safe – Protecting You. Protecting Others' was developed as a guide for all staff based on national guidelines and the evidence base where it existed. A task and finish group were established to develop, review, and standardise a range of information leaflets for patients, visitors, and staff.
- An enhanced programme of cleaning frequencies was agreed for COVID-19 wards/departments and communal access points, (corridors, lifts, etc). In November 2020 a further temporary programme of enhanced cleaning was agreed with Sodexo for the hospitals experiencing the highest incidence of Nosocomial transmission of COVID-19.

- A COVID-19 Testing Strategic Group was set up to ensure that all aspects of staff and patient testing was implemented in accordance with national guidance. The group was supported by operational and workforce sub-groups to implement the Strategy.

Board decision	Action	Responsible officer	Completion date
The Board received the IPC Annual Report for 2020/21 and approved for publication.	None	N/A	N/A

103/21 Annual Safeguarding report (2020/21)

The Group Chief Nurse presented the report which reflects the safeguarding work undertaken throughout MFT and outlines some of the key safeguarding priorities across the city of Manchester and Trafford. The MFT safeguarding teams work with other health organisations and multi-agency partners to ensure a cohesive and consistent approach to safeguarding children and adults at risk across the MFT footprint.

Supporting staff to ensure that all patients and service users are protected is crucial to ensuring safe and effective safeguarding of all age groups regardless of ethnicity, religion, gender, or background. Central to the work is listening and hearing the voice of children, young people, adults at risk and their families and ensuring that safeguarding is always made personal.

MFT's Care Quality Commission (CQC) Inspection report, published in March 2019, recognised that effective systems were in place to safeguard patients in the organisation, citing several examples of good practice. The Report also highlighted that the Trust should review its systems to provide assurance that the required staff have completed their mandatory safeguarding training. This was a key priority for the safeguarding service working with the Hospitals, MCS and LCOs in 2020/2021. The year-end data identifies those substantial improvements in compliance have been achieved, however work is still required in relation to Level 3 Adult and Child Safeguarding in order to achieve the Trust's target compliance level of 90%.

This year the Safeguarding service has noted an increase in reporting of mental health safeguarding concerns. In response, the Suicide Prevention Policy was revised with strengthening of the environmental ligature risk assessment and incident management training across all acute sites and the inclusion of suicide prevention in the site safeguarding assurance visits. This was followed up by a partnership Suicide Summit and a Trust-wide mental health awareness event to review the partnership response to preventing suicide during the pandemic.

The Trust has completed the Manchester Safeguarding Partnership self-assessment 'Section 11' of the Children Act 2004 audit, the Adult Assurance self-assessment and the Greater Manchester Safeguarding Contractual Standards 2020-21 audit tool to measure compliance with the NHS Assurance and Accountability Framework for Safeguarding (Safeguarding Vulnerable People in the NHS 2015)3. The outcome of these audits has demonstrated that MFT is compliant with the statutory requirements.

Mrs Chris Mcloughlin, Group Non-executive Director, highlighted the increased vulnerability of children and adults during the Covid pandemic. She commended the Group Chief Nurse and Deputy Chief Nurse for the priority they have given to

Safeguarding over the last year and noted that the 'Section 11' assessment is very thorough and to achieve compliance is impressive.

Mr Trevor Rees, Group Non-executive Director, asked for clarity on why referral numbers were reducing in some areas, for example, to Child Protection Case Conferences, but increasing in others, for example from police and ambulance referrals.

The Group Chief Nurse responded by explaining that the two figures are substantively different and therefore cannot be compared. Police and ambulance services can collect people from their home and find increased level of vulnerability which requires a referral. However, these do not naturally convert to child protection case conferences.

Board decision	Action	Responsible officer	Completion date
The Board noted the report and approved it for publication on the Trust's website and sharing with Manchester Safeguarding Partnership.	None	N/A	N/A

104/21 Board Assurance Framework (June 2021)

The Group Executive Director of Workforce and Corporate Business presented the Board Assurance Framework (BAF) which is one of several tools the Trust uses to track progress in delivering the organisation's Strategic Aims.

The acquisition of NMGH reached practical completion on 1st April 2021. Although there is follow-up work that remains to be done, the two BAF items associated with the acquisition now show that the risks are substantially mitigated. In both cases there are well established controls in place and good assurance evidence. It is proposed that these two principal risks are deleted from the BAF, and that any residual risk issues are incorporated into other BAF schedules as appropriate.

The Trust's Scrutiny Committees, on behalf of the Board of Directors, utilise the BAF alongside other sources of information to inform and guide their key areas of scrutiny and especially targeted 'deep dives' into areas requiring further assurance.

The BAF is received and noted at least twice a year by the full Board of Directors.

Board decision	Action	Responsible officer	Completion date
The Board accepted the June 2021 Board Assurance Framework	Delete NMGH principal risks from BAF and incorporate residual risk issues within other schedules as appropriate	Trust Board Secretary	November 2021

105/21 Committee Meetings

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

- Finance Scrutiny Committee held on 27th April 2021 and 29th June 2021
- Group Risk Oversight Committee held on 17th May 2021
- Quality & Performance Scrutiny Committee held on 1st June 2021
- Local Care Organisation Scrutiny Committee held on 2nd June 2021
- HR Scrutiny Committee held on 15th June 2021
- NMGH Scrutiny Committee held on 22nd June 2021

Board decision	Action	Responsible officer	Completion date
The Board noted the meeting which had taken place	None	N/A	N/A

106/21 Date and Time of Next Meeting

The next meeting of the Board of Directors will be held on **Monday, 13th September 2021** at **2pm**.

107/21 Any Other Business

No issues were raised.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING (Public)

ACTION TRACKER

Board Meeting Date: 10th May 2021			
Action	Responsibility	Timescale	Comments
Delegated authority to the MFT Audit Committee for the formal sign-off of the MFT Annual Report & Accounts (inc. the Annual Governance Statement) for 2020/21.	Group Chief Finance Officer, and, Chair of the Audit Committee	June 2021	Complete

Board Meeting Date: 12th July 2021			
Action	Responsibility	Timescale	Comments
To schedule an update on MFT's Genomics service for a Board Development session.	Trust Board Secretary	October 2021	Actioned
Item on 'Learning from Covid deaths' to be presented to the next Board of Directors meeting.	Trust Board Secretary	13 September 2021	Complete
Scrutiny of cash position to continue to be undertaken at the Finance Scrutiny Committee	Group Chief Finance Officer	26 October 2021 and ongoing	Actioned
Delete NMGH principal risks from BAF and incorporate residual risk issues within other schedules as appropriate	Trust Board Secretary	November 2021	To be completed

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Directors
Paper prepared by:	Alfie Nelmes, Head of Information Services
Date of paper:	September 2021
Subject:	Board Assurance Report – July 2021
Purpose of Report:	Indicate which by ✓ • Information to Note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	The Board Assurance Report is produced on a bi-monthly basis to inform the Board of compliance against key local and national indicators as well as commenting on key issues within the Trust.
Recommendations:	The Board of Directors is asked to note the content of the report.
Contact:	Name: Alfie Nelmes, Head of Information Services Tel: 0161 276 4878

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS

BOARD ASSURANCE REPORT

(July 2021)

1. Introduction

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

2. Overview

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

The established AOF process reviews the performance for all MFT Hospitals / MCS and LCOs and is reported into MFT's Quality and Performance Scrutiny Committee. To ensure the Board is sighted on all performance within the Group, the Board Assurance Report will be updated for the next meeting to include compliance for the LCOs against the Board assurance domains and standards.

3. Key Priority Areas

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

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

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

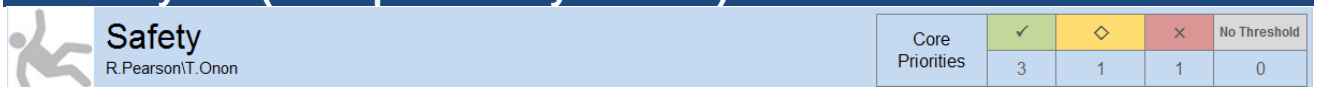
The narrative is provided by the person(s) accountable for the individual priority areas.

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

> Board Assurance Narrative Report – Guidance Notes

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

Summary Bar (Example –Safety Domain)



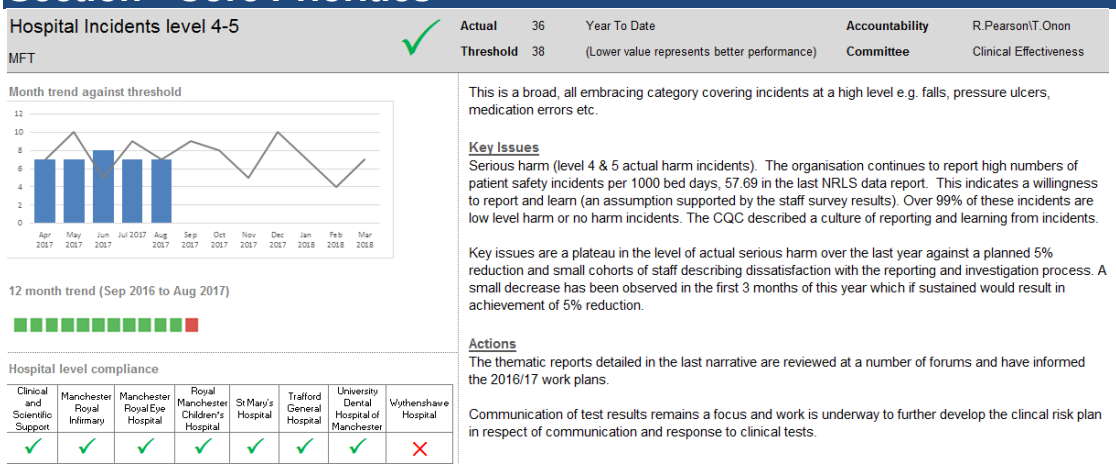
The bar at the very top of each page identifies the domain and accountability. To the right of the top bar is a summary of the core priority indicators associated with the domain. For the example of Patient Safety:

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

Headline Narrative

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

Section - Core Priorities



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

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

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

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

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

NHS
Manchester University
NHS Foundation Trust

> Board Assurance

July 2021

Safety

J.Eddleston\T.Onon

Core Priorities	✓	◇	✕	No Threshold
	5	0	1	0

Headline Narrative

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

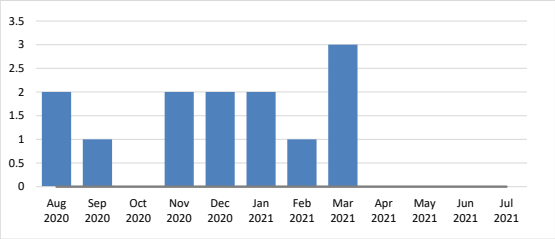
The Trust has reported 5 Never Events (YTD April 21 to August 21). The recently reported never events are currently under investigation. As a result the Trust-Wide never event risk has been reviewed and reframed in light of the recent never events and the need to focus on human/system interaction in the way we approach improvement.

Safety - Core Priorities

Mortality Reviews - Grade 3+ (Review Date) ✓

Actual	0	FY YTD (Apr 21 to Mar 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	0	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Hospital level compliance

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

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

Key Issues

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

The data has not yet been available for review for Q1 21/22 - the narrative will be updated when it is.

Actions

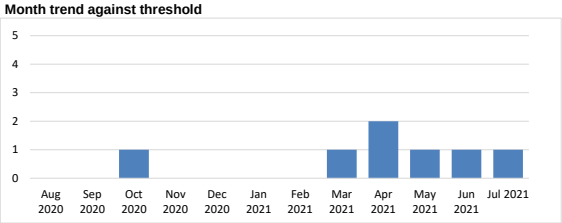
The focus is now on dissemination of the resulting changes and developments in practice across the organisation.

A key focus in Q1 21/22 has been understanding the impact of COVID-19 on mortality, understanding the improvements required and early implementation of lessons learned and completion of duty of candour.

Never Events ✕

Actual	5	YTD (Apr 21 to Mar 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	0	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



Hospital level compliance

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

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

Key Issues

Never events are those clinical incidents that should not happen if appropriate policies and procedures are in place and are followed.The list is determined nationally.
YTD (Aug 2020- July 2021) there have been 7 Never Events reported. There are key themes within the Never Events (and associated near-miss incidents) in relation to culture, psychological safety, communication, the use of checklists, the availabilty of guidance and the ergonomics of clinical enviroment design.

Detailed reports have been made at Group Risk Oversight Committee and Quality and Performance Scrutiny Committee.

Actions

The Never Events risk has been reassessed and reframed aligned to the Trust's approach to integrating safety I and safety II data to enhance our learning and improvement

The Human Factors academy has been tasked to review the current approach to the implementation of checklists, with a particular focus on non-theatre areas
The Trust is developing a revised patient safety culture assessment tool, and designing a Human Factors based intervention tool for teams to support the development of psycholical safety
All near miss never events will be subject to a high impact learning assessment

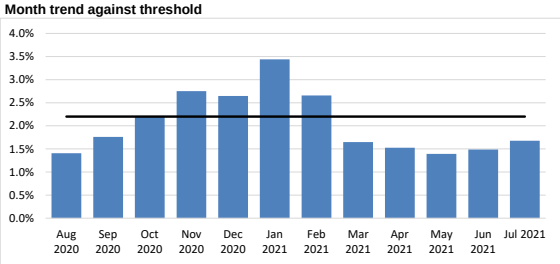
> Board Assurance

July 2021

Crude Mortality

Actual	1.52%	YTD (Apr 21 to Mar 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	2.20%	(Lower value represents better performance)	**Committee**	Audit Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
✗	✓	✓	✓	✓	✓	◇	✓
12.9%	1.7%	0.2%	0.2%	0.0%	0.0%	2.6%	1.7%

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

Key Issues

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

The crude mortality has been impacted by the pandemic. Work is underway to fully understand the impact - this work includes detailed reviews of deaths, focussed reviews e.g. in Critical Care, triangulation of information including covid-19 and non-covid-19 deaths and MFT contribution to GM work on analysis.

Hospital Incidents level 4-5

Actual	14	YTD (Apr 21 to Mar 22)	**Accountability**	J.Eddleston\T.Onon
Threshold	16	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
✓	✗	✓	✓	✓	✓	✓	✓
0	9	1	0	0	0	4	0

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

Key Issues

The graph presented in relation to this indicator provides a summary of the number of incidents reported. At a group wide level 0.15% of incidents were graded as level 4/5 harm between 1/8/20 and 31/7/21. 0.85% of incidents being notifiable (graded 3 and above). Currently work is underway to benchmark this data effectively.

SPC analysis has recently identified special cause variation in relation to staffing, disruptive behaviour and discharge planning incidents across the incident profile. These have all been analysed and where required escalated to ensure any emergent risk is identified and mitigated effectively.

Actions

Routine examination of themes and trends through the safety oversight system which has led to additional high impact learning/assurance work in relation to a number of areas including:
- Nutrition and hydration
- Discharge
- Intra and inter hospital transfer
- Restraint

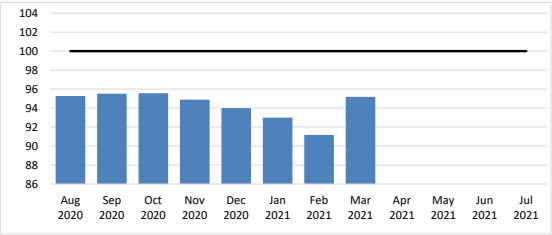
The Hospital Onset COVID infection reporting process was agreed during this period. The reports relate to incidents over the past 12 months and are not reported within this data set, once validated they will be included.

> Board Assurance

July 2021

SHMI (Rolling 12m)

Actual	90.2	R12m (Feb 20 to Jan 21)	**Accountability**	J.Eddleston\T.Onon
Threshold	100	(Lower value represents better performance)	**Committee**	Clinical Effectiveness



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
NA	✓	NA	NA	NA	NA	✓	NA
NA	93.4	NA	NA	NA	NA	87.6	NA

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The SHMI indicator gives an indication of whether the mortality ratio of a provider is as expected, higher than expected or lower than expected when compared to the national baseline.

Progress

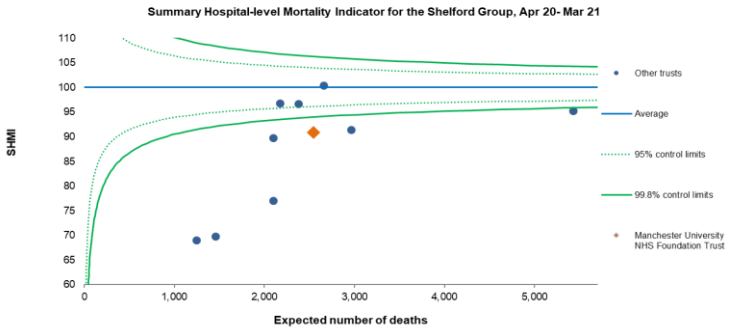
SHMI is a weighted metric for all adult acute settings (RMCH, REH, UDHM and SMH are excluded).

Risk adjusted mortality indices are not applicable to specialist children's hospitals.

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

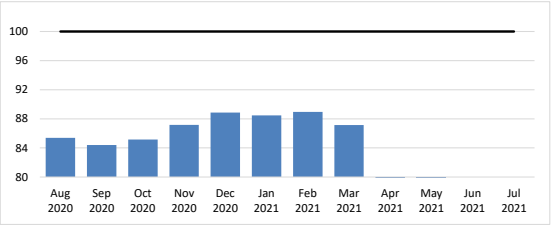
Performance is well within the expected range.

NMGH Data, not yet available. Legacy data reviewed suggesting SHMI of 115 which is under review.



HSMR (Rolling 12m)

Actual	87.2	R12m (Apr 20 to Mar 21)	**Accountability**	J.Eddleston\T.Onon
Threshold	100	(Lower value represents better performance)	**Committee**	Clinical Effectiveness



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
NA	✓	NA	NA	NA	NA	✓	NA
NA	79.6	NA	NA	NA	NA	93.4	NA

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

HSMR is a metric designed for adult practice.

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

Performance is well within the expected range.

Progress

The Group HSMR is within expected levels.

Patient Experience

C.Lenney

Core Priorities	✓	◇	✕	No Threshold
	4	1	2	2

Headline Narrative

In July 2021 the percentage of formal complaints that were resolved in the agreed timeframe was 86.1% this is a decrease of 11.1% from the previous two months. MFT have consistently exceeded the set 90% target since August 2020. The number of new complaints received across the Trust during July 2021 was 140, which is a decrease of 9 when compared to 149 in June 2021. Performance is monitored and managed through the Accountability Oversight Framework (AOF).

The Friends and Family Test (FFT) was paused nationally between March and December 2020 in order to release capacity to support the response to the COVID-19 pandemic. The Trust overall satisfaction rate for FFT (including data from the NMGH acquisition on 1st April 2021) The Trust overall satisfaction rate for FFT is 94.3% in July 2021 which is an increase compared to 92.4% in June 2021. There is a continued focus for all areas of the Trust to use both the positive and negative FFT feedback to improve the experience of our patients.

Infection prevention and control remains a priority for the Trust. Trust performance is above trajectory for both MRSA and CDI: when comparing MFT's Q1 position to that of Q2, CDI rates have increased from 24.8 to 33 cases per 100,000 overnight beds and MRSA bacteraemia rates have increased from 1.6 to 2.3 cases per 100,000 overnight beds. E. coli rates have increased from 31.8 to 35.1 cases per 100,000 overnight beds.

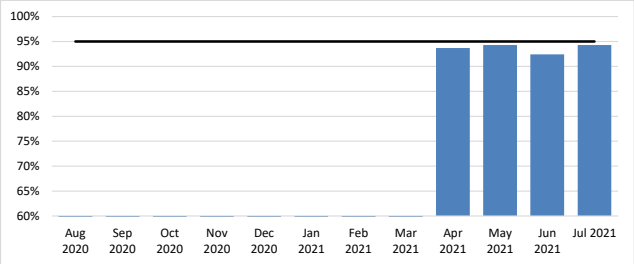
New national targets have recently been released for CDI and E. coli and will be applied in the next Board Assurance Report once broken down by site. There have been 60 trust-attributable CDI reported so far this year, against a threshold of 52. There is a zero tolerance approach to MRSA bacteraemias, and a 15% reduction objective applied to E.coli bacteraemias. There have been 3 trust-attributable MRSA bacteraemia and 27 E. coli bacteraemia so far this financial year.

FFT: All Areas: % Very Good or Good

✕

Actual	94.0%	YTD (Apr 21 to May 22)	**Accountability**	C.Lenney
Threshold	95.0%	(Higher value represents better performance)	**Committee**	Quality & Safety Committee

Month trend against threshold



Hospital level compliance - latest month performance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
✓	✓	✕	✓	✓	✓	✓	✕
95.9%	96.9%	91.1%	96.8%	96.6%	99.3%	98.2%	90.1%

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

Progress

In response to the Covid - 19 pandemic and in line with NHSE/I Guidance that was issued in March 2020, the submission of FFT data to NHSE/I was suspended. Further guidance that was received in May 2020 advised that where a provider was confident that any feedback collection method, including those received on electronic devices and on FFT cards, could be implemented safely, it may recommence and use those methods of patient feedback collection. Following consultation with the Infection Prevention and Control Team the Trust recommenced the collection of FFT data in May 2020 via these routes. The Health and Care Leaders update issued on 4th September 2020 advised that Acute and Community Providers should restart submitting the data to NHS Digital from December 2020 . The Trust overall satistaction rate for FFT (including data from the NMGH site following acqisition) for July 2021 is 94.3 % compared to 92.4% in June 2021.There is a continued focus for all areas of the Trust to use both positive and negative FFT feedback to improve the patient experience.

Actions

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

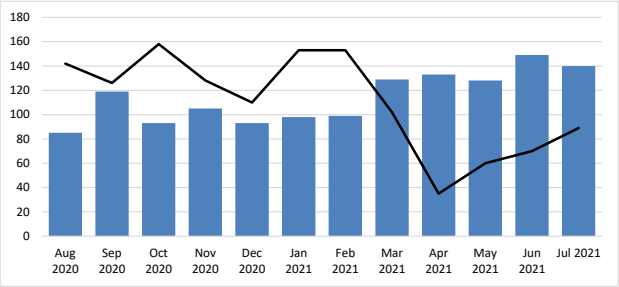
> Board Assurance

July 2021

Complaint Volumes

Actual	550	YTD (Apr 21 to Mar 22)	**Accountability**	C.Lenney
Threshold	95	(Lower value represents better performance)	**Committee**	Quality & Safety Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
✓	✓	✓	✗	✓	✓	✓	✗
28	126	57	80	20	13	122	64

The KPI shows total number of complaints received. Complaint volumes allow the Trust to monitor the number of complaints and consider any trends.

Key Issues

The number of new complaints received across the Trust in July 2021 was 140, when compared with the 149 complaints received in June 2021 and 128 in May 2021.

WTWA received 28 complaints in July 2021 which is the highest number of complaints in the Trust (20.0% of the Trust total), when compared with the 35 received in June 2021 and 27 in May 2021.

Of the 28 WTWA complaints received the top specific themes were 'Attitude of Staff' and 'Clinical Assessment (Diagnostic/Scan)'. There were no specific areas identified in the complaints relating to these themes.

At the end of July 2021 there was a total of 33 complaints that were over '41 days old', 10 of which had not been resolved within the agreed timeframe (30.3% of the total). This represents an increase when compared to 28 complaints over '41 days old' at the end of June 2021 and 22 at the end of May 2021.

The service area with the highest number of cases over 41 days at the end of July 2021 was Saint Mary's Hospital who had 7 (21.2% of the total) cases over 41 days old.

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

Actions

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

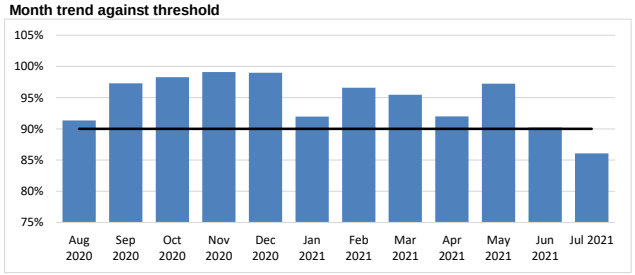
Progress

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

Percentage of complaints resolved within the agreed timeframe

Actual	90.7%	YTD (Apr 21 to Mar 22)	**Accountability**	C.Lenney
Threshold	90.0%	(Higher value represents better performance)	**Committee**	Quality & Safety Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
✓	✓	✓	◇	✓	✓	✓	✓
92.3%	97.1%	100.0%	84.7%	94.7%	100.0%	96.9%	100.0%

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

Progress

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

The July 2021 data identifies that 86.1% of complaints were resolved within the agreed timescales compared to 90.2% in June 2021 and 97.2% in May 2021: this is a decrease of 11.1%.

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

Actions

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

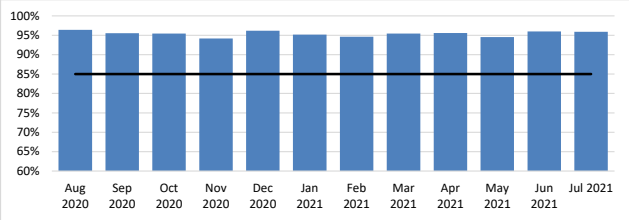
> Board Assurance

July 2021

Food and Nutrition

Actual	95.1%	YTD (Apr 21 to Mar 22)	**Accountability**	C.Lenney
Threshold	85.0%	(Higher value represents better performance)	**Committee**	Quality & Safety Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
✓	✓	✓	✓	✓	✓	✓	✓
99.5%	97.6%	90.8%	95.8%	98.5%	100.0%	96.5%	93.6%

The KPI data shows the % of the total responses to food & nutrition questions within the Quality Care Rounds that indicate a positive experience.

Progress

In response to the low score achieved by the Trust within the last National Inpatient Survey, improvement work continues both Trust wide and at ward level in respect of all aspects of food and nutrition . Patient dining forums are established on the ORC and WTWA sites.The MFT Nutrition and Hydration (food and drink) Strategy 2019-2022, sets out the Trust commitment to improving nutrition and hydration.
The Hospital's/ MCS's/LCO's progress on delivering on the commitments within the Nutrition and Hydration Strategy is monitored through the Patient Experience and Quality Forum.

In recognition of the need to further improve the quality of the food, a designated work programme was established in December 2019 with representatives from both Nursing and Estates and Facilities, with the intention of identifying several high impact changes. A key work stream, 'the Model Ward' was established in November 2019 with the aim of developing an 'exemplar ward' in respect of the catering provision and the dining experience for patients. It was anticipated that following the identification of the changes that would achieve the highest impact, these would be replicated across the wider Trust.

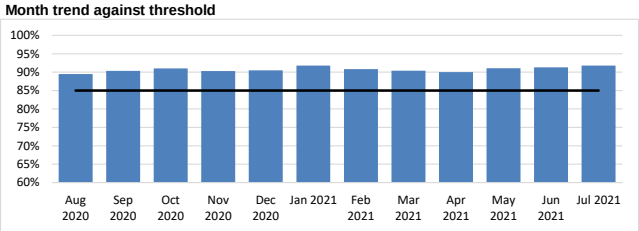
Utilising the Improving Quality programme (IQP) methodology, the MDT workstream engaged with patients and staff on Ward 12, at TGH to identify key areas to focus on improvement. Work commenced on the introduction of a hot breakfast and a 'snack round' from February 2020 with initial feedback reporting an improved dining experience.

Whilst the Model Ward Programme was suspended due to the Covid - 19 pandemic from March to August 2020, the group continued to meet to provide support to the staff on Ward 12 to support the provision of a personalised dining experience during a period of change which resulted in a disruption to normal services. Work on the Model Ward Programme has now resumed with the re-introduction of a cooked breakfast, and a workplan to progress the other key areas that were identified at the onset of the programme. A responsive review of nutrition will be presented to the Quality and Safety Committee in June 2021 with a view to informing a future actions and a revision of governance arrangements in July 2021.

Pain Management

Actual	90.5%	YTD (Apr 21 to Mar 22)	**Accountability**	C.Lenney
Threshold	85.0%	(Higher value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
✓	✓	✓	✓	✓	✓	✓	✓
95.5%	85.5%	91.1%	91.1%	100.0%	100.0%	94.2%	95.0%

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

Progress

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

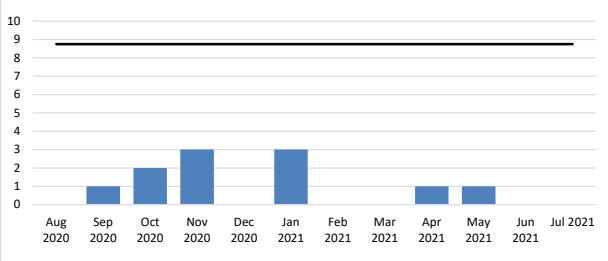
The oversight for this work is now provided by the Deputy Director of Nursing, CSS who continues to lead work to establish a future work programme. Performance against this KPI is monitored through the Trust Harm Free Care structure.

Clostridium Difficile – Lapse of Care

✓

Actual	2	YTD (Apr 21 to Mar 22)	**Accountability**	C.Lenney
Threshold	35	(Lower value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

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

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

Progress

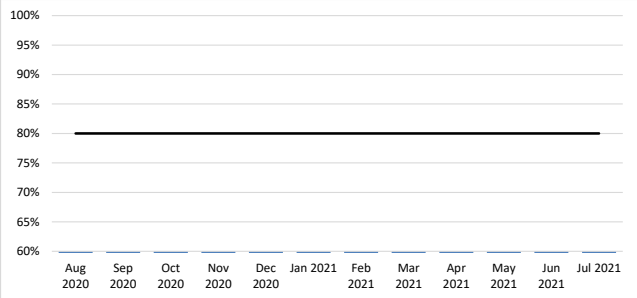
A total of 215 CDI cases were reported during 2020/2021: 179 (83%) of which were trust-attributable against a trajectory of 132. There have been 60 trust-attributable CDI reported so far this year, against a current threshold of 52. Of these cases, 2 have been identified as demonstrating a lapse in care. There were 21 trust-attributable CDI cases reported for July 2021, all of which are pending review.

Nursing Workforce – Plan v Actual Compliance for RN

●

Actual		(July 2021)	**Accountability**	C.Lenney
Threshold	80.0%	(Higher value represents better performance)	**Committee**	Quality & Safety Committee

Month trend against threshold



Hospital level compliance

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

As part of Safer Staffing Guidance the Trust monitors wards compliance with meeting their planned staffing levels during the day and night.This KPI provides the overall % compliance across all wards within the Trust with meeting the planned staffing levels.The actual staffing includes both substantive and temporary staff usage.

Progress

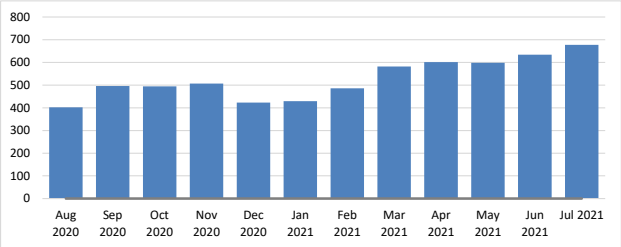
The monthly NHSI Safe Staffing report detailing the planned and actual staffing levels has been suspended since March 2020 due to the significant number of changes that have taken place within the clinical areas across the Trust during the pandemic. The planned daily staffing levels changed daily as the services altered to adapt to the patient needs. The data available is not considered accurate with the risk of providing false assurances internally and externally and potentially leading to misguided decision making if used. As wards are been reconfigured as part of the pandemic workforce recovery plan, the Health Roster templates and funded establishments are been adjusted to reflect the changes. This work is being led by the Hopistals/MCS DONs, HRDs and FDs to ensure ward/department establishment and staff in post support safe staffing levels and is expected to be completed by the end of Q3.

A safe staffing daily risk assessment is undertaken by the Director of Nursing for each hospital/MCS and the escalation level reported to the Trust Tactical Commander. Established escalation and monitoring processes are in place to ensure delivery of safe and effective staffing levels that meet the acuity and dependency of the patient group. Daily senior nurse staffing huddles are in place across the Hospitals.

PALS – Concerns

Actual	2510	YTD (Apr 21 to Mar 22)	**Accountability**	C.Lenney
Threshold	None	(Lower value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
-	-	-	-	-	-	-	-
168	560	228	345	108	72	656	267

Key Issues

A total of 677 PALS concerns were received by MFT during July 2021 compared to 634 PALS concerns in June 2021 and 598 in May 2021.

WTWA received the highest number of PALS concerns in July 2021; receiving 187 (27.6% of the total). This is an increase for WTWA when compared to the 169 in June 2021 and 145 in May 2021. The specific themes for WTWA related to 'Communication', 'Appointment/Delay/Cancellation (OP)' and Treatment and Procedure.

Surgery Directorate Mangement and Medical Specialties - Directorate Management are specific areas identified in the concerns relating to 'Communication' and Appointment/Delay/Cancellation (OP)' with Surgery Directorate Management and ENT Outpatients (Withington) being noted as a specific area identified in PALS concerns relating to 'Appointment/Delay/Cancellation (OP)'. There were no specific area identified in PALS concerns relating to 'Treatment/Procedure'.

Actions

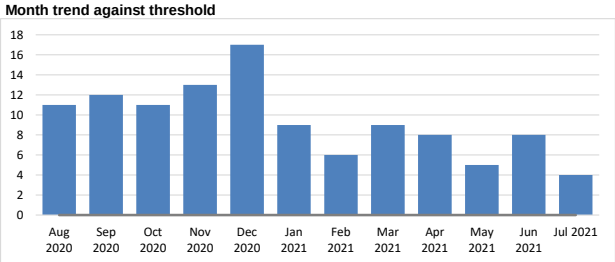
PALS concerns are formally monitored alongside complaints at the weekly meetings within each Hospital/MCS/LCO.

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

All Attributable Bacteraemia

Actual	25	YTD (Apr 21 to Mar 22)	**Accountability**	C.Lenney
Threshold	None	(Lower value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
-	-	-	-	-	-	-	-
2	4	6	3	0	0	6	4

MRSA and E.coli. There is a zero tolerance approach to MRSA bacteraemia. For healthcare associated Gram-negative blood stream infections (GNBSI), trusts are required to achieve a 25% reduction in healthcare associated GNBSIs by April 2022, and a 50% reduction by April 2024. There are currently no sanctions applied to this objective.

Progress

There were 595 incidents of E.coli bacteraemia reported to PHE during 2020/2021. Of these, 136 cases (23%) were determined to be hospital-onset. There have been a total of 27 trust-attributable E. coli bacteraemia reported so far in 2021/2022, of which 9 were reported during July 2021.

There were 15 trust-attributable MRSA bacteraemia cases reported to PHE during 2020/2021, and 9 community-attributable cases reported. There have been 3 trust-attributable MRSA bacteraemia reported for the current financial year, with the last case reported in May.

Operational Excellence

J.Bridgewater

Core Priorities	✓	◇	✕	No Threshold
	0	0	10	0

Headline Narrative

The ongoing prevalence of Covid, and the need to stand down elective activity for significant periods since March 2020 continues to have a profound detrimental impact on MFT performance against constitutional standards, particularly those related to elective access. Each peak of Covid inpatient and Critical Care demand requires the redeployment of nursing, medical and other operational staff for extended periods of time in order to support critical care demand.

Between February and May 2021 there was a period of slow decline in Covid inpatient and critical care patient numbers, that supported a staged approach to reconfiguration and desclation agreed through Strategic Group. However since the start of June there has been increasing incidence of Covid in the community, and this has resulted in a sharp increase in Covid inpatient and Critical Care numbers again at MFT.

In addition, since Mid-February, MFT Emergency Departments have encountered significant pressures with high attendances and an increase in acuity of patients. As a result of the high demand, and a continued need to split estate and flow to manage IPC requirements, MFT continues to have a significant number of breaches across main EDs.

Nothwithstanding these continuing operational challenges, MFT continues to progress actions aimed at improving performance against standardsand meeting national planning gudiance. The Trust's recovery programme ismanaged through a Recovery and Resiilence Board. The bi-weekly Recovery and Resilience Board meeting is overseen by the Chief Transformation Officer and reports into the Trust Strategic Group chaired by the Group Chief Operating Officer.

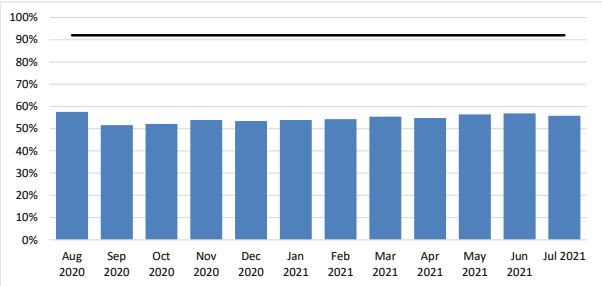
July summary:
• MFT waiting list size has continued to grow throughout 2020 and into Q2 of 2021. At the end of July 2021 there were 145,823 patients on the wait list compared to 134,434 (inc. NMGH) at April 2021, an increase of 8.4%.
• At the end of July, MFT has 14,442 patients who have waited longer than 52 weeks for treatment. The July figure is however a 14.4% decrease on the April position of 16,882.
• The number of patients waiting longer than 104 weeks in July was 732 (0.20%) of the overall waiting list. This is a significant increase on April's position of 129. This cohort relates to patients who are not categorised as clinically urgent for treatment.
• MFT 4 hour performance of 67.85% was ranked 3rd in July across GM (average GM performance was 68.51%). Performance % reflects high levels of attends across MFT EDs and ongoing challenges to meet the demand whilst maintaining screening and separating possible Covid patients.
• As a result of significant operational pressures, Wythenshawe and North Manchester sites have both reported 12 hour wait breaches during July, 1 and 5 respectively.
• Whilst there has been improved performance in 3 of the 6 cancer standards (Urgent 2 week wait referrals, 2 week wait- Breast and 62 day screening), the Trust is underachieving against all 6 of the cancer standards. Within these standards some sites are however meeting performance targets.

Operational Excellence - Core Priorities

RTT - 18 Weeks (Incomplete Pathways)

Actual	55.8%	(July 2021)	**Accountability**	J.Bridgewater
Threshold	92.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



The percentage of patients whose consultant-led treatment has begun within 18 weeks from the point of a GP referral. Incomplete pathways are waiting times for patients waiting to start treatment at the end of the month.

Key Issues
• Periodic suspension of elective programme activities across 2020 and 2021 as a result of Covid waves and critical care support requirements.
• Cautious resumption of the elective programme during Q1/Q2 of 2021/22 using a clinically prioritised basis through regular Group MESH meetings.
• Periodic redeployment of staff to support critical care requirements associated with Covid, and subsequent need for cautious release given ongoing underlying covid incidence.

Actions
• Group MESH has been mobilised to ensure patients with urgent clinical needs are treated, and maintain oversight and effective use of resources across MFT sites. This includes Independent Sector capacity already agreed for use by MFT.
• The potential to utilise private sector capacity, GM and regional pathways is under constant consideration in order to maximise delivery of patient care.
• Processes to review individual patients for clinical harm continue at hospital / MCS level.
• Ongoing Outpatient Improvement work as part of Recovery Programme to develop transformation opportunities. Weekly RTT oversight and performance meetings holding hospitals / MCS to account on delivery.
• Group COO teams (Transformation and RTT) continue in place to support hospitals/ MCS, including consistent, safe approach to development of Attend Anywhere, Virtual triage and Patient initiated follow up programmes.
• Working with MHCC to expand advice and guidance with support from the transformation team.
• Additional timely validation of PAS/waiting lists by Hospital sites and Group resource continues.

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
✕	✕	✕	✕	✕	✕	✕	✕
74.8%	51.0%	60.5%	51.6%	64.5%	58.9%	59.0%	49.4%

Progress
• The impact of Covid and the suspension of the elective programme has had a detrimental impact on MFT's waiting list and RTT position since April 2020, which is also reflected nationally.
• The end of July wait list stands at 145,823. This is an increase of 4,278 (3.0%) on June and 11,389 (8.5%) on the position at April (the first month including NMGH).
• The number of patients waiting longer than 52 weeks in July was 14,442 (9.9%) of the overall waiting list. This is a 14.4% decrease on the April position of 16,882.
• The number of patients waiting longer than 104 weeks in July was 732 (0.20%) of the overall waiting list. This is a significant increase on April's position of 129. This cohort relates to patients who are not categorised as clinically urgent for treatment.
• MFT continue to treat the most clinically urgent patients, and the longest waiters are prioritised for treatment through the Group and Site MESH committees.
• The number of virtual outpatient appointments undertaken in July was 30% of all appointments.

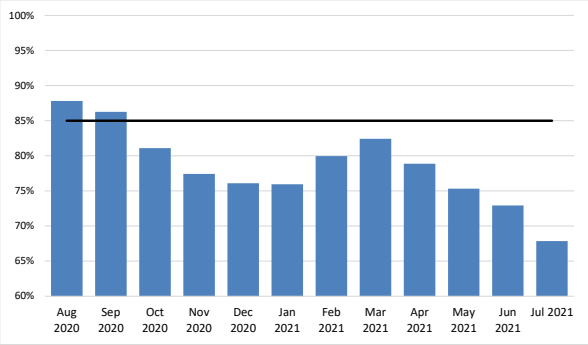
> Board Assurance

July 2021

A&E - 4 Hours Arrival to Departure

Actual	67.9%	Q2 21/22 (Jul to Jul 21)	**Accountability**	J.Bridgewater
Threshold	90.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
NA	✗	✗	✓	✓	NA	✗	✗
NA	62.7%	72.4%	99.1%	100.0%	NA	73.3%	57.8%

The total time spent in A&E - measured from the time the patient arrives in A&E to the time the patient leaves the A&E Department (by admission to hospital, transfer to another organisation or discharge). With a target that 95% of all patients wait no more than four hours in accident and emergency from arrival to admission, transfer or discharge.

Key Issues

• Historic underperformance against this standard throughout 2019/20, primarily due to demand pressures, higher acuity of presentations, flow constraints due to long length of stay and delayed transfers of care.
• At the start of the Covid pandemic in March 2020 the number of patients attending A&E declined considerably and resulted in an unexpected positive impact on performance against the standard, however this was not sustained.
• As a result of increased ED demand, some increase in the acuity of patients, and continued need to split estate and flow to manage IPC requirements MFT continues to have a significant number of breaches across EDs.

Actions

• Hospital Senior leadership teams at MFT are responding to current performance pressures and have submitted action plans. Patient safety remains a key priority.
• These plans are underpinned by implementation of a number of key programmes of operational improvement and transformational programmes of work. Key areas include, but are not limited to:
i. Working with system partners to promote redirection at streaming stage through initiatives such as helicopter nurse;
ii. Continued development of Same Day Emergency Care capacity across sites;
iii.Expansion of appointments for urgent care available to 111 at ED and Urgent Treatment Centre services;
iv. Care and management of mental health patients presenting in conjunction with Mental health services;
v. Further integrated work with system partners to support discharge process and timely transfers of patients; and
vi. Review of workforce capacity and out of hours presence (medical and nursing).
MFT has also developed ED safety standards that are being implemented across the ED departments. Each site is undertaking a safety and point prevalence review. MFT Urgent Care Recovery work is aligned to GM urgent care recovery work.

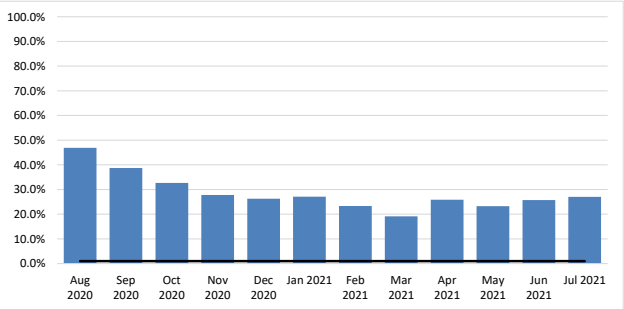
Progress

• July 2021 saw 5,316 (14.5%) additional attendances compared to April 2021. Volume, higher acuity of patients and IPC measures have impacted performance and the number of breaches has increased from 7,779 in Apr 2021 to 13,531 in July 2021(74% increase).
• As a result of significant operational pressures, Wythenshawe and North Manchester sites have both reported 12 hour wait breaches during July, 1 and 5 respectively.
• MFT reported performance of 76.94% for Q1 2021/22, and 67.85% for the month of July 2021.:
• The number of patients with 7+ and 21+ days Length of Stay in MFT beds at 25th July was 815 and 345 respectively. nb. The Trust will always have a element of LLoS due to clinical complexity.

Diagnostic Performance

Actual	27.0%	(July 2021)	**Accountability**	J.Bridgewater
Threshold	1.0%	(Lower value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
✗	✗	✗	✗	NA	NA	✗	✗
12.2%	53.6%	83.0%	40.0%	NA	NA	39.0%	41.3%

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

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

Key Issues

• Cancellation of diagnostics in March 2020 in line with National directive to cancel elective and OPD activity meant that performance dipped significantly through the first Quarter of 2020/21.
• Subsequently though as the pandemic impact declined during the Summer of 2020 performance improved and this was maintained during the 3rd Covid wave in January and February 2021.
• The rise in April 2021 overall waiting list size and subsequent breach numbers was as a result of the merger with North Manchester General Hospital from the 1st April 2021.

Actions

• Whilst there is not an individual workstream related to diagnostics, this is a critical consideration and cuts across all outpatient, elective and cancer workstreams.
• Activity has been undertaken for clinically urgent / priority patients, improvements in the reporting backlog were achieved as a result of less demand during the pandemic.

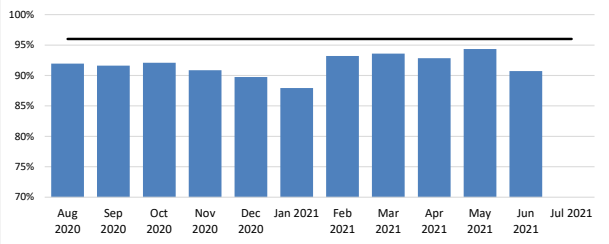
Progress

• Prior to merger the waiting list size for diagnostic tests reduced for legacy MFT month on month from June 2020 and stood at 21,557 at end March 2021.
• Post integration and inclusion of NMGH diagnostic numbers, the waiting list as reported in July 2021 has increased to 27,435.
• Group Performance, whilst remaining challenged with a 27.0% breach rate in July 2021, has improved when compared to performance in August 2020 of 46.9%.

Cancer 31 Days First Treatment

Actual	92.6%	Q1 21/22 (Apr to Jun 21)	**Accountability**	J.Bridgewater
Threshold	96.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
NA	✗	✓	✗	NA	NA	✗	✗
NA	76.6%	100.0%	83.3%	NA	NA	94.4%	93.0%

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

Key Issues

• Cancer Demand, Theatre and HDU capacity, exacerbated by Covid impact.

Actions

• Cancer treatments are being prioritised during the Covid pandemic, in line with national guidance on priority patients.
• Undated patients over 14 days are discussed at the group level MESH meeting with hospital / MCS leads.
• Capacity is assessed weekly by Cancer Managers, Hospital and Clinical Leads.
• Mutual aid for capacity is being coordinated via MESH internally and the GM surgical hub is still available for use.
• Cancer Recovery Workstream in place, details under the 62 day standard.
• Use of the Independent Sector throughout the Covid pandemic for thoracic and breast surgery.

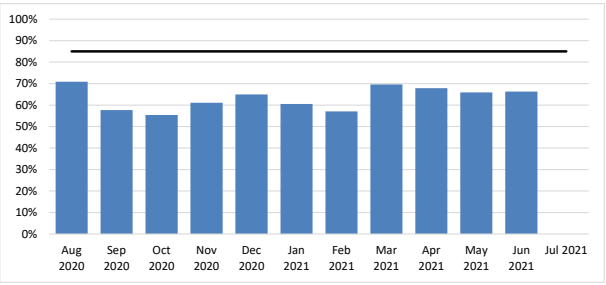
Progress

• The most challenged tumour sites are Urology, Gynaecology, Head and Neck and GI services (especially HPB where a large number of patients require HDU capacity).
• Skin also underperformed in July but there is more emphasis on patient choice in these groups.
•The number of undated patients waiting over 14 days is reducing week on week.
• Urology capacity is being sought at the GM hub.
• Cancer Recovery Workstream in place, details under the 62 day standard.
• WTWA and NMGH are marginally underachieving against the standard. RMCH is achieving the standard

Cancer 62 Days Referral to Treatment

Actual	66.7%	Q1 21/22 (Apr to Jun 21)	**Accountability**	J.Bridgewater
Threshold	85.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
NA	✗	NA	✗	NA	NA	✗	✗
NA	52.7%	NA	40.0%	NA	NA	68.3%	71.9%

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

Key Issues

• Historical underperformance against the standard due to demand pressures, and diagnostic delays.
• The impact of Covid has resulted in capacity constraints and affected the ability of cancer systems across the UK to deliver planned cancer treatment for all its cancer patients.

Actions

• A number of immediate actions were undertaken to support the continuation of the most urgent cancer activity during the Covid pandemic, with the cancer patient tracking lists clinically triaged in line with a national urgency criteria.
• New referrals continue to be received and clinically triaged, with telephone assessments and progress to diagnostics as appropriate. Referral rates have increased to pre covid levels whilst the Trust is still reducing its backlogs due to diagnostics delays and patient choice.
• The wider GM system has put a number of actions in place to coordinate system capacity, including mutual aid for capacity coordinated via a GM Cancer Surgical Hub. In addition, GM wide work is taking place on the introduction of a single PTL for 4 specialist diagnostic tests.
• MFT is supporting a GM led LGI improvement week in August. These LGI patients are the highest volumes of long waiters on the PTL.

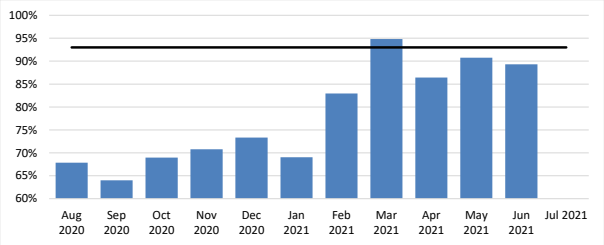
Progress

• Demand – average monthly referrals were 2,921 in 2019 (Jan to June) and this has increased to average 3,290 per month in 2021. This is excluding NMGH for comparison. Including NMGH MFT average at 3,700 referrals a month.
• Performance - Both 62 day and 31 day are improving month on month Q4 21 was 62.7%
• Trajectories are in place for all tumour groups to reduce the longest waits by September. However MFT is currently not meeting the month on month trajectory and remedial actions are being planned with hospitals / MCS.
• Safety remains a key priority and harm reviews continue to be undertaken for the longest wait patients.

Cancer Urgent 2 Week Wait Referrals

Actual	88.8%	Q1 21/22 (Apr to Jun 21)	**Accountability**	J.Bridgewater
Threshold	93.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
NA	✓	✓	✓	NA	NA	✗	✗
NA	94.6%	100.0%	97.6%	NA	NA	88.1%	91.7%

The percentage of patients urgently referred for suspected cancer by their GP that were seen by a specialist within 14 days of referral.

Key Issues
- Demand has increased to >100% of pre covid position
- Breast performance is reduced across GM.
- Demand – average monthly referrals were 2,921 in 2019 (Jan to June) and this has increased to average 3,290 per month in 2021. This is excluding NMGH for comparison. Including NMGH MFT average at 3,700 referrals a month

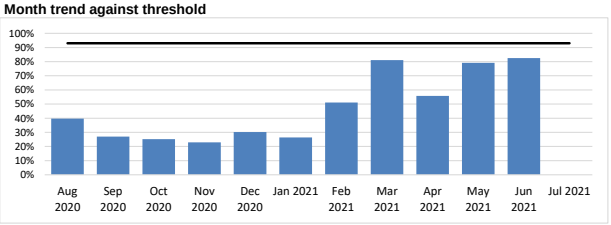
Actions
- Actions are noted under the above cancer standards, in addition the actions being undertaken as part of the outpatient recovery workstream will support resilience of this standard.

Progress
- Cancer 2ww referrals have returned to >100% pre covid averages. Head and Neck and LGI have the biggest increases over the pre covid position. Lung has the lowest numbers compared to pre covid, Urology is also slightly reduced
- MRI and RMCH met the target across Q1, NMGH narrowly underperformed at 92.6%. SMH was affected in June by a mismatch with radiology for one stop clinics but this has now recovered.
- The Breast cancer site is affecting the overall Group performance, due to its size, and also capacity challenges as a result of Covid. This services doesn't lend itself to virtual appointments. Performance here is improving and patients are treated quickly once diagnosed.
- Skin still remains an issue with patient choice being a factor and the face to face element. Head and Neck servcies at both WTWA and MRI are a challenge due to increased referrals, more so at WTWA where the closure of the service at East Cheshire has had a huge effect. MRI is looking to provide mutual aid and the service set up at WTWA is being reconfigured.

Cancer 2 Week Wait - Breast

Actual	72.4%	Q1 21/22 (Apr to Jun 21)	**Accountability**	J.Bridgewater
Threshold	93.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
NA	NA	NA	NA	NA	NA	✗	✗
NA	NA	NA	NA	NA	NA	79.6%	87.0%

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

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

Actions
- All referrals are being triaged with high risk patients invited to attend a face to face appointment, and physical examination.
- Clinics are running at reduced numbers to maintain social distancing precautions and reduce Covid risk
- Cancer Recovery Workstream in place, details under the 62 day standard.

Progress
See the 2ww measure.

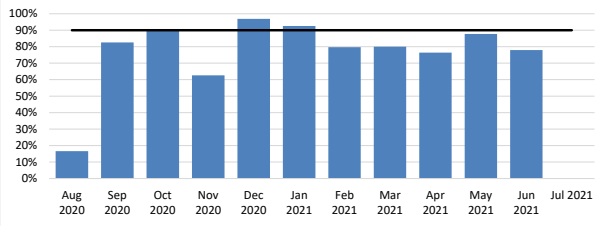
> Board Assurance

July 2021

Cancer 62 Days Screening

Actual	80.2%	Q1 21/22 (Apr to Jun 21)	**Accountability**	J.Bridgewater
Threshold	90.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
NA	✗	NA	✗	NA	NA	◇	•
NA	0.0%	NA	0.0%	NA	NA	87.6%	

The percentage of patients receiving first definitive treatment for cancer following referral from an NHS cancer screening service that began treatment within 62 days of that referral.

Key Issues

- Prior to Covid there was risk to the bowel screening programme due to the national introduction of a less invasive and more sensitive screening test. This led to an increase in uptake by participants, over and above the original planning assumptions which led to a temporary suspension of the programme as agreed with the regional hub.
- Nursing workforce capacity constraints have been a factor impacting on capacity.
- Covid impact.

Actions

- The Actions listed under Cancer 62 Days are applicable to this standard.

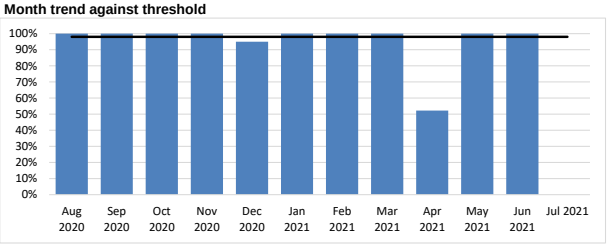
Progress

- Approval has been given by the MFT strategic group to restart the Bowel screening programme, along with high risk breast patients, and the lung health checks has recommenced.
- As noted above performance is likely to reduce as activity increases and the backlog is reduced.
- Treatment numbers remain low - only WTWA performed against the target due to the number of breast treatments. The screening backlog over 62 days is reducing.

Cancer 31 Days Sub Chemo Treatment

Actual	88.2%	Q1 21/22 (Apr to Jun 21)	**Accountability**	J.Bridgewater
Threshold	98.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

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

The percentage of patients that waited 31 days or less for second or subsequent treatment, where the treatment modality was an anti-cancer drug regimen.

Key Issues

- Small numbers of breaches In April reduced in month performance.

Actions

- Actions are outlined under the cancer 62 day standard.

Progress

•Standard achieved in month.

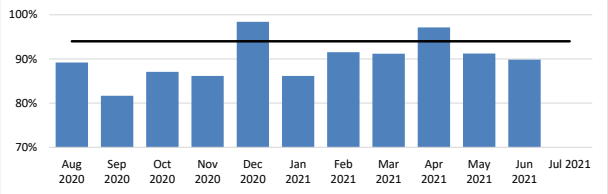
> Board Assurance

July 2021

Cancer 31 Days Sub Surgical Treatment

Actual	92.9%	Q1 21/22 (Apr to Jun 21)	**Accountability**	J.Bridgewater
Threshold	94.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
NA	✗	NA	✗	NA	NA	✓	✓
NA	42.9%	NA	83.3%	NA	NA	95.5%	100.0%

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

Key Issues

- Cancer Demand increasing
- Smaller volume of treatments on this pathway

Actions

Actions noted under the above cancer standards.

Progress

- Progress noted above under the 31 day first standard.
- MRI underachieved against the standard, most of the specialties here require HDU input. SMH narrowly underachieved with only 1 breach for the quarter in June. WTWA and NMGH achieved standard in month.
- WTWA treat the most patients on the subsequent pathway with breast and skin surgery.

Workforce and Leadership

P. Blythin

Core Priorities	✓	◇	✕	No Threshold
	5	1	5	3

Headline Narrative

Work continues to progress the MFT People Plan. A variety of communications materials have been issued to raise the profile of the plan including all-staff emails, social media posts attracting positive engagement from staff, and intranet content including notifications via staff app. Communications will focus on a monthly theme, with the first month's theme being 'Recognition - We feel valued and heard'. The launch of 'Our MFT Story' (part 1), e-book and wall art has been mounted at sites across the Trust to conclude the first month. The People Plan Delivery Group (PPDG) has now been established receiving progress updates and escalations from Deliverable Owners.

The COVID-19 workforce recovery programme is progressing. Accelerated recruitment initiatives are taking place in key areas and a variety of recovery focused team development packages have been developed. Work to further enhance our psychological support for staff is underway and partnership arrangements with Greater Manchester Mental Health (GMMH) are currently being explored.

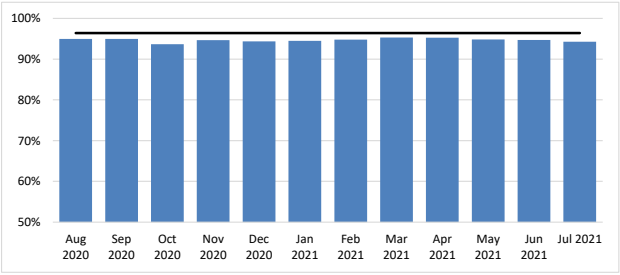
HIVE workforce preparations are moving ahead at pace. The procurement of a new Learning Management System is near completion and preparations for HIVE end user training have commenced.

Workforce and Leadership - Core Priorities

Attendance

Actual	94.3%	(July 2021)	**Accountability**	P. Blythin
Threshold	96.4%	(Higher value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
✕	✕	✕	✕	✕	✕	✕	✕
95.0%	93.5%	94.7%	94.5%	91.4%	93.7%	93.6%	94.6%

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

Key Issues

The Group attendance rate for July was 94.3% which is lower than the previous month's figure (94.7%). This is also lower that the attendance rate at the same point last year (July 2020) of 95.0%. The latest figures released by NHS Digital show that for March 2021 the monthly NHS staff sickness absence for the whole of the North West HEE region was 4.8% or 95.2% attendance rate (these figures include all provider organisations and commissioners) which was the highest in England.

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

Actions

Attendance is one of the key metrics which is closely monitored through the Accountability Oversight Framework (AOF). Focussed discussion with the HR Directors of each Hospital / Managed Clinical Service (MCS) / LCO also features prominently in the actions to improve performance. Corporate performance is addressed though the Corporate Directors' Group.

The Absence Manager system is in place across all MFT sites. The system was introduced at North Manchester at the beginning of August 2021 to enable real-time absence reporting. Using recovery monies four new Absence Coordinator posts have been introduced across the Trust to support our managers make best use of the Absence Manager system in the effective management of absence and to support the health and wellbeing of our staff.

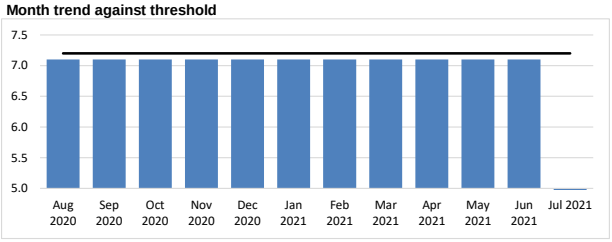
> Board Assurance

July 2021

Engagement Score (quarterly)

Actual	7.10	Q2 21/22	**Accountability**	P. Blythin
Threshold	7.20	(Higher value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
✗	✗	✓	✗	✗	✓	✗	NA
7.0	7.0	7.2	6.9	7.1	7.6	7.1	NA

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

Key Issues

The staff engagement score for the MFT Group is 7.1 from the 2020 NHS Staff Survey, which ran from September to November 2020 with results provided in February 2021. NHSEI suspended the Staff Friends and Family Test (SFFT) until further notice, in response to the pandemic.

The SFFT has historically been incorporated into MFT Pulse Surveys and consistent with national decision, MFT also paused its Pulse Survey. Prior to this, these questions were contained in the Trust quarterly administered Pulse Survey. NHSEI have recently communicated they are replacing the SFFT to provide consistency; a standardised approach nationally and enable more regular reporting of NHS staff working experience. This will now be referred to as the Quarterly Staff Survey (QSS). The requirement has been implemented as part of the commitment within the national People Plan and the People Promise.

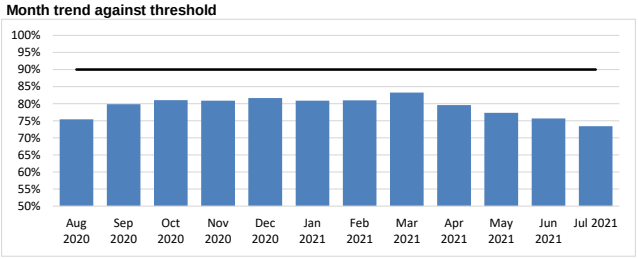
Actions

The 2021 Staff Survey will launch at MFT late September, and will provide the next update to staff engagement scores. As has been the case since 2017, it will run as a full census, giving the opportunity for as many staff as possible to complete the survey.

Appraisal- non-medical

Actual	73.4%	(July 2021)	**Accountability**	P. Blythin
Threshold	90.0%	(Higher value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
✗	✗	✗	✗	◇	◇	✗	✗
69.1%	74.7%	81.1%	78.6%	87.2%	87.4%	79.1%	52.0%

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

Key Issues

Compliance decreased by 2.3% across the Group in July 2021. Only North Manchester General Hospital and the Eye Hospital increased their compliance score from June 2021, all other Hospitals and MCS's have a lower compliance rate compared to the previous month. CSS had the biggest drop in compliance at 8.0% with a score of 69.1% compared to 77.1% in June.

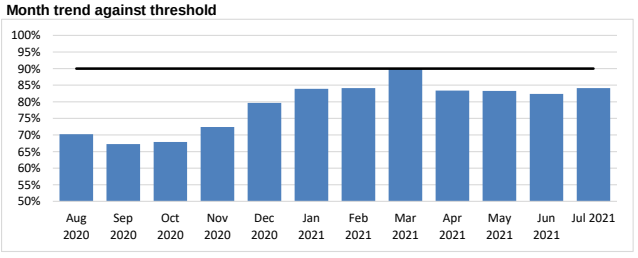
Actions

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

Appraisal- medical

Actual	84.1%	(July 2021)	**Accountability**	P. Blythin
Threshold	90.0%	(Higher value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
◇	◇	◇	◇	✓	✗	✓	✗
89.0%	86.0%	88.7%	88.0%	95.4%	82.2%	90.3%	51.0%

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

Key Issues

Compliance increased by 1.7% across the Group in July 2021. Only CSS, Dental Hospital and Saint Mary's have a lower compliance score from June 2021, all other Hospitals and MCS's have a higher compliance rate compared to the previous month. North Manchester General hospital had the biggest increase in compliance at 9.6% with a score of 51.0% compared to 41.4% in June.

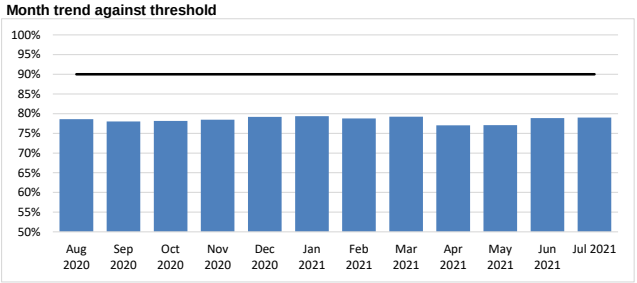
Actions

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

Level 2 & 3 CSTF Mandatory Training

Actual	79.0%	(July 2021)	**Accountability**	P. Blythin
Threshold	90.0%	(Higher value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
✗	✗	✗	✗	✗	✗	✗	✗
77.8%	79.9%	80.6%	82.4%	78.6%	78.2%	81.8%	69.1%

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

Key Issues

Compliance increased by 0.1% across the Group in July 2021. Only Corporate Services, the Dental Hospital, NMGH and WTWA have a higher compliance score from June 2021, all other Hospitals and MCSs have a higher compliance rate compared to the previous month. NMGH had the biggest increase in compliance at 3.6% with a score of 69.1% compared to 65.5% in June.

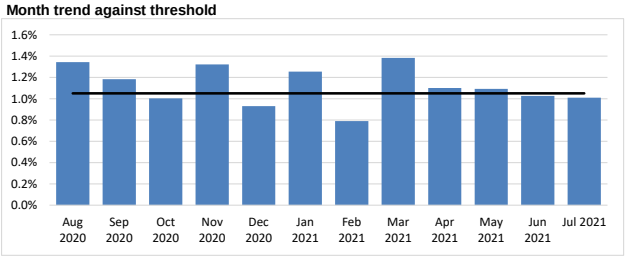
Actions

The 5 key Mandatory Training work streams, overseen at CEO / Director level, have progressed in line with the KPMG audit where we received significant reassurance. Work to integrate this programme into business as usual processes is now underway. All courses are now assigned within individual's dashboards on the Learning Hub helping to drive understanding and compliance. Work continues to drive compliance through the weekly reporting and regular communications.

B5 Nursing and Midwifery Turnover (in month)

Actual	1.0%	(July 2021)	**Accountability**	P. Blythin
Threshold	1.05%	(Lower value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
✓	✓	✓	◇	✓	NA	✗	✗
0.93%	0.59%	0.36%	1.00%	0.00%	NA	1.07%	1.94%

This indicator measures and monitors the turnover of Band 5 Qualified Nursing & Midwifery staff within the organisation by comparing the total number of leavers and the total number of Full Time Employment (FTE) staff as a rate (excludes Fixed Term Contract staff). The graph shows the rate in a single month.

Key Issues

The turnover for July 2021 is 1.0% against a monthly target of 1.05%. This is the same as the previous month (June 2021). The rolling 12 month average for B5 Nursing and Midwifery turnover was 13.7% in July 2021 which is 1.0% lower than last year (14.7%, July 2020).

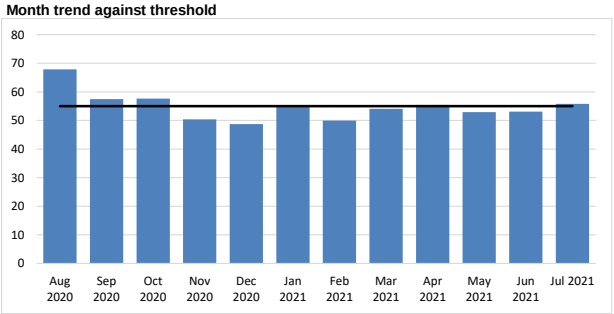
Actions

Retention of Nurses and Midwives remains a key focus for the Trust. Through the development of MFT CPD the Trust is focused on staff engagement to develop career opportunities that meet staff need and the needs of our patients. A new series of leadership programmes have been launched to support NMAHP staff to develop leadership skills.

Time to Fill Vacancy

Actual	55.8	(July 2021)	**Accountability**	P. Blythin
Threshold	55.0	(Lower value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
✗	◇	✗	✗	✗	✓	✓	✗
60.2	55.7	71.3	67.6	75.1	46.5	48.5	58.6

This indicator measures the average time it takes, in days, to fill a vacancy. It measures the time taken from the advertising date (on the TRAC Recruitment System), up to the day of unconditional offer. The graph shows an in month rate. The metric does not include Staff Nurses as there is a separate metric for this provision.

Key Issues

The Time to Fill (TTF) figure, exluding Band 5 Nursing, has slightly increased from 53.1 in June to 54.9 in July, albeit still within the target of 55 days. July saw a 14% increase in applicants completing the pre employment process during this period (FY1s and other priority groups).TTF in all areas other than the Dental Hospital and LCO has increased slightly during this period and this is largely due to the increased volume of recruitment activity across the Trust.

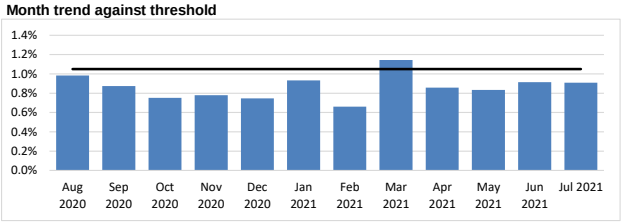
Actions

Work continues at pace to identify and remove blockages within the recruitment process, as a result of the ongoing streamlining programme of work. A key part of this programme is the provision of accurate reports to all Hospitals / MCSs and LCO on vacancies and applicants. These weekly reports are now a key component of the Resourcing reporting regime . This will be further supplemented in the next few months by the regular provision of data depicting performance against each stage of the recruitment process with the view to highlighting inefficiencies at a local level to support the continued improvement in TTF performance.

Turnover (in month)

Actual	0.91%	(July 2021)	**Accountability**	P. Blythin
Threshold	1.05%	(Lower value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
✓	✓	✓	✓	✗	✗	◇	✗
0.69%	0.89%	0.65%	0.96%	1.15%	1.37%	1.02%	1.29%

This indicator measures and monitors the turnover of staff within the organisation by comparing the total number of leavers and the total number of Full Time Employment (FTE) staff as a rate (excludes the naturally rotating Foundation Year 1 and Year 2 junior medical staff and the Fixed Term Contract staff). The graphs shows a single month rate.

Key Issues

The single month turnover position for the Group has remained the same at 0.9% when compared to the previous month (0.9%).

The turnover rate was slightly lower at the same point last year (July 2020) at 0.6%.

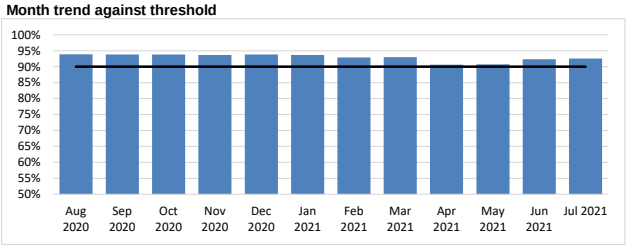
Actions

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

Level 1 CSTF Mandatory Training

Actual	92.6%	(July 2021)	**Accountability**	P. Blythin
Threshold	90.0%	(Higher value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
✓	✓	✓	✓	✓	✓	✓	✗
92.4%	94.4%	93.5%	94.3%	93.8%	95.1%	94.0%	86.5%

This indicator measures the % of staff who are compliant at the point the report is run. Staff are compliant if they have undertaken corporate mandatory training within the previous 12 months.

Key Issues

Compliance is monitored against the aggregate of all 11 Core Level 1 subjects. In July the aggregate compliance increased by 0.3% to 92.6%. Only NMGH has a compliance score below the 90% Trust target.

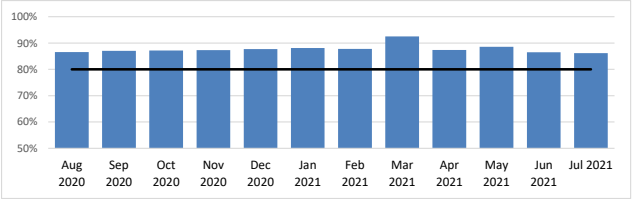
Actions

The 5 key Mandatory Training work streams, overseen at CEO / Director level, have progressed in line with the KPMG audit where we received significant reassurance. Work to integrate this programme into business as usual processes is now underway. NMGH have now been successfully integrated into the Learning Hub from 26th April 2021 which enables us to manage compliance levels.

Nurse Retention

Actual	86.1%	(July 2021)	**Accountability**	P. Blythin
Threshold	80.0%	(Higher value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
✓	✓	✓	✓	✓	✓	✓	✗
86.2%	84.9%	88.3%	85.5%	85.1%	89.1%	85.4%	50.0%

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

Key Issues

In July 2021, Nursing and Midwifery retention stands at 86.1% which continues to be above the threshold of 80%.

Actions

The retention threshold target for Nursing and Midwifery staff provides a strong indication of whether we are able to retain staff across the Trust and whether our polices, procedures and practices are supportive of the Trust being seen as a good place to work. The Trust has implemented a guaranteed job offer for Student Nurses and Midwives whom have completed their studies within the Trust as part of the retention of home grown Nurses and Midwives.

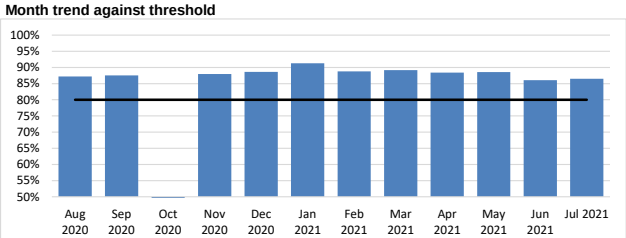
BME Staff Retention

✓

Actual 86.5% (July 2021) **Accountability** P. Blythin

Threshold 80.0% (Higher value represents better performance) **Committee** HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
✓	✓	✓	✓	✓	✓	✓	NA
86.8%	86.2%	87.6%	85.6%	88.0%	94.4%	83.7%	NA

This indicator measures the Black Minority & Ethnic (BME) staff retention rate. It measures, by %, the BME staff in post for the Trust 12 months ago who are still employed in the organisation to date. The retention rate information excludes the naturally rotating Foundation Year 1 and Foundation Year 2 junior medical staff as they are employed by the lead employer St Helen's & Knowsley Trust. The rate is shown as a rolling 12 month position.

Key Issues

The BME retention rate remains consistently above the Trust's threshold of 80% month on month, the retention rate for July was 86.5%.

Action

All Hospitals / MCS / LCO are tracking this KPI within their AOF and their retention rates are all above the Trust's threshold of 80% and developing plans to address where negative gaps are being identified.

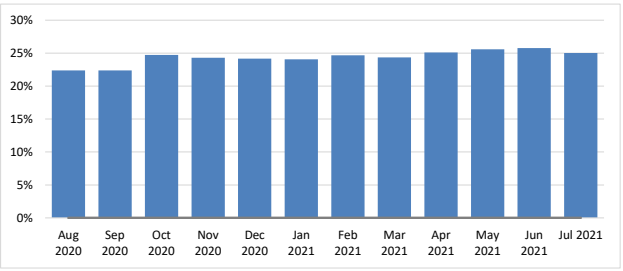
% BME Appointments of Total Appointments

-

Actual 25.0% (July 2021) **Accountability** P. Blythin

Threshold None (Higher value represents better performance) **Committee** HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
-	-	-	-	-	-	-	-
25.9%	27.1%	25.1%	19.5%	37.7%	41.7%	27.7%	18.8%

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

Key Issues

One in four appointments is of black and minority ethnic origin (25.0%); which is consistent month on month.

The Trust has increased its % BME appointments of Total Appointments by 2.7% when compared to the same point last year (July 2020, 22.3%). The Workforce Directorate has completed the Workforce Race Equality Standard Report for 2020/21 and reported to HR Scrutiny Committee. Hospital / MCS / LCO / Corporate action plans near completion.

Actions

The Group figure is higher than the Greater Manchester BME population of almost 17% but lower than the Manchester BME population of over 30%.

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

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

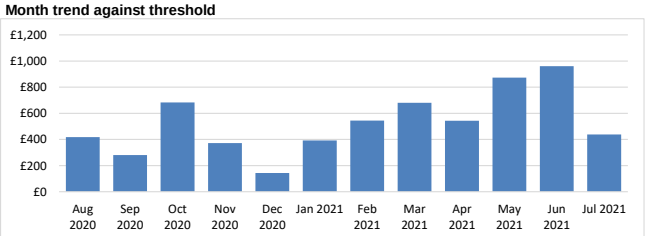
Medical Agency Spend

-

Actual £439 (July 2021) **Accountability** P. Blythin

Threshold None (Lower value represents better performance) **Committee** HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
-	-	-	-	-	-	-	-
-£15.0	£355.9	-£9.1	£21.1	£69.0	£0.0	£158.8	£0.0

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

Key Issues

The July total value of Medical and Dental agency staffing was £439k compared to £960.1k in June. This is a considerable drop from June but we predict that this will increase in August due to doctor change over and holidays.

Actions

Spend continues to be reviewed for both bank and agency medics across all Hospitals/ MCSs and grades. This is including an in-depth monthly review of all of the cost centres using medical agency workers and opportunities identified where possible to reduce this. A more concentrated focus has been put on the Emergency Departments across the Trust.

A new booking platform for bank and agency medics was launched in November 2020, which has taken longer than expected to operationally embed but is delivering a lower cost per agency transaction compare to the previous supplier.

> Board Assurance

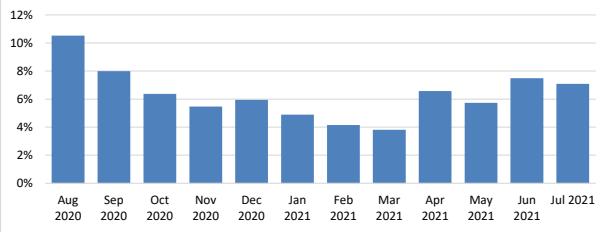
July 2021

Qualified Nursing and Midwifery Vacancies B5 Against Establishment

-

Actual	7.1%	(July 2021)	**Accountability**	P. Blythin
Threshold	None	(Lower value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Wythenshawe, Trafford, Withington & Altrincham	North Manchester General Hospital
-	-	-	-	-	-	-	-
-8.1%	7.0%	1.5%	6.2%	12.1%	NA	9.8%	16.0%

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

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

Key Issues

The majority of vacancies within Nursing and Midwifery are within the Staff Nurse (band 5) role. At the end of July 2021 there were 337.7 (7.1%) Staff Nurse / Midwife / ODP (band 5) vacancies across the Trust Group.

This data reflects the current vacancy position based on current financial establishment data compared to HR staff in post data. However, some concerns have been raised that this may not be an accurate reflection of operational vacancy levels. Work is underway to review both data sets following the transfer of NMGH and the budget setting process.

Actions

A Group Resourcing Plan supports recruitment activity including virtual events and social media campaigns. A group level targeted theatres campaign is going to run through September, with an accompanying paid recruitment campaign, to support the COVID-19 recovery plans.

> Board Assurance

July 2021

Finance

A.Roberts

Core Priorities	✓	◇	✕	No Threshold
	0	0	0	0

Headline Narrative

The monthly update on Operational Financial Performance is provided through regular papers provided to the Finance and Scrutiny committee and the MFT Board Meeting.

Finance - Core Priorities

Operational Financial Performance

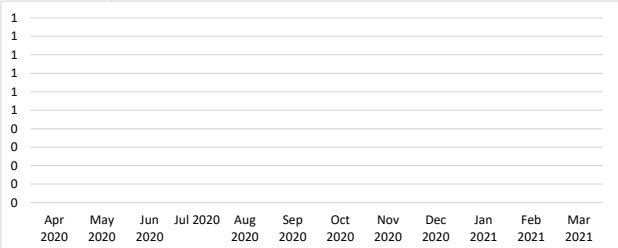
Actual

Threshold

Accountability A.Roberts

Committee TMB and Board Finance Scrutiny Committee

Month trend against threshold



Hospital level compliance

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

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

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

Regulatory Finance Rating

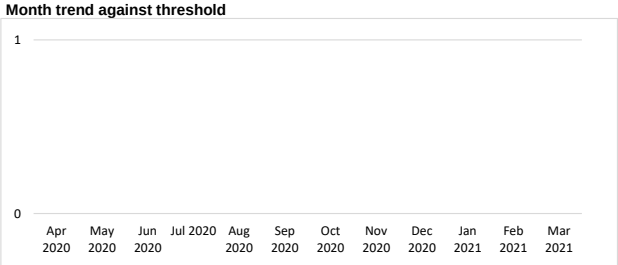
Actual

Threshold (Lower value represents better performance)

Accountability A.Roberts

Committee TMB and Board Finance Scrutiny Committee

Month trend against threshold



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

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

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Chief Operating Officer
Paper prepared by:	James Allison, Director of Turnaround
Date of paper:	September 2021
Subject:	Update on MFT's ongoing response to Covid: General update, performance standards, and recovery 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:	To achieve high standards of patient safety and clinical quality across the Trust demonstrated through performance outcome measures
Recommendations:	The Board of Directors is asked to note the contents of the report.
Contact:	Name: James Allison, Director of Turnaround Tel: 0161 276 6718

COVID – UPDATE ON THE TRUST ONGOING RESPONSE

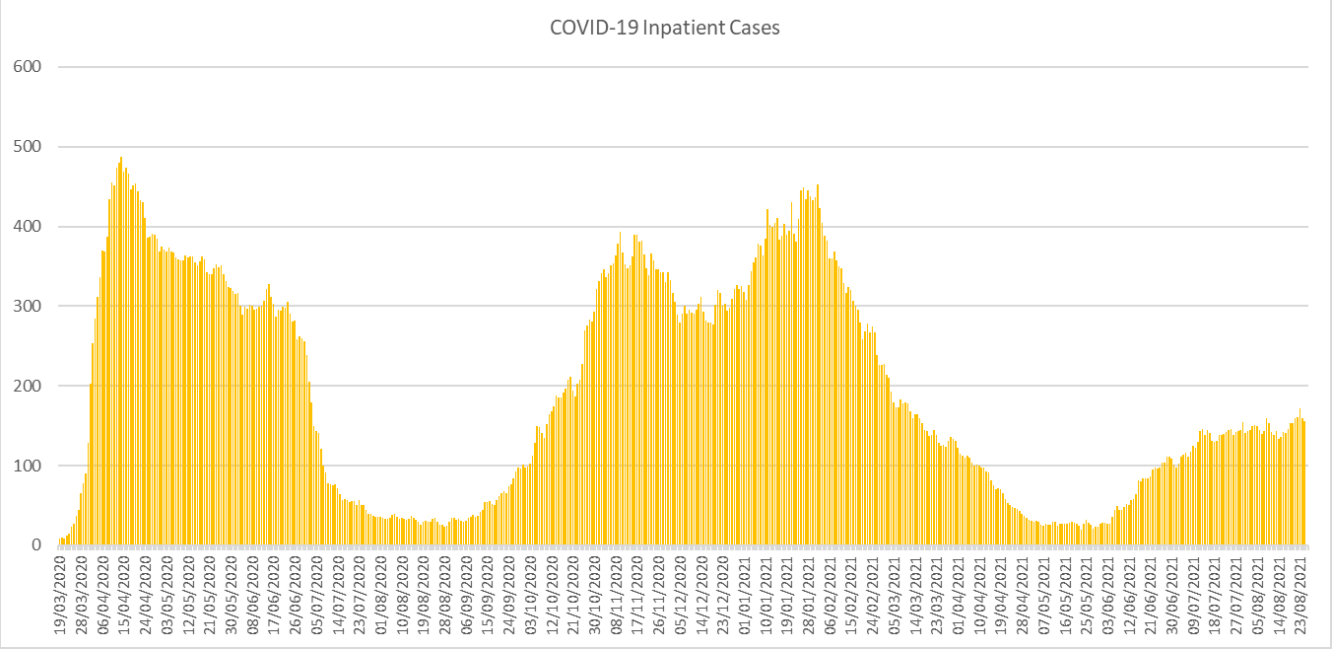
1. PURPOSE

The purpose of this briefing is to provide Board of Directors with an overview of the MFT ongoing response to the Covid 19 pandemic ("Covid"). This 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

- During Quarter 1 of 2021 MFT had a peak of Covid attendances at the end of January with 453 Covid patients occupying in-patient beds, and 64 patients in Critical care beds (level 2/3).
- This number of Covid inpatients represented 93% of the wave 1 Covid peak (487 inpatients, 14th April 2020).
- Between February and May 2021 there was a slow decline in Covid inpatient and critical care patient numbers that facilitated operational efforts to progress resumption of certain services.
- However, since the start of June 2021 there has been an increasing incidence of Covid in the community, and this resulted in a sharp and sustained increase in Covid inpatient and Critical Care numbers at MFT.
- At 25th August MFT had 156 Covid inpatients and 23 Covid patients in Critical Care.

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



3. CONTINUED COVID PLANNING

The decision-making process to support ongoing Covid management continues to be led by the Chief Operating Officer (and AEO); Medical Directors; Chief Nurse and the Group Executive Directors through the MFT Strategic Group.

Individual Hospital / MCS escalation plans continue into Quarter 2 of 2021/22 and the ongoing response to Covid has resulted in a sustained impact on the Trust's recovery workstreams and performance against national standards across the first two quarters of 2021/22.

In order to address Covid demand, a tiered approach to escalation processes remains in place to balance the impact on all activity programmes. Following a slow decline in Covid inpatient and critical care patient numbers in the period from February to May 2021, MFT Strategic Group took the decision to cautiously increase routine elective activity, focusing on priority patients including Cancers in line with national guidance.

However, the marked and sustained increase in Covid patients since June requiring inpatient and critical care support has continued to require focus on the re-implementation of appropriate estate escalation plans across relevant sites. The tiered escalation approach allows MFT to quickly flex ward configurations to balance the provision of care to Covid and Non-Covid patients. Further, sustained numbers of non-Covid Urgent Care, inpatient and critical care patients at the same time as Covid attendances has resulted in significant operational pressures across MFT sites, addressed in following sections of this progress paper.

Notwithstanding the most recent increase in Covid demand across sites, operational efforts continue to progress the resumption of services whilst balancing Covid demand.

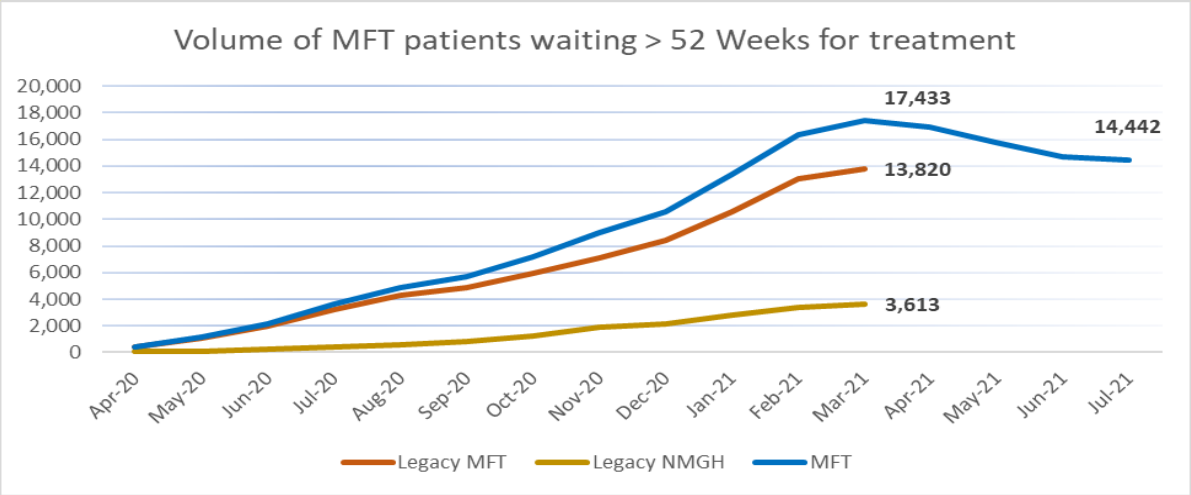
- Utilisation of available elective capacity continues to be managed through the Clinical and Operational leadership of The Manchester Elective Surgical Hub (MESH);
- Ongoing managed release of clinical staff from Covid wards including Critical Care has allowed Outpatient activity to increase; and
- Specific Committee and programme governance meetings have been re-introduced and returned to pre Covid format.

Strategic Group remains focused on the efficient and timely management of Covid attendances, whilst balancing the needs of Urgent Care, and non-Covid inpatient and outpatients. MFT continues to take actions to improve performance by addressing elective backlogs in line with national planning guidance for 2021/22. Where possible, the Independent Sector is being utilised to support 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 ON LONG WAITS

The continued prevalence 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. The overall waiting list size at the end of July 2021 was 141,545 of which the volume of >52-week waiters at the end was 14,442, a decrease of 2,991 (17.2%) on the position at the end of March 2021(17,433). See table 2 over the page.

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



MFT continues to follow national guidance to ensure it treats its most clinically urgent patients first. The impact of this is that whilst the overall number of 52+ week waiters is decreasing currently, the number of non-urgent patients waiting longer than 104+ weeks for treatment is increasing. At the end of April 2021 MFT had 129 patients who have waited more than 104 weeks for treatment. By the end of July this has increased to 732.

The Trust continues to performance manage hospital / MCS delivery, clinical validation of patients, and support the modelling of capacity at hospital / MCS and specialty level. The priority of this work is to ensure the number of long waiters is minimised where possible, using GM hub and Independent Sector provision where appropriate.

5. RECOVERY PROGRAMME

5.1 RECOVERY PLANNING

Working collaboratively with other GM Health provider organisations, MFT continues to support and influence planning efforts for elective recovery across 2021/22. Plans set out the GM ambition for elective recovery; including details of how collectively GM will work to address the overall waiting list size and take the opportunity to transform service delivery in the process. GM recovery principles include:

- Taking a system approach to ensure equity of access across GM for those on waiting lists;
- Ensuring best use of current available capacity, including the utilisation of Independent sector capacity;
- Development of additional capacity through transformational and efficiency work;
- Ensuring available capacity to deliver elective activity is sufficient to cope with short term capacity issues and / or staff shortages, and peaks in Covid activity;
- Protecting Covid free pathways – ensuring ability to maintain adequate segregation of Covid positive and negative patients; and
- Guarding against increased IPC risk through regular changes to wards between Covid and Non-Covid.

Elective recovery will be supported at GM level through the planned use of GM Covid-secure “green” surgical sites. Initially these sites will be utilised to focus on key specialties with the highest number of long waiting patients.

To progress restoration of elective care a GM Task and Finish Group has been established, and continues to meet, reporting into the GM Elective Recovery and Reform Programme Board. The Recovery Task and Finish Group is chaired by MFT's Professor Jane Eddleston.

The MFT elective recovery programme is aligned to the GM principles listed above and the national planning requirements for H1 (see section 5.3). The MFT programme has four main workstreams:

- Theatre modelling – the introduction of an enhanced theatre allocation model that will support the MFT recovery programme to allocate theatre activity on the basis of clinical urgency.
- Theatres efficiencies – a review of capacity on Trafford General Hospital site (Trafford) with cross-site clinical engagement, and development and implementation of actions to enhance utilisation and support recovery across all MFT sites;
- GM Hubs – working with GM to secure green capacity for high volume, low complexity work, to be focussed on the Trafford site; and
- Single Patient Treatment Lists – implementing cross-site, single PTL working across key specialties in order to equalise wait times across specialties. This will be managed through the MESH process.

In respect of plans to use Trafford sites as a standalone elective hub facility, bids have been submitted for funding from GM through the Elective Recovery Fund mechanism. Funding has been bid for to support additional evening and weekend work primarily in Trauma and Orthopaedic and Paediatric dentistry specialties.

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 continues to be required to ensure MFT treats its most clinically urgent patients first given infection prevention and control and staffing constraints. This is playing a critical role in delivering elective activity as part of the recovery phase.

Enhanced site-based MESH (Manchester Emergency & Elective Surgical Hub) groups have continued to meet regularly since the start of the year. Given current pressures on availability of critical care beds, MESH processes have been strengthened and each hospital / MCS is now required to rank patients in order of clinical priority and need for post-operative critical care bed.

5.3 RECOVERY MODELLING

Planning for 2021/22 has been split into two sections: H1 planning, which covered April to September, and H2 planning, which will cover October to March. The H1 plan was based on a set of NHSE guidance issued in March 2021, with which MFT submitted plans via the Integrated Care System ("ICS") in May. Guidance for H2 has not yet been issued. It is anticipated this will be released in early September, and that MFT will support GM planning work for a final submission in October or November.

The planning guidance for H1 set out some limited 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% during the H1 Period; and
- Infection Protection Control: continued, reliable application of the UK IPC guidance (and therefore implications for productivity and capacity).

These three assumptions have broadly held out, although the rise in Covid inpatients in the H1 period means MFT has double the level of bed occupancy, approaching 10% rather than 5% of Covid bed occupancy.

There has been limited information released about the H2 requirements, however it is apparent that there will be further national focus on reduction of long waiters over 104+ weeks. It is also understood that targets will be set for Outpatient transformation, with a 2% target for follow-up patients added to Patient Initiated Follow Up ("PIFU") and a 15% target for advice and guidance ("A&G") to be given to new referrals.

Once the guidance has been issued MFT expects to take a similar approach as in the previous planning rounds with a draft planning model that is based on specialty and POD level of detail. Plans will be taken through EDT for sign-off before submission.

6. PROGRESS ON RECOVERY WORKSTREAMS

The Recovery and Resilience Board (RRB) has been driving the ongoing Recovery programme with a much greater focus on operational delivery. 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 Urgent Care and Outpatient work. In addition, more recently work has been undertaken on diagnostic validation (see section 6.3).

6.1 URGENT CARE AND FLOW

Since Mid-February, MFT EDs have encountered significant pressures with high attendances and an increase in acuity of patients. As a result of high demand, and a continued need to split estate and flow to manage IPC requirements MFT continues to have a significant number of breaches across EDs.

Hospital Senior leadership teams at MFT are responding to current performance pressures and have submitted action plans underpinned by implementation of a number of key programmes of operational improvement and transformational programmes of work. Key areas include, but are not limited to:

- Working with system partners to promote redirection at streaming stage;
- Continued development of Same Day Emergency Care capacity across sites; with direct conveyance to these services by NWAS and primary;
- Expansion of appointments for urgent care available to 111 at ED and Urgent Treatment Centre services;
- Care and management of mental health patients presenting in conjunction with Mental health services;
- Further integrated work with system partners to support discharge process and timely transfers of patients; and
- Review of workforce capacity and out of hours presence (medical and nursing).

MFT has also developed ED safety standards that are being implemented across the ED departments. Each site is undertaking a safety and point prevalence review and consideration has been given within the development of these safety standards to workforce escalation triggers that outline the provision of mutual aid across sites at times of severe operational pressure.

Given current attendance and performance levels, monitoring of delivery is taking place on a daily basis through routine reporting, and weekly through Strategic Group. There is also significant focus from the North West regional team on GM and MFT performance. Delivery of these actions by MFT sites remains challenged by the ongoing need to manage increasing Covid and Non-Covid attends and the increasing use of capacity for elective activity as this work gathers pace.

6.2 OUTPATIENTS

MFT made significant progress against Outpatient recovery in the first quarter of H1. Overall levels of recovery were at 88% of 19/20, which was 4% below the H1 plan. Virtual activity levels reduced to 30% as a proportion of overall activity but this was due to the recovery being focused on face to face activity, though this level remained above NHSE's target of 25%.

At the mid-point of Q2 the overall levels of activity have fallen to 82% with all hospitals experiencing a fall in activity compared to 19/20. This is in part due to site pressures as Covid inpatients have increased on the acute sites and staff redirected from outpatients. However, it is also driven by the greater than usual staff sickness absence and annual leave. Virtual activity levels have remained at close to 30% across Q2.

Outpatient transformation has focused on the implementation of virtual triage and Patient Initiated Follow Up (PIFU), in alignment with national transformation priorities. Virtual triage ensures all GP referrals are triaged before acceptance, to ensure these patients are seen in the right place, first time. This allows Advice & Guidance (A&G) to be provided at this point and the referral rejected. It also means patients can be redirected to the right specialty or clinic, can be upgraded to a suspected cancer referral, sent straight to a test or procedure, or listed for a virtual first appointment.

Virtual triage supports transformation of the patient pathway as well as supporting A&G. Overall levels of A&G are around 4-5% of the first appointments. An evaluation of virtual triage will be undertaken in October 2021.

PIFU moves MFT from a scheduled, clinician-directed follow-up to a flexible, patient-led follow-up. It is appropriate where a clinical decision is taken that conditions are stable but may experience short term flare ups, and where overall risk is low. Overall levels of PIFU doubled between April and July as the transformation team worked with individual specialties, so that July levels are around 1% of follow-ups. However, there is greater potential usage for PIFU and this work will continue into the Autumn.

Working with the Local Community Organisation we have also established community-based phlebotomy clinics for patients seen in virtual outpatient settings.

6.3 DIAGNOSTIC WAITING LIST VALIDATION

Following the elective waiting list validation ("EWLV") programme that started in October 2020 and ran to February 2021, NHSI initiated the diagnostic waiting list validation ("DWLV") programme in May 2021. This sought to (a) assign patients a priority diagnostic code, and (b) contact patients to understand their preferences with regards to their diagnostic procedure.

Nationally, the DWLV programme considered a sub-set of patients waiting more than 6 weeks for their test and for MFT this meant consideration of endoscopy patients. These patients were already clinically prioritised and work was undertaken with the clinical lead to map patient back to the national codes. Patients are being contacted as per the guidance.

6.4 TACKLING HEALTH INEQUALITIES & DEPRIVATION

MFT has recently established a Health Inequalities Group to tackle health inequalities including analysing data by characteristics and deprivation. The Group is chaired by the Joint Group Medical Director and attended by representatives from the hospitals/MCS, corporate teams and the Clinical Commissioning Group.

A programme of work is being developed and there is an expectation that in the H2 period there will be a need for national reporting on measures of inequality and deprivation. Further, this requirement will influence the content of future Board reporting.

7. STAFF TESTING

The programme of asymptomatic staff Lateral Flow Testing (LFT) is ongoing. MFT staff and affiliates continue to self-test twice a week, with the aim of helping to reduce the level of nosocomial infection rates within MFT and community transmission in the region.

As at 18th August 2021, a cumulative total of 340,195 tests had been undertaken and reported by staff. The number of staff who have reported a positive LFT was 828, a 0.24% positive rate, with 82% of LFT positives being confirmed by a subsequent PCR test.

The Trust has taken a number of steps to promote continued testing and recording of results. This has included the introduction a text reminder service with text messages being sent to staff who have registered via the app and collected a kit but have not reported any results in the last 7 days. In addition, improved functionality allows staff the option to scan and submit a photo of the completed test cassette.

All centrally held stocks of test kits have been distributed to hospitals / MCS / MLCO and staff that require further test kits now have to request them via a national pull model, ordering through a Government online portal.

8. PERFORMANCE

Urgent Care:

- Safety remains a key priority for the organisation.
- MFT was ranked 3rd in both June and July for the 4-hour performance target and is ranked 4th for Quarter 2 2021/22 at 24th August.
- Acuity of patients presenting and limitations on bed capacity due to flow restrictions and social distancing at times of attendance have impacted performance in both Q1 and Q2 of 2021/22.
- WTWA and NMGH have reported 1 and 5 twelve-hour breaches at their respective sites. No patient harms have been reported.

4 Hour Performance	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Q2 to date *
MFT 21/22 %	81.07	77.40	76.10	75.95	79.96	82.41	78.87	75.73	72.93	67.85	67.53
MFT GM Rank	2	2	3	3	4	3	3	6	3	3	4
GM %	76.30	74.70	74.30	75.30	79.43	79.97	79.43	78.04	73.65	68.51	68.56
National %	84.42	83.84	80.28	78.51	83.92	86.14	85.40	83.70	81.30		

* Q2 upto and including 24th August 2021

Planned Care:

RTT & 52 Weeks:

- Whilst the total waiting list size has increased since April 2021, the number of patients waiting >52 weeks has decreased from 16,882 to 14,442 at end of July (reduction of 14.4%).
- MFT continue to treat the most clinically urgent patients, and the longest waiters are prioritised for treatment through the Group and Site MESH committees.

		Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July
MFT (inc NMGH from April 2021)	Wait List	106,438	106,706	109,452	111,006	113,659	115,222	134,434	137,393	141,545	145,823
	52 Weeks	5,946	7,100	8,443	10,602	12,999	13,820	16,882	15,755	14,706	14,442
	% of W/L >52 weeks	5.6%	6.7%	7.7%	9.6%	11.4%	12.0%	11.86%	11.47%	10.39%	9.90%
National position	Wait list *Million	4.44	4.21	4.28	4.31	4.42	4.67	4.73	4.99		
	52 Weeks	162,888	186,310	215,641	288,160	366,194	269,953	367,142	321,317		
	% of W/L >52 weeks	3.7%	4.4%	5.0%	6.70%	8.3%	5.78%	7.76%	6.4%		

Diagnostics:

- The waiting list size for diagnostic tests at MFT has reduced by a further 405 patients between May and June to 26,275 (from 26,680).
- The breach rate for the 6-week standard decreased in May by 2.56% to 23.25%. However, in June the breach rate has increased close to April value at 25.71% (+2.46% on May).
- In March the breach rate was 19.14% of the total wait list for MFT, the lowest rate so far during the 2020/21 year.

DMO1 Breach rate	Oct	Nov	Dec	Jan	Feb	Mar	April	May	Jun
MFT	32.70%	27.80%	26.30%	27.10%	23.35%	19.14%	25.81%	23.25%	25.71%
NMGH	34.00%	27.80%	31.30%	16.60%	6.30%	9.91%			
National	29.20%	27.50%	29.20%	33.30%	28.50%	24.30%	24.00%	22.30%	Not available

Cancer:

- Total referrals for suspected cancer have returned to at least to pre-Covid levels across MFT sites, although there is variability both month on month and between tumour groups.
- Performance against the 62 day standard has slowly improved since March 2021, but is likely to remain below the target standard whilst backlog cases are cleared.
- In respect of 2 week waits, WTWA continue to 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 March and April resulting in a period of underperformance in the 2ww % across MFT, picking up to 90.7% in May then decreasing slightly to 89.3% in June.
- Head and Neck referrals at WTWA and North continue to increase over and above expected levels following the closure of the East Cheshire service. Work is ongoing to reconfigure the pathway across MFT to allow the use of an electronic triage tool and telephone appointment to allow for earlier removal from the pathway as appropriate. A GM audit of referrals is planned.

Cancer		Target	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
MFT	2WW %	93%	63.2	67.9	64.0	68.9	70.8	73.3	69.0	82.9	94.8	86.4	90.7	89.3
	31 Day %	96%	94.5	92.0	91.6	92.1	90.9	89.7	87.9	93.2	93.5	92.8	94.3	90.7
	62 Day %	85%	69.3	71.8	57.7	55.4	61.1	65.0	60.5	57.1	69.6	67.9	65.9	66.3

>104 day and >62 day cancer waits

- Prioritisation reviews are undertaken through Trust MESH process and general PTL management to support the reduction of cancer waits above 104 and 62 days.
- At the end of July, MFT was above trajectory to reduce the backlog of 104 and 62+ days to pre-covid baseline. Actions are being planned with hospitals / MCS to address this.
- A GM led Lower GI improvement week is underway as this is the tumour group across GM with the largest number of backlog patients.

9. RECOMMENDATION

MFT 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:	September 2021
Subject:	Update on MFT's ongoing response to Covid: 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 is 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. The national vaccination programme commenced in December 2020. So far, more than 47 million people have had a first vaccine dose - about 87% of the adult (over 16 years of age) population - and over 41 million (about 75%) have had their second dose.

2. Manchester University NHS Foundation Trust (MFT) Vaccination Programme

2.1. The MFT vaccination programme commenced in December 2020, delivering both AstraZeneca and Pfizer vaccines across the four clinics at Manchester Royal Infirmary, North Manchester General Hospital, including North Manchester General Hospital and Trafford General Hospital[1].

2.2. Through the MFT staff vaccination programme[2]:

91.9% have received their first vaccine[3]
88.2% 2nd dose vaccines have either been administered or booked
100% of MFT staff have been offered the vaccination.

3. Context of vaccine delivery in Manchester

3.1. MFT are supporting the Manchester Vaccination programme, specifically working with Manchester Health Care Commissioning Group to increase vaccine coverage in Manchester where 65%[4] of people over the age of 16 years have received their 1st dose.

4. MFT's contribution to date

4.1. MFT continue to work in partnership with MHCC in delivery of the Manchester vaccine programme, by:

- Walk-in clinics to specifically targeted groups.
- Offer of vaccination to pregnant women of all ages, including staff who are booked for care at St Mary's.
- Opportunistic in-patient vaccination, including paediatric in-patients[5] and particularly vulnerable groups, for example patients who have undergone stem cell transplant since initial vaccination course completed
- The Your Household offer, which ran between January and July 2021

5. JCVI interim guidance[6] suggested stages

5.1. The primary objective of any potential COVID-19 booster vaccine programme is to reduce serious disease, and death. Although the guidance is in the interim stage, it is clear that where studies are supportive, a 3rd dose (booster) should be offered to the most vulnerable first, starting from September 2021 to maximise individual protection and safeguard the NHS ahead of Winter.

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[1] Trafford delivered AZ vaccine only – will move to deliver an alternate vaccine in Phase 3
[2] Data accurate at 18th August 2021 – numbers fluctuate due to new starters and leavers
[3] Including those exempt or declined as at 18th August 2021
[4] Data accurate at 23rd August 2021
[5] MFT are already considering the offer to children's vaccination programme if it is agreed this is a requirement. JCVI are currently deliberating the benefits to children and others of a vaccination programme in children.
[6] JCVI interim advice issued

5.2. Almost all the people identified for a booster dose, will also be eligible for an annual influenza vaccine.

5.3. Any potential COVID-19 booster programme should be offered in 2 stage, the MFT vaccination Phase 3 programme concentrates on primarily on Stage 1:

- Stage 1. The following persons should be offered a third dose COVID-19 booster vaccine and the annual influenza vaccine as soon as possible from September 2021:
  - adults aged 16 years and over who are immunosuppressed
  - those living in residential care homes for older adults[7]
  - all adults aged 70 years or over[8]
  - adults aged 16 years and over who are considered clinically extremely vulnerable
  - frontline health and social care workers

- Stage 2. The following persons should be offered a third dose COVID-19 booster vaccine as soon as practicable after stage 1, with equal emphasis on deployment of the influenza vaccine where eligible:

  - all adults aged 50 years and over
  - adults aged 16 to 49 years who are in an influenza or COVID-19 at-risk group.
  - adult household contacts of immunosuppressed individuals

6. MFT Phase 3 Planning

6.1. As described above, the JCVI have advised that 'early evidence on the concomitant administration of COVID-19 and influenza vaccines used in the UK supports the delivery of both vaccines where appropriate'.

6.2. MFT planning aligns with the national approach, supporting co-administration of flu and COVID-19 vaccines for MFT staff in the same appointment to allow more efficient use of resources, as well as supporting improved uptake of both vaccines.

7. Vaccine Programme, Delivery and Supply

7.1. Whilst supply is constrained, the MFT vaccination programme has delivered over 142,000 vaccines through the four clinics. The pharmacy team work closely with the vaccine clinic teams to ensure sufficient supply is available to match demand.

7.2. The vaccination programme moved into its second phase during May to September 2021, vaccination offers continue to new employees or those who have not yet been vaccinated across the hospital clinics.

8. Responding to National Guidance

8.1. On 4th August 2021, the JCVI issued advice on COVID-19 vaccination of young people aged 16 to 17. As previously advised, children aged 12 – 15 years with specific underlying conditions have been offered both doses of the vaccination through RMCH where appropriate.

[7] This cohort will receive their vaccination through primary care provision

[8] This cohort will be included opportunistically through the in-patient offer where appropriate

8.2. The updated guidance includes offering the vaccine (single dose) to 16 – 17 year olds, and a 2 dose vaccination to those aged 17 years and 9 months. MFT will support with this cohort on an opportunistic basis in the situation that they are admitted to hospital for any reason.

8.3. Recent responses to updates to PHE's Green Book[9] and the National Protocol used to deliver the vaccine have been incorporated into MFT policies and procedures.

9. Policies, procedures and guidelines

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

10. Data and reporting

10.1. 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

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

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

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

11. Communications and Engagement

11.1. Protecting vulnerable people this winter is even more important, COVID-19 continues to be a live concern for people, including MFT staff and patients.

11.2. The Phase 3 campaign aims to deliver clear, targeted effective communications and engagement activity to drive uptake of flu and COVID-19 booster vaccines, with a 100% offer recorded for all staff.

11.3. A coordinated and creative engagements plan has been developed for the Phase 3 programme to ensure that all people offered the vaccine have the information required to help make decisions. The plan includes building on what went well in the successful 2020/21 flu campaign, and what we have learned through the COVID-19 vaccination Phase 1 & 2 programmes, including:

- Weekly champions meetings
- Interactive Q&A panels with experts from across the Trust
- Myth busting sessions
- Partner external channels
- Manager discussion packs
- Use of national resources

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

12. Governance

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

12.2. 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.

13. Summary

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

13.2. There has been good uptake of the COVID-19 vaccination across MFT staff:

13.3. 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.

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

14. Recommendations

14.1. The Board of Directors are asked to note the report and the planning taking place for the flu 2021 programme and the Covid-19 booster programme.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse/Director of Infection Prevention and Control (DIPC)
Paper prepared by:	Michelle Worsley, Head of Nursing for Infection Prevention & Control/Tissue Viability
Date of paper:	September 2021
Subject:	Update on MFT's ongoing response to Covid: To provide assurance to the Board of Directors on IPC management of Covid-19 and 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:	The Board of Directors are asked to note the actions and progress to reduce the risk of transmission of COVID-19 across all our services
Contact:	Name: Michelle Worsley, Head of Nursing for Infection Prevention & Control / Tissue Viability 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 August 2021 (Appendix 1).

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.

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

1.4 The paper also provides information in relation to Structured Judgement Reviews where a death has occurred associated with a Covid-19 acquisition.

2. IPC BAF

2.1 As previously reported the Trust has regularly undertaken assessments against the standards in the Board Assurance Framework (BAF) developed by NHS England/Improvement (NHSE/I). The main purpose of the Framework is to support healthcare providers to identify, address risk and self-assess compliance with Public Health England (PHE) and other COVID-19 related infection prevention and control guidance.

It also serves as an improvement tool to optimise actions and interventions. NHSE/I updated the IPC BAF in June 2021[1] to include additional indicators in 7 of the 10 IPC standards, and some minor alterations to sentence formation in 8 of the standards to reflect where implementation rather than planning should have occurred.

3.0 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.

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

[1] NHSE Infection Prevention and Control Board Assurance Framework V1.6 30th June 2021

- 11th January 2021. Board of Directors Meeting
- 8th March 2021. Board of Directors Meeting
- 20th April 2021. Group Infection Control Committee
- 10th May 2021. Board of Directors Meeting (as part of a report relating to the COVID-19 response and Nosocomial Infections).
- 12th July 2021. Board of Directors Meeting
- 21st July 2021. Group Infection Control Committee

3.1 **For ease of reference updates are highlighted to the 10 standards of the BAF.**

- Systems are in place to manage and monitor the prevention and control of infection. These systems provide risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users (updates included on pages 5, 6, 8, 9, 12, 13, 16 – 19)
- Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections (updates included on pages 23 – 30)
- Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance (No change)
- 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 (updates included on page 33, 34 & 35)
- 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 (update included on pages 37, 41 – 44)
- 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 (updated on page 45 - 49)
- Provide or secure adequate isolation facilities (updated on page 54)
- Secure adequate access to laboratory support as appropriate (updates included on page 55 - 57
- Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections (no change)
- Have a system in place to manage the occupational health needs and obligations of staff in relation to infection (updated on pages 62 and 65)

3.2 Assurance can be provided that:

- the Trust has assessed the systems and processes in place against the new indicators in the IPC BAF
- the Trust has a risk-based approach to patient pathways in place, including use of Hierarchy of Controls[2]

- patients and visitors are fully aware of the measures staff are required to take to prevent COVID infections, and the measures they are themselves required to take to prevent COVID infections
- national IPC Public Health England (PHE) guidance is regularly checked for updates and any changes are communicated to staff in a timely way
- a COVID-19 dashboard has been developed to provide oversight of nosocomial infections at Trust-wide level, and by hospital and clinical area
- the key measures of hand hygiene, appropriate PPE and social distancing are embedded within all staff groups; regular audits are undertaken
- the PHE campaign 'Hands, Face, Space' is visible across the Trust, clear signage is in place at all egress points as well as in clinical areas
- measures are in place to ensure staff are able to comply with social distancing and PPE in non-clinical areas
- measures are in place to routinely test staff using both Lateral Flow Testing and PCR testing; including PCR testing if an outbreak occurs
- regular audits of patient testing guidelines take place, with actions in place to improve compliance where required
- the trust has developed a database to monitor mask fit testing
- decontamination policies and procedures are in place
- identified gaps relating to monitoring of cleaning standards and frequencies in clinical and non-clinical areas are being addressed
- the Board receive regular reports relating to the IPC BAF, which is also incorporated into the main Board of Directors BAF

4. Nosocomial Transmission of COVID-19 - Current Position

41 The most recent figures from the Scientific Advisory Group for Emergencies (SAGE) accessed 19th August 2021 indicate the latest reproduction number (R) rate of coronavirus (COVID-19) in the North West is 0.8 to 1.0, which is a decrease from the previous report.

3.2 There is a direct relationship between the transmission of the virus in the community with the transmission within health care settings as indicated in recent increases nationally and locally in incidents of HOCI and outbreaks of HOCI in June and July 2021.

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

[2] PHE COVID-19: Guidance for maintaining services within health and care settings V1.2 (June 21)

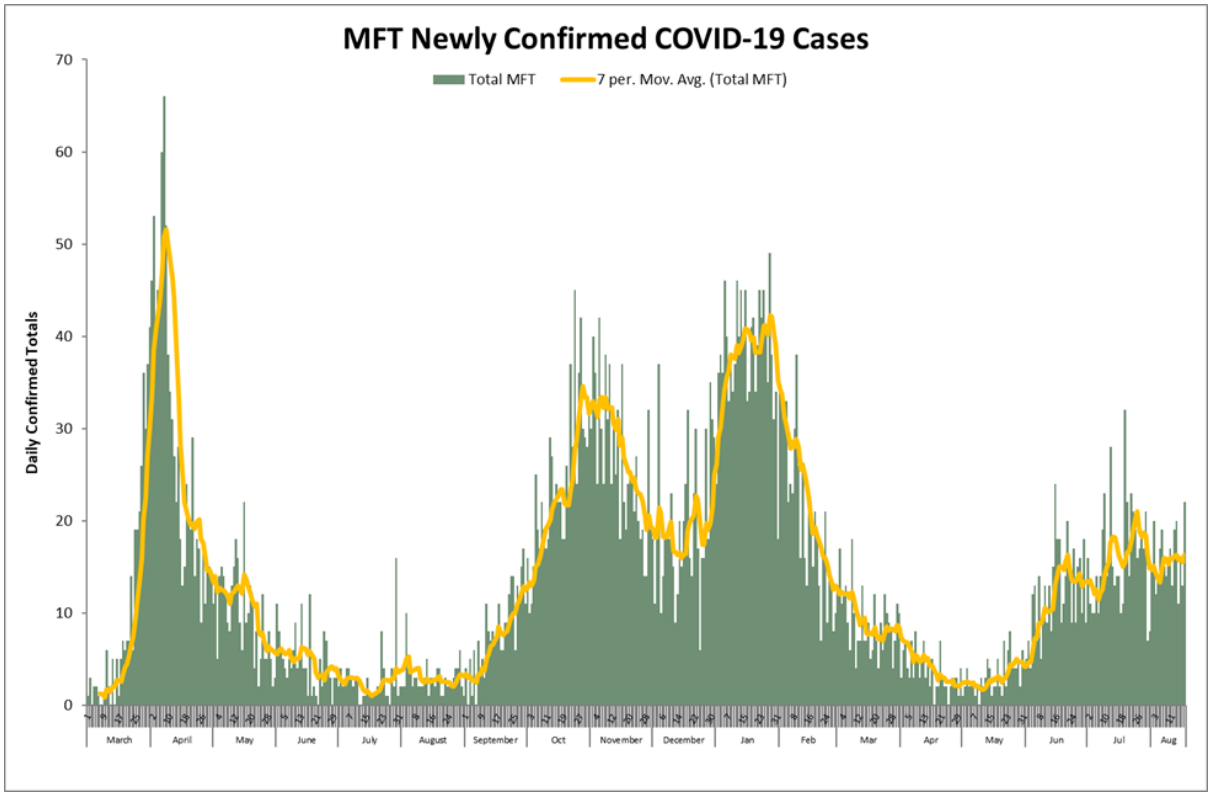


Chart 1- MFT newly confirmed COVID-19 cases presented as MFT total with 7 day moving average, March 2020 – August 2021

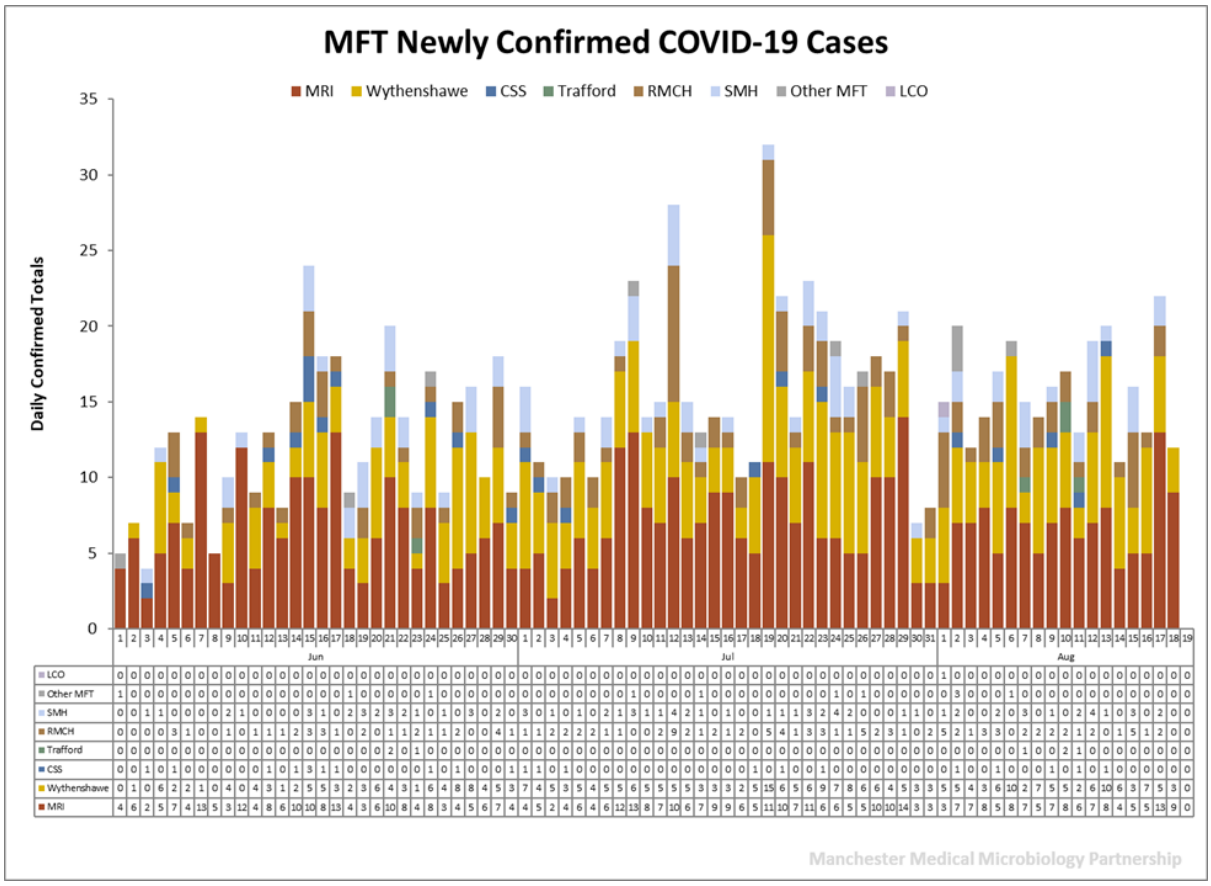


Chart 2 – Daily MFT inpatient burden of COVID-19 cases (laboratory-confirmed cases), June 2021 – 18th August 2021.

3.4 An outbreak is two or more cases of Covid-19 infection in patients occurring on or after day 8 of admission within the same ward/department with a 14-day period. If an outbreak is declared 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 August 2021)

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
May 2021	0
June 2021	6
July 2021	4
August 2021 (up to 23rd)	3

Table 1: MFT COVID-19 Outbreaks

4. Implementation of Actions from COVID Outbreak Reviews

4.1 The Trust has an unrelenting focus on the fundamentals of IPC measures of hand hygiene, correct use of PPE, risk assessments using the Hierarchy of Controls, maintenance or risk assessment of social distancing and strict adherence to IPC practice for interventional procedures.

4.2 Actions from outbreak reviews are monitored via the Directors of Nursing and through the Group Infection Control Committee.

5. The Infection Prevention and Control Development Pathway

5.1 An educational pathway, intended to increase awareness, skills and knowledge for all healthcare staff, has been launched as part of the wider system response to nosocomial infections. The Infection Prevention and Control Development Pathway (IPCDP) was developed across GM by a working group of infection prevention and control specialists and led by MFT Group Chief Nurse.

The pathway is designed to assist development from a fundamental awareness of IPC skills and knowledge, through intermediate understanding to a more specialist level of understanding across all areas of infection prevention and control. The IPCDP consists of three pathways:

- 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

5.2 The Foundation pathway has a total of 70 participants enrolled from within MFT, and a further 25 participants enrolled from across GM.

5.3 The Intermediate pathway will commence during October and November 2021.

6. Nosocomial Transmission of other Healthcare Associated Infection (HCAI)

6.1 There has been a sustained focus on other healthcare associated infections throughout the COVID-19 pandemic.

6.2 As reported in the Infection Prevention and Control Annual report in 2020/21, there were **14** trust attributable Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia cases compared to **8** trust attributable cases in 2019/20.

6.3 There have been **3** trust-attributable MRSA bacteraemia cases to date[2]. Key findings from investigations include:

- compliance with MRSA screening policy
- compliance with decolonisation therapy

6.4 There were **189** *Clostridium difficile* Infection (CDI) cases reported during 2020/2021. Of these, **162** were trust-attributable, against a threshold of **132**. There have been **65** Trust attributable cases to date[3]. Key findings from investigations include:

- adherence to stool sampling guidance
- timely isolation of patients with diarrhoea.

[3] Data correct as of 23rd August 2021
[4] Data correct as of 23rd August 2021

6.5 There were **264** Gram Negative Bloodstream Infections (GNBSI) in 2020/21. Ongoing workstreams to further reduce the GNBSI include a set threshold for each hospital based upon a 15% reduction target to maintain the national trajectory of a 50% reduction overall. An action plan to achieve the reduction targets have been completed by each of the hospitals and will be monitored as part of the AOF for GNBSI. There have been **85** GNBSI to date across MFT.

7. Reviewing Deaths from Nosocomial Infection

7.1 The Group medical directors have supported the development of guidance[5] 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 captures all the information required.

7.2 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 facilitates 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
- Overall analysis and learning points from Mortality reviews
- Agreed process for the reporting of individual cases of Hospital Onset Covid Infection (HOCI)
- Agreed template Duty of Candour letters for bereaved families

8. Sustaining and Improving the Current Position

8.1 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.

8.2 It is vital to maintain focus on the importance of IPC practices and processes in all aspects of patient care in view of the relaxation of national restrictions in July 2021 and the new guidance around self-isolation following notification of contact in August 2021.

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

9. Summary

9.1 The prevention and management of COVID-19 Nosocomial Infections continues in line with national guidance.

9.2 Good IPC practice is paramount to maintaining patient safety in view of easing of national restrictions in July

9.3 There is evidence that the number of new cases of COVID-19 amongst in-patients is declining however the potential impact upon patient pathways remains.

9.5 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.

10. Recommendation

10.1 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 V10 August 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: • local risk assessments are based on the measures as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff; • the documented risk assessment includes: - a review of the effectiveness of the ventilation in the area; - operational capacity; - prevalence of infection/variants of concern in the local area. • triaging and SARS-CoV-2 testing is undertaken for all patients either at point of admission or as soon as possible/practical following	• 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 • Alerting system in place for other	• 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) have COVID-19

admission across all the pathways; • when an unacceptable risk of transmission remains following the risk assessment, consideration to the extended use of Respiratory Protective Equipment RPE for patient care in specific situations should be given; • infection risk is assessed at the front door and this is documented in patient notes	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) • Risk Assessments for Interventional Radiology		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 • All clinical areas undertake a risk assessment using Hierarchy of controls where there is an increased risk of transmission https://intranet.mft.nhs.uk/content/important-information-about-covid-19-

	• Risk assessments in place for Maternity and neonatal services		coronavirus/safe-working-environment https://intranet.mft.nhs.uk/content/important-information-about-covid-19-coronavirus
• there are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative • 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	• 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,

	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). • COVID-19: Guidance for maintaining services within health and case settings *Infection prevention and control recommendations* updated in June 2021 have been reviewed by the IPC team – principles remain unchanged • 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 • Guidance for reducing isolation facilities produced in April 2021 by the IPC team to support recovery of elective programmes whilst still maintaining all IPC measures and keeping staff and patients safe.		negative and undetermined) in support of flow and ensuring right patient in right place.

• resources are in place to enable compliance and monitoring of IPC practice including: - staff adherence to hand hygiene; - patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas, unless staff are providing clinical/personal care and are wearing appropriate PPE	• HH/PPE audits completed weekly and updated to the Trust Dashboard monthly. • Non compliance issues addressed at time of the audit – escalation process in place for any continued issues • Compliance reviewed in appropriate IPC meetings, with action plans reviewed regularly. • Risk assessments in place across RMCH/MCS wards and departments supporting social/physical distancing for both patients, parents/carers and staff • HH & PPE audit leads identified for all clinical areas. • Support offered if required re HH & PPE audits, i.e. audit adapted to meet specific needs of an area. • Workplaces / workspaces / rest areas reviewed against 2m social distancing requirements and adjusted as needed to comply. • Alternative workspaces / rest areas identified and utilised to optimise compliance. • Senior staff monitor use of workplaces / workspace / rest areas to ensure compliance. • Trust notices re safe working displayed. • Furniture and equipment in workplaces / workspaces / rest		

	areas reviewed to remove all unnecessary items to optimise space. • Staff reminded of recommended social distancing when travelling to and from work, to avoid car sharing and follow public health guidance when outside of work. • Within community in-patient facilities visiting is also facilitated within garden areas/outside as appropriate • Hand hygiene posters advising when to clean hands and how to clean hands located in appropriate areas are visible in clincal areas • Posters, hand hygiene stations and Face covering stations are located at every entrance to the hospital. Posters, clinical waste bins and alcohol gel are located at the exits of the hospitals • Ward visiting booking process in place within all areas with additional visiting provided through virtual platforms in line with Trust Visiting Policy. • Risk assessments in place to manage physical distancing, which are reviewed regularly when capacity exceeds demand to ensure further mitigation is in place to manage any risk.		

• 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 setting and context as per national guidance patients and staff are protected with PPE, as per the PHE national guidance	• Appropriate PPE defined by procedures in accordance with national guidance, including: • Face Masks and Covering Guidance • Communication with procurement/materials management • 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	• 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 • Estates/environment review has progressed with permanent barriers and other structures now on site.

	• 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 in place • See above for additional details		
• 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 • 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		• 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 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

	❖ IPC Operational Group bi-weekly chaired by Hospital Deputy Director of Nursing		❖ 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 • Risk register updated • Risk assessments in place, risk assessment documentation available via the Trust Intranet	• 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 and care settings – Infection Prevention and control recommendations).	• 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 Board of Directors July 2021 • 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 July 2021	• 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	• 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

	❖ Testing ❖ Enhanced cleaning • Visibility of Executives and Directors. Frequent observation and review by DIPC, AMD and IPC team to address environmental issues as well as clinical practice		❖ 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	• 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

	❖ Communication channels are in place ❖ IPC staff are present on wards • Various monitoring tools are in place to support compliance with IPC practice; including ❖ Hand hygiene ❖ PPE audit ❖ Increase in frequency of audits on outbreak wards ❖ Hands, Face, Space Audits • Data is collected monthly and Feedback to Directors of Nursing to address areas of concern • See earlier section for further information		
• Monitoring of staff compliance with wearing appropriate PPE, within the clinical setting • that the role of PPE guardians/safety champions to embed and encourage best practice has been considered	• 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 • that twice weekly lateral flow antigen testing for NHS patient facing staff has been implemented and that organisational systems are in place to monitor results and staff test and trace; • additional targeted testing of all NHS staff, if your location/site has a high nosocomial rate, as recommended by your local and regional infection prevention and control/Public Health team.	• 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 positive LFT test. • Staff with positive results advised to follow national guidance • App in place to support ease of reporting LFT results • SOP for Staff Test and Trace updated in July 2021 • SOP for Staff Returning to Work Early following contact from NHS Test and Trace developed and agreed in July 2021, and further updated in line with PHE Gguidance following government changes to self-isolation on 16th August 2021. • Processes include involvement of the Director of Infection Prevention and Control oversight of decision making	• Access to external test results • Compliance with staff reporting LFT results, specific gap noted in recording of results on a national system that is not fully visible to the Trust and separate from the Trust's own reporting system	• 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 • COVID Testing Strategy Group will monitor compliance through refreshed Terms of Reference • Database being further developed to monitor compliance with testing • Task & Finish group supporting increased take up with the voluntary bi-weekly staff LFT testing programme • MFT app now able to retain staff testing history and scan QR codes, making it easier for staff to record their results

• 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, • Mandatory training compliance is in place, with action plans to address areas for improvement • COVID-19 training adapted to meet requirements of specific areas when required, for example MREH Emergency Eye Department.	New and temporary staff are updated on the local and most up to date practice when being introduced to the clinical area	

• 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, including at safety huddles • Monthly audits of HH, PPE, Hands Face space audit results are fed back to teams for information regarding compliance. Areas for improvement are addressed at the time and through local action plans. • IPC team provide additional support and training in high risk/outbreak areas on Hand Hygiene/other IPC practices		
• 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 • there are visual reminders displayed communicating the	• 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		

importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace • 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	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 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		
• The Trust Chief Executive, the Medical Director or the Chief Nurse approve and personally signs off, all daily data	• The Chief Nurse/DIPC is responsible for all data submissions	• Easily accessible information in one place to support sign	• A COVID-19 infection dashboard is under development. Once implemented this will

submissions via the daily nosocomial sitrep.		off requires development.	provide Trust, hospital and ward overview of nosocomial infections. The purpose is to provide further clarity of a range of information in order to support nosocomial infection prevention and management.
• The 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 ❖ Hospital/MCS Infection Control Committees • There are opportunities for senior leaders to provide check and challenge in both clinical and non-	• See above	• See above

	clinical areas with IPC principles agreed in advance, through: ❖ Senior Leadership Walkrounds with executive / senior leaders from clinical and non-clinical backgrounds ❖ Accreditation Visits ❖ Informal visits to clinical and non-clinical areas ❖ Monthly Quality Care Rounds in place		

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 nursing/medical 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 and other national guidance • Assurance processes are in place for monitoring and sign off terminal cleans as part of outbreak management and actions are in place to mitigate any identified risk;	• 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 • Action plans are held locally when required to mitigate any risk following terminal sign off	• 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. • Local area walk rounds by Matrons and senior nursing team to ensure cleanliness compliance is maintained. • Senior Leadership / Director Team undertake Senior Leadership Walkrounds on a monthly basis with orpportunities

			taken to observe IPC activity
• 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 and decontamination 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. • Decontamination of patient shared equipment in outbreak/high risk areas is undertaken using a combined solution of detergent and 1,000ppm available chlorine (Chlor-clean tablets) • Electronic equipment is cleaned with a detergent wipe followed by 70% isopropyl alcohol wipe **u**sed in accordance with manufacturers recommendation as described in the Trust Cleaning Policy, adhered to, as per COSHH data sheet held by facilities.	• Cleaning Policy in process of update, due to be ratified in September 2021 • There are some gaps in monitoring cleaning frequencies and standards across some clinical and non-clinical areas of the Trust	• Regular walk rounds occur with senior nurses and the estates and facilities team to monitor compliance. • Any areas raised as a concern are visited and an action plan implemented. • The Estates and Facilities team are undertaking a full review of both clinical and non-clinical as part of preparations for the implementation of National Standards of Cleanliness
• manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products as per national guidance	• See above		
• a minimum of twice daily cleaning of: - areas that have higher environmental contamination rates as set	• Enhanced cleaning specifications in place for clinical and non-clinical areas	• There are some gaps in monitoring cleaning frequencies and	• Currently working with PFI partners to review enhanced cleaning and

out in the PHE and other national guidance; - 'frequently touched' surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails; - electronic equipment e.g. mobile phones, desk phones, tablets, desktops & keyboards; - rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff; - • 'frequently touched' surfaces, eg door/toilet handles, patient call bells, over-bed tables and bed rails, should be 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	• 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	standards across some clinical and non-clinical areas of the Trust	align with new national cleaning standards • Regular walk rounds occur with senior nurses and the estates and facilities team to monitor compliance. • Any areas raised as a concern are visited and an action plan implemented. • The Estates and Facilities team are undertaking a full review of both clinical and non-clinical as part of preparations for the implementation of National Standards of Cleanliness.

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) • cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment;			

• 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		
• reusable non-invasive care equipment is decontaminated: - between each use or after blood and/or body fluid contamination - at regular predefined intervals as part of an equipment cleaning protocol - before inspection, servicing or repair equipment; • 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. • Dynamic mattress contract includes re-processing (off site), between each patient use • Patient shared equipment decontaminated in the clinical area is marked with a green tape to indicate that it has been cleaned) • UVc and HPV used to decontaminate equipment in high risk/outbreak areas • Reusable non-invasive care equipment is decontaminated: - between each use - after blood and/or body fluid contamination - at regular predefined intervals as part of an equipment cleaning protocol	• Policy to be incorporated into Cleaning Policy, to be ratified in September 2021	• Policy will be updated by IPC Team

	- before inspection, servicing or repair equipment. • Individual use blood pressure cuffs and stethoscopes are utilised in outbreak and high risk areas. • Individual use pens are provided in areas of high risk or outbreak.		
• 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
• where possible ventilation is maximised by opening windows where possible to assist the dilution of air. • 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	• Air filtration units (filtrex and Dentair unit) deployed in areas following AGP's in ENT and dental • Use of micro-motors in dentistry to reduce AGP procedures	• Old estate unable to provide good ventilation in areas • Local weather conditions may make it difficult to maintain internal temperature if	• Considering use of window and other air filtration systems of ventilation in older estate

• monitor adherence environmental decontamination with actions in place to mitigate any identified risk • monitor adherence to the decontamination of shared equipment	• 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	door and windows are open	
• 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 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 • There are some gaps in monitoring cleaning frequencies and standards across	• Trust wide incident reporting effectively used to escalate concerns. • National Standards of Healthcare Cleanliness published April 2021. https://www.england.nhs.uk/wp-content/uploads/2021/04/B0271-national-standards-of-healthcare-cleanliness-2021.pdf

		some clinical and non-clinical areas of the Trust	• Project group in place will review and agree the development of a standardised Commitment to Cleanliness Charter. To be in place by October 2021 • Regular walk rounds occur with senior nurses and the estates and facilities team to monitor compliance. • Any areas raised as a concern are visited and an action plan implemented.

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines 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: • national guidance on visiting patients in a care setting is implemented;	• 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 • Interim Visiting Policy available via Trust Intranet and information published on the Website		• 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 (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 • Signage on entrances, signs are available to download and print via Trust Intranet • Screens in place at reception areas • Available guidance: ○ 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	• Insufficient single rooms and isolation facilities	• Risk assessments in place • Environments investment (see previous pods/curtains/2m space)

	• 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)		• 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. • Clinell readirooms utilised to isolate inter hospital transfer whilst covid status is confirmed. •
• 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

• Implementation of the Supporting excellence in infection prevention and control behaviours implementation Toolkit has been considered C1116- supporting-excellence-in-ipcbehaviours-imp-toolkit.pdf (england.nhs.uk)	• Principles have been implemented across MFT examples below: - in messaging patients/visitors and staff - role modelling -senior leadership walk rounds - support resources provided by EHWB • identified ‘wobble rooms’ for staff		

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: • screening and triaging of all patients as per IPC and NICE guidance within all health and other care facilities is undertaken to enable early recognition of COVID-19 cases; • 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 • Clear signage in place to support effective streaming of patients presenting at ED • Identified respiratory pathway in ED with dedicated triage, waiting and resuscitation space. • Respiratory Receiving unit to support assessment and ambulatory pathways • Virtual ward pathway in place to support management of covid positive patients at home and avoid admission.	• 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		• Triage audits are undertaken
• 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 • Identified pathway for patients where reasonable adjustments need to be made as they are unable to wear face mask	• 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 • Posters displaying FRSM masks and requirements to wear developed	• Not all patients are willing/able to comply	• Risk assessment undertaken. • Local escalation process is in place

• clear advice on the use of face masks is provided to patients and all inpatients are encouraged and supported to use surgical facemasks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs; • monitoring of Inpatients compliance with wearing face masks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs; - patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff. - isolation, testing and instigation of contact tracing is achieved for patients with new-onset symptoms, until proven negative;	• All patients are requested to wear a facemask when moving from their bed unless there are clinical indications otherwise • Patient information posters are in place • Advice information is provided to patients/parents/carers and families around mask wearing in ward department areas (includes moving around the ward) • Posters in clinical areas encouraging patients to wear face coverings. • Staff actively encourage patients to wear face coverings when outside of their bed space and offer a replacement on regular intervals. • Staff request patients to wear a face covering when moving between departments. • Patient pathways are compliant with Infection Prevention and Control guidance, and limit internal patient movement to comply with amber / green pathways. External transfers occur only if clinically justified	• As above	• Non-compliance is addressed locally in with local processes for escalation when there is an identified risk.

• individuals who are clinically extremely vulnerable from COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation	• Individuals who are clinically extremely vulnerable from COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation – including Individual patient risk assessment undertaken by senior nurse with IPC support to develop specific plan of care to mitigate risk • Side room usage is regularly reviewed to ensure patients who require a side room are prioritised appropriately. • There are principles to support RSV/COVID Surge Response Plan highlight requirement for protective isolation for vulnerable groups and prioritisation of side room		
• 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 • Covid MDT in place to review COVID-19 positive patients and facilitate discussion in relation to covid symptomatic patients.		• 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 (clinical and non-clinical) have appropriate training, in line with latest PHE and other national guidance to ensure their personal safety and working environment is safe;	• 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		

• 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 put put it on and remove it	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		
• The use of hand dryers should be avoided in all clinical areas. 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 (even if experiencing mild symptoms) 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 • SOP's in place to support staff to return to work following guidance published in July and August 2021	• 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
• 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)	• Regional COVID-19 prevalence reviewed by Clinical Sub-Group and used to inform PPE practice. • Daily HOCI report generated by IPC surveillance and reviewed by IPC team to provide early identification of outbreaks.		

	• Daily reporting of other HAIs to identify outbreaks. • Review of regional HPT alerts to provide early warning of community outbreaks. • Review of HAI rates and comparison to Shelford group as indicator of performance/ compliance with best practice.		
• 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
  • staff maintaining physical distancing of 2 meters wherever possible unless wearing PPE as part of direct
	• 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.
		• Whilst staff are reminded to maintain social distancing when travelling to work, it is not possible to monitor compliance	

care. • Staff are maintaining social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace	• Social media campaigns remind staff and public to follow public health guidance outside the workplace		
• 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 fa**ce 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 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	• Reliance on staff reporting Pillar 2 test results	• Staff requested to report external testing results to absence manager

• 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 diarrhoea)
• 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 support services (e.g. Radiology) and provision of essential services (e.g. monitoring for Cardiac	• 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 patient occupancy, flow and

		patients) • some areas of estate particularly old and in poor condition	activity adjusted to align to the environment • Good IPC practice implemented in all areas of cross infection
• patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	• Daily alerts/surveillance for all relevant organisms (such as CPE, MRSA and C-diff) is currently reviewed by the IPC team • Daily report of new resistant HAIs generated by IPC surveillance and reviewed by IPC team to ensure appropriate management in line with national and local policies.	• Potential delay between testing and identification of new resistant HAIs	• Rapid screening for some HAIs (e.g. CPE) • Pre-emptive risk assessment to manage high risk patients before results are known.
• 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 • An Interim 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	• 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

understand the different risk areas.			

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 • A further Roche analyser has been procured and will be on site in Autumn 2021 • See previous on testing	• Lab capacity was initially affected by availability of reagents – this has significantly improved – therefore the risk to the lab due to analysers is reduced (improved).	• Sufficient reagent supply
• screening for other potential infections takes place	• Screening for alert organisms continued in line with trust policy.		

• that all emergency patients are tested for COVID-19 on admission • Ensure screens taken on admission given priority and reported within 24hrs.	• Tracking system on electronic records systems, chameleon and Allscripts, prompts screening		
• 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	• The Staff and In-Patient COVID-19 Testing Guidelines reflect national guidance in routine and responsive testing – the SOP has been updated and is now called COVID-19 Testing, Streaming and Stepdown Guidelines. Information that - Patients discharged to a nursing home must complete their remaining isolation - Elective patients should self-isolate for at least 3 days prior to admission, depending on their own clinical condition • 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.	

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 • that patients being discharged to a care facility within their 14 day isolation period are discharged to a designated care setting, where they should complete their remaining isolation; • that all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission			

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 with staff. • Queries around disposal routes for visitor PPE – options for disposal which are both legal and practical are not currently clear.	• 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 emerging risks and issues associated with waste. • Weekly conference call between Trust and its main clinical waste collection provider (SRCL)

		• 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. • 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	• 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

		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 • Daily staffing process are in place to manage safe and effective staff deployment	• Limited by access to reagents	• Prioritisation based on clinical and staff need
• all staff adhere to national guidance and are able to maintain 2 metre social distancing in all patient care areas 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 stff 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 obtain advice and receive information regarding next steps, recovery and return to work.	• Some staff may choose to access alternative community test centres which means the results will not be known by the line manager and may be received via text message.	• Staff can contact Silver Command, Workforce Bronze, their line manager or the HR Team to seek advice 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	
• members of staff who fail to be adequately fit tested a discussion should be had regarding re deployment	• There are Trust Policies in place based on national guidance agreed with HR and EHWB to ensure that		

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.	those who have failed fit testing are redeployed • The trust is in the process of extending fit testing to include at least 2 alternative FFP3 respirators. Reasons for fail to fit test are recorded and escalated where appropriate		
• 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:	Paul Fantini, Head of Group Reporting & Financial Planning Rachel McIlwraith, Operational Finance Director
Date of paper:	September 2021
Subject:	Financial Performance for Month 4 2021/22
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:	To note the following: • Strong financial governance and control is essential as the Trust is operating in a changing financial environment • Hospital/MCS/LCO Control Totals have been formally issued to Chief Executives for the year ending March 2022. These control totals underpin the plan submitted to GM and NHSEI for the first six months of 2021/22 (H1) with a H2 planning process requirement to be advised. • It is of paramount importance that decisions are not made that commit the Trust to new recurrent expenditure without the appropriate level of scrutiny and authorisation.
Contact:	Name: Jenny Ehrhardt, Group Chief Finance Officer Tel: 0161 276 6692

Executive Summary

1.1	**Delivery of financial plan**	The financial regime for 2021/22 has been split into 2 halves (H1 and H2) with the first half of 2021/22 representing a period of recovery and potentially stabilisation as the intensity of the activity directly related to Covid reduces but the implications of reduced activity over the previous period manifest themselves across almost all areas of clinical activity. This is also in the context of a range of workforce implications and ongoing health and wellbeing concerns. MFT is required to deliver a surplus of £23.1m for H1 and has developed the H1 plan to reflect this requirement, with a break-even position for H2. There is a significant assumption, and therefore risk, included in the H2 plan of system funding being available at a level of half that in H1. The Trust will also need to maintain tight financial control across the balance sheet and management of technical items during the forthcoming months in the context of the challenging environment and several significant provisions at the end of 2020/21 including annual leave and the HCSW pay banding review. Year to date to Month 4, July 2021, the Trust has delivered a surplus of £2.4m against the break-even plan. This represents steady performance but significant improvement in the financial position is required to meet the H1 target.
1.2	**Run Rate**	During July, the expenditure run rate has continued to increase with expenditure increasing across the hospitals. Subsequently some of the Hospitals/MCS/LCO forecasts are significantly above the levels of agreed control totals. Work is ongoing with each Hospital/MCS/LCO to understand the reasons for the variance and to bring the variance down. It is recognised that we are in a particularly challenging operational environment, however the need to maintain strong financial governance and control remains essential, particularly in view of the revised financial framework for 2021/22. The Trust undertakes a top down forecast on a monthly basis based on the YTD run rate and key known changes and this is compared to the more detailed hospital and department forecasts. The controls over additional investment linked to activity recovery have been established, in the short term these have been supported by additional income from the Elective Recovery Fund (ERF) however the Trust must maintain a strong grip of the recurrent level of spend as elements may prove unaffordable in a revised financial regime.
1.3	**Remedial action to manage risk**	The “expenditure led” financial regime that was in place in the last financial year presented a significant risk to the Trust, through the changed behaviours which it created. Through the governance structures, there has been a consistent message that maintaining control of expenditure is key even during the pandemic. Formal notification has been received that the current financial regime will largely remain in place for H2 of 2021/22, although the scale of funding has not yet been released. The Finance Accountability Framework has been updated and clarified, and is now being implemented, as part of the overall Accountability Oversight Framework.

1.4	**Cash & Liquidity**	As at 31st July 2021, the Trust had a cash balance of £279.4m, which includes £4.1m transferred in from the North Manchester balance sheet disaggregation. Overall this position represents a decrease of £3.0m from the underlying MFT position at the end of May, with the reduction primarily due to final VAT submission for 20/21. The overall high cash balance reflects ongoing levels of accruals and provisions such as the annual leave and HCSW pay review provisions at the end of 20/21 and ongoing slippage against the Capital programme
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 system capital envelope. The "envelope" plan value for 2021/22 is £199.2m with the potential outturn estimated to be £208.5m, reflecting backlog maintenance pressures. Slippage across the programme during the year will bring the actual spend back in line with the agreed envelope. The position across GM is that additional funding streams identified through the year will also be applied to assist in closing the gap, where appropriate, as opposed to being entirely new spend. Up to July 2021 £31.9m capital expenditure has been incurred against a plan of £40.9m – an underspend of £9.0m. The majority of the slippage, £6.2m, relates to the HIP2 project and is due to delays in the approval of the Park House scheme and associated enabling works.
1.6	**NMGH Transfer**	The transfer by absorption of the NMGH transaction was incorporated into the balance sheet in month 3 and is reflected in the I & E as a below the line Transfer by Absorption gain of £76.4m. This gain is reflected through the Trust reserves on the balance sheet.

Financial Performance

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

I&E Category	NHSI Plan M4 £'000	Year to date Actual - M4 £'000	Year to date Variance £'000
INCOME			
Income from Patient Care Activities			
Commissioner Block Payments - CCGs / NHSE	581,432	585,437	4,005
NHSE - Cost passthrough drugs (increase above threshold)	26,620	23,502	(3,118)
Trust (Rapid Diagnostic Centres)	0	185	185
GM System Funding 1-6 £85.846m M7-M12 £15.710m / £43.0m	57,231	57,231	0
GM System Funding 1-6 £5m	3,333	0	(3,333)
Elective Recovery Funding	7,467	7,467	0
Other (Other devolved / IOM / NORs & Wales)	2,532	2,779	247
Additional Funding outside financial envelope	855	2,375	1,520
Local authorities	12,844	12,878	34
Sub -total Income from Patient Care Activities	**692,314**	**691,854**	**(460)**
Private Patients/RTA/Overseas(NCP)	3,340	2,631	(709)
Total Income from Patient Care Activities	**695,654**	**694,485**	**(1,169)**
Training & Education	23,747	23,747	0
Training & Ed Non HEE	968	1,166	197
Training & Ed Notional	894	986	92
Research & Development	21,973	22,460	487
Misc. Other Operating Income	30,049	30,017	(32)
Other Income	**77,631**	**78,376**	**745**
TOTAL INCOME	**773,285**	**772,861**	**(424)**
EXPENDITURE			
Pay	(454,013)	(454,027)	(14)
Non pay	(293,157)	(290,032)	3,125
Training & Ed Notional Spend	(894)	(986)	(92)
TOTAL EXPENDITURE	**(748,064)**	**(745,045)**	**3,019**
EBITDA Margin	**25,221**	**27,816**	**2,595**
INTEREST, DIVIDENDS & DEPRECIATION			
Depreciation	(11,569)	(11,763)	(194)
Interest Receivable	0	0	0
Interest Payable	(13,653)	(13,648)	5
Loss on Investment	0	0	0
Dividend	0	0	0
Surplus/(Deficit)	**0**	**2,405**	**2,405**
Surplus/(Deficit) as % of turnover	**0.0%**	**0.3%**	
Transfers by Absorption	**0**	**76,397**	**76,397**
Impairment	**(30,135)**	**(24,780)**	**5,355**
Non operating Income	**442**	**253**	**(189)**
Depreciation - donated / granted assets	**(368)**	**(307)**	**61**
	(30,061)	**53,968**	**84,029**

In line with national planning requirements the Trust submitted a H1 plan for the first half of the year, this plan reflected the breakeven position identified as the GM requirement and excludes the anticipated technical adjustments referred to in the Month 1 report of £20m which would support delivery of the £23.1m surplus required to support the planned capital investment programme.

The NHSI Plan has been resubmitted in June to include £8.266m of anticipated Elective Recovery Funding income matched by increased pay (medical and nursing) and clinical supplies additional expenditure budget. Within the Year to Date (YTD) position, £7.47m income has been accounted for, offset by an equal value of expenditure accruals, plus a small amount distributed to MRI as the first call on use of these funds, approved during July. Further business cases submitted by the hospitals, to improve patient flow and reduce waiting lists, have been reviewed, with an expectation that the majority of expected earned funds will be allocated by the end of August 2021.

The overall Trust income is slightly front loaded across the year given the inclusion of system funds in H1. The current activity recovery trajectory was expected to increase spend on clinical consumables during the first quarter as activity increased, and this was seen in June, with July broadly remaining in line across the hospitals. The overall plan profile also reflects backloading of WRP plans and delivery into H2.

As at month 4, against the profiled YTD budget, the under recovery of Cost Pass Through (CPT) drugs reported last month has reduced to about half of the month 3 value and is reflected in expenditure with £2.8m increase in expenditure across the hospitals. The main adverse variance to plan against income in July is the YTD value of £3.3m against the £5m system monies related to the NMGH transaction. As reported last month, the risk around non-receipt of these monies crystallised in month 3 and the Trust will continue to reflect an under recovery of £0.833k per month over the first 6 months of the year.

Research and Development and Education and Training income are ahead of the planned position YTD by £0.5m however this is matched by associated increased expenditure.

Pay costs in month 4 include £5.0m to deliver elective recovery which is also within the budget. There is an equal amount accrued in income. The YTD variance has reduced from £1.2m favourable in month 3 to breakeven at month 4, with the Hospitals/MCS/LCO reporting an increase in pay spend of £0.5m over month 3, primarily costs of Medical agency and locums.

The underspend on non-pay has reduced to circa 47% of the underspend at month 3 and the balance remains due to the underachievement of Drugs and Devices CPT income – this is reflected in the reported Trust income as noted above.

Close monitoring of run rate is part of the system of financial control together with forecast outturn reviews against the agreed control total values at hospital level, these meetings are taking place on a regular basis as part of the AOF governance process.

Financial impact related to the fire at Trafford Hospital

The Trust and Insurance loss adjusters are in the early stages of determining the cost to rectify the damage sustained due to the fire at Trafford Hospital. Early estimates suggest costs in the region of £4m, which will be covered by £1m from NHS Resolution with the remaining balance from the Trust's insurers. The potential CDEL issue (capital expenditure will be required above the Trust's limit) is being discussed with the regional NHSE/I team. At this stage, rebuild works are expected to last for approximately 12 months, so will have an impact in 22/23 also.

Statement of Financial Position

	Audited MFT Accounts 31/03/2021 £000	NMGH Opening SoFP 01/04/2021 £000	Enlarged MFT 01/04/2021 £000	Enlarged MFT 31/07/2021 £000	Enlarged MFT Movement in Year to Date £000
Non-Current Assets					
Intangible Assets	4,665	-	4,665	4,506	(159)
Property, Plant and Equipment	642,394	93,511	735,905	731,090	(4,815)
Investments	1,498	-	1,498	1,498	0
Trade and Other Receivables	5,645	-	5,645	5,645	0
Total Non-Current Assets	**654,202**	**93,511**	**747,713**	**742,739**	**(4,974)**
Current Assets					
Inventories	21,892	936	22,828	22,473	(355)
NHS Trade and Other Receivables	61,707	-	61,707	98,930	37,223
Non-NHS Trade and Other Receivables	46,854	484	47,338	38,099	(9,239)
Non-Current Assets Held for Sale	210	-	210	210	0
Cash and Cash Equivalents	271,199	4,130	275,329	279,423	4,094
Total Current Assets	**401,862**	**5,550**	**407,412**	**439,135**	**31,723**
Current Liabilities					
Trade and Other Payables: Capital	(33,594)	66	(33,528)	(24,826)	8,702
Trade and Other Payables: Non-capital	(287,755)	(2,690)	(290,445)	(336,117)	(45,672)
Borrowings	(20,290)	(1,448)	(21,738)	(21,898)	(160)
Provisions	(24,875)	(923)	(25,798)	(27,634)	(1,836)
Other liabilities: Deferred Income	(35,084)	(5)	(35,089)	(51,272)	(16,183)
Total Current Liabilities	**(401,598)**	**(5,000)**	**(406,598)**	**(461,747)**	**(55,149)**
Net Current Assets	**264**	**550**	**814**	**(22,612)**	**(23,426)**
Total Assets Less Current Liabilities	**654,466**	**94,061**	**748,527**	**720,127**	**(28,400)**
Non-Current Liabilities					
Trade and Other Payables	(2,598)	-	(2,598)	(2,598)	-
Borrowings	(374,948)	(17,664)	(392,612)	(387,279)	5,333
Provisions	(16,622)	-	(16,622)	(16,489)	133
Other Liabilities: Deferred Income	(3,817)	-	(3,817)	(3,413)	404
Total Non-Current Liabilities	**(397,985)**	**(17,664)**	**(415,649)**	**(409,779)**	**5,870**
Total Assets Employed	**256,481**	**76,397**	**332,878**	**310,348**	**(22,530)**
Taxpayers' Equity					
Public Dividend Capital	258,929	76,397	335,326	335,226	(100)
Revaluation Reserve	63,492	10,200	73,692	73,692	0
Income and Expenditure Reserve	(65,940)	(10,200)	(76,140)	(98,570)	(22,430)
Total Taxpayers' Equity	**256,481**	**76,397**	**332,878**	**310,348**	**(22,530)**
Total Funds Employed	**256,481**	**76,397**	**332,878**	**310,348**	**(22,530)**

The values shown for the transfer from NMGH have been slightly amended this month to reflect additional guidance received from NHSI regarding the treatment of the revaluation reserve associated with the assets transferring. There will be a further amendment in next month's report for the final values of assets etc transferred which is expected to see a reduction in Non-Current assets and PDC of approx. £11m to correct the treatment of IT assets included above.

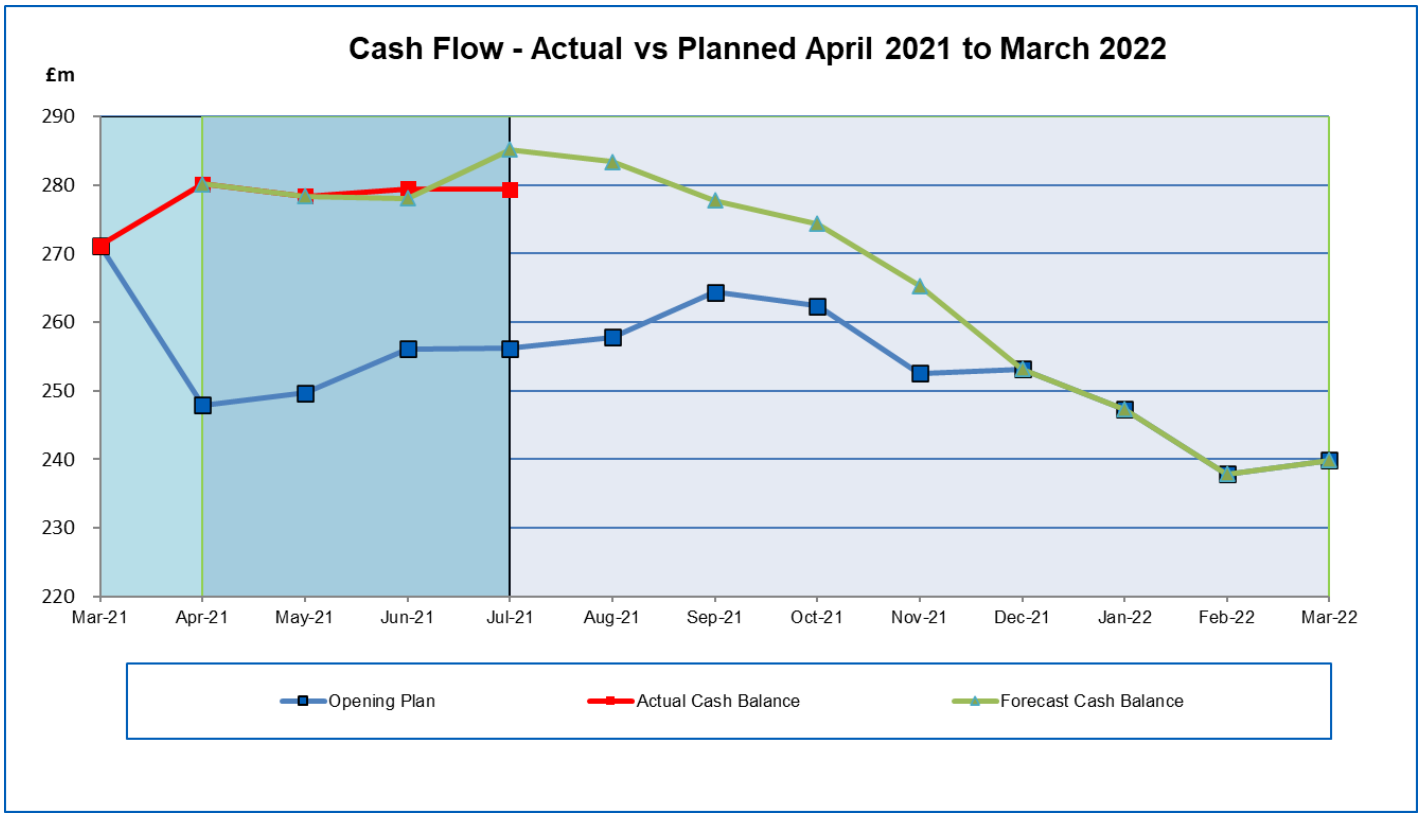
While there has been a reanalysis of amounts between NHS and Non-NHS receivables, there is also an overall increase of around £28m which relates to invoices and accruals for income from commissioners during

the year. This reflects the normal pattern of income for this period of the financial year and is consistent with the trend noted in the prior year.

The increase in Trade payables: Non-Capital relates to accruals carried at local Hospital / MCS level for contracted costs which are not invoiced in monthly amounts.

The increase in deferred income is mainly caused by Health Education England paying their income to the Trust in quarterly allocations at the start of each quarter which are then deferred across the months to which the income relates.

Cash Flow

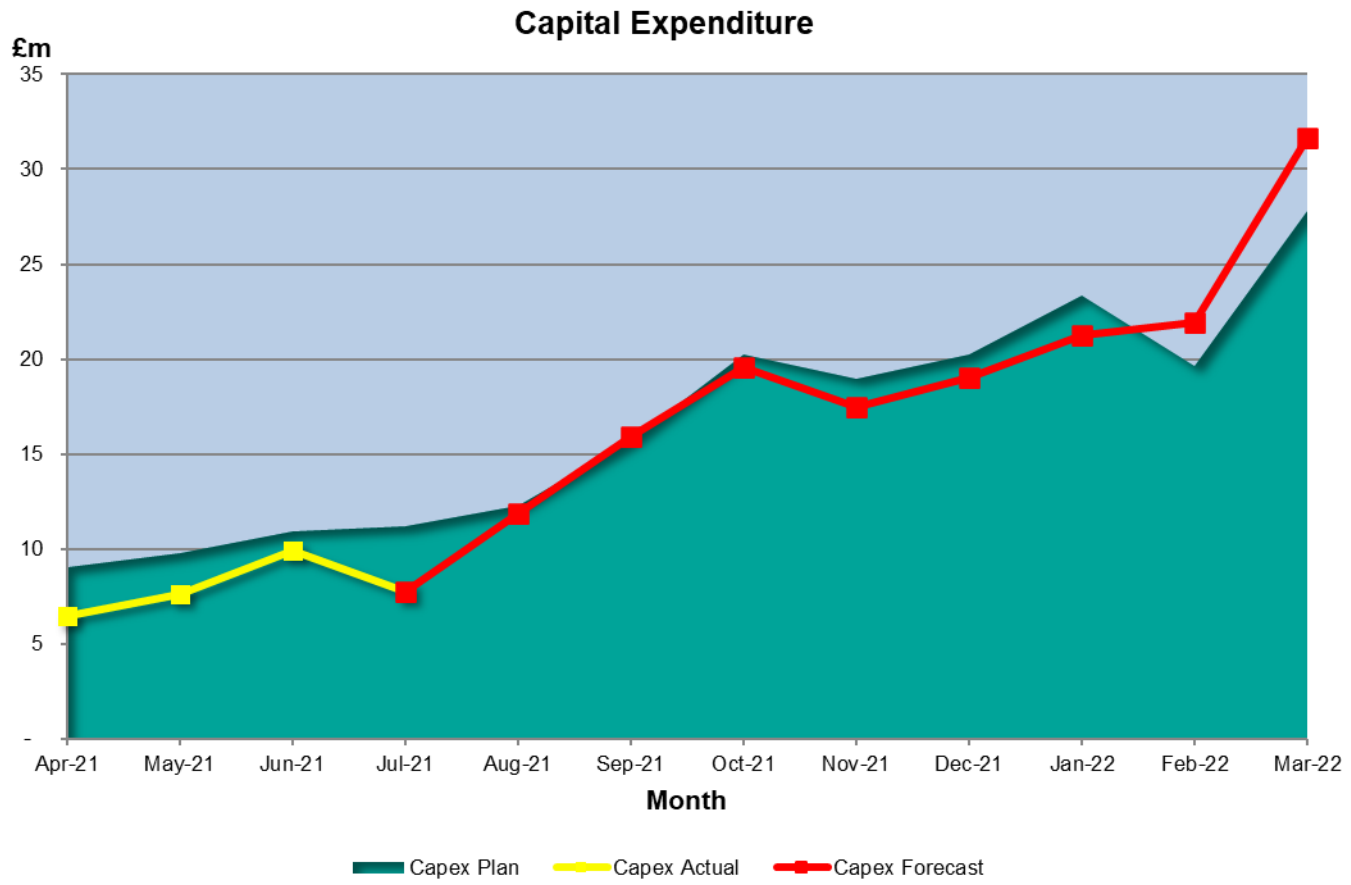


A reasonable measure of the level of liquidity required for the Trust could be that the amount of operational working capital consumed in 10 days is £59.3m. Clearly the current and forecast cash balances sit well above this level throughout the financial year.

As above, the cash balances now include £4.1m for the NMGH transaction opening balances.

The cash balance held by the Trust at the end of July 2021 was £279.4m which was lower than forecast by approximately £6m. July has seen an increase from previous months in payments to creditors both in number and value of invoices paid. The cashflow forecast for the remainder of the year has been revised to take into account the actual performance in the year to date which reflects an increase in accruals and cash held, and the likely changes in coming months as these balances reduce. At this stage, the forecast does not include adjustments for changes to the trust pay bill relating to the 3% pay award, Clinical Excellence Awards, payments relating to Band 2/3 re-gradings and holiday pay accruals (including the Flowers overtime claim) as there are various uncertainties in relation to the timing, quantum and funding of these items at this point in time.

Capital Expenditure



The chart above reflects a forecast of £190.6m which has reduced from the £199.4m forecast in month 3. The lower forecast is due to:

- a £6.995m reduction in the HIP2 forecast, with expenditure on professional fees having slowed as the Trust awaits confirmation on the next stage from the New Hospitals Programme (NHP) and delays on the car park resulting in a lower year end forecast, and;
- a £1.798m reduction in the Charity funded NBIA scheme, due to a revised business case. The majority of this expenditure will now fall in 22/23.

The potential outturn is £208.5m although it is expected that the actual spend and the agreed plan will become aligned during the course of the year, due to a combination of slippage and additional funding approvals.

Better Payment Practice Code

NHSE/I have indicated that there will be a focus on each organisation's performance against the Better Payment Practice Code (BPPC) numbers this financial year, with scrutiny initially falling on the worst performers. The target for all NHS organisations is to pay 95% of invoices within payment terms. As yet there has been no formal notification of the value that will trigger further investigation.

The intention is for NHSE/I to write to Trusts that have 'good levels of cash' but report 'poor BPPC performance' asking for an action plan to bring the performance up to target.

Originally all Trusts had to report BPPC figures against payment terms within 30 days. However, there are now organisations that report adverse performance over longer payment terms, having decided to include longer terms in their terms and conditions note issued along with invoices. Additionally, some organisations adjust their payment numbers for invoices in dispute, whereas other organisations do not. It is not yet known how NHSE/I will approach these issues in order to ensure a level playing field for all organisations.

NHSE/I require BPPC numbers to be provided in their monthly return from month 3 onwards. An extract of MFT's submission for month 4 is shown below:

Better Payment Practice Code (BPPC)	Actual By Value (£000) YTD 31/05/2021	YTD 30/06/2021	YTD 31/07/2021
Non NHS			
Total bills paid in the year	159,369	231,514	345,494
Total bills paid within target	139,132	202,293	298,426
Percentage of bills paid within target	**87.3%**	**87.4%**	**86.4%**
NHS			
Total bills paid in the year	23,768	31,496	70,199
Total bills paid within target	20,566	26,926	56,575
Percentage of bills paid within target	**86.5%**	**85.5%**	**80.6%**
Total			
Total bills paid in the year	183,137	263,010	415,693
Total bills paid within target	159,698	229,219	355,001
Percentage of bills paid within target	**87.2%**	**87.2%**	**85.4%**
Target	95.0%	95.0%	95.0%
Distance from target	***(7.8%)***	***(7.8%)***	***(9.6%)***

In comparison with other GM organisations, MFT is middle of the table. Although there was a slight decrease in performance in month 4 the Accounts Payable team have put in the following measures:

- Action Plan agreed with CFO to address departmental areas within MFT where specific issues exist with additional compliance training provided
- Embedding good practice and process, such as ensuring all orders/invoices have Purchase Orders
- Regular review of specific high value disputed invoices in the NHS category
- There is a specific issue around Pharmacy systems standardisation and the impact of loss of functionality which is being addressed

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Strategy
Paper prepared by:	Caroline Davidson, Director of Strategy
Date of paper:	September 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

Integrated Care Systems

The White Paper 'Integration and Innovation: working together to improve health and social care for all' set out proposals for the establishment of statutory Integrated Care Systems (ICS) across the whole of England. The Health and Care Bill, which is the legislation that would enable this to happen, has had its first and second reading in parliament and is now working its way through the House of Commons and the Lords.

NHS England has published a range of guidance documents to support the establishment of Integrated Care Boards (ICB) by 1 April 2022. This sets out the requirements for ICS leaders, and designate ICB leaders to:

- recruit required members of the ICB board, as well as any other locally agreed executive and non-executive roles
- develop and submit an ICB constitution for approval by NHS E/I, following engagement with relevant partners.
- develop a 'functions and decision map' showing the arrangements that will be put in place within the ICB and with ICS partners to support good governance and effective decision-making.

The new legislation is planned to be in place by 1 April 2022. Nationally chairs have been appointed for 25 of the 42 NHS integrated care boards. Where this is not the case, as in Greater Manchester, the appointment process has begun and it is expected that it will be completed by the end of September. Recruitment of Chief Officers will follow shortly after.

Provider Collaboratives

Provider Collaboratives will be a key component of ICSs and will be one way in which providers work together to plan, deliver and transform services. Working at scale, provider collaboratives are able to tackle unwarranted variation and service improvement in order to deliver better care for patients.

Guidance recently published by NHS E sets out expectations of provider collaboratives. All trusts providing acute and mental health services are expected to be part of one or more provider collaboratives by April 2022. ICS leaders, trusts and system partners are expected to identify shared goals and ensure that the work of the collaborative is aligned with ICS priorities.

3. Regional Issues

Greater Manchester Health & Social Care Partnership

In order to facilitate the transition from an STP to a statutory Integrated Care System, shadow governance arrangements are being put in place. This includes the establishment of an Integrated Care Board and a new Health & Care Partnership that replaces the existing

GM Health & Care Partnership Board. It is expected that implementation of the shadow arrangements will start from October.

Work is also on-going to agree how we should work together as an ICS, in particular which functions are best done once at Greater Manchester (GM) level and which it makes sense to do at locality level. This piece of work, known as the spatial planning, will inform decisions about how resources within GM should be reallocated and where staff should be deployed.

The Health & Social Care system has identified its priority programmes that the ICS will need to focus on over the coming years. These include:

1. Maintaining physical, social and mental well being
2. Creating more consistent evidence based preventive and proactive primary care
3. Greater integration of the community based reablement, residential, rehabilitative, palliative and social care services
4. Coordinating and improving the urgent and emergency care service response
5. Delivering more consistent planned care and delivering the planned care recovery programme
6. Further developing access to and delivery of world class specialised care and building a hugely capable innovation capability in Health Innovation Manchester (HInM).

Provider Collaboratives in Greater Manchester

As described above, one of the features of Integrated Care Systems is 'Provider Collaboratives'. In Greater Manchester we already have the Provider Federation Board which brings together all of the acute, mental health, ambulance and community service provider organisations and the Primary Care Board, which brings together providers of primary care, in place.

Proposals are being developed for the role that PFB will play in the new arrangements and specifically where it will take greater leadership of the GM priority programmes (see six GM priority programmes set out above), in line with requirements set out in the national guidance described in section 1.

4. MFT issues

<u>MFT Clinical Service Strategy</u>

Haematology

MFT has been designated as a Haemaglobinopathy Coordinating Centre (HCC). As a HCC we are responsible for coordinating, supporting and promoting a system-wide networked approach to the delivery of haemoglobinopathy services. We will support hospitals in the area who have less expertise in these conditions, so that all patients have access to specialist advice when needed.

This is an important achievement and was one of the key aims set in our Haematology Clinical Service Strategy.

Community Diagnostic Hubs

Funding for the development of Community Diagnostic Hubs (CDH) for Manchester and Trafford for year 1 has been approved. This will mean a CDH will be established at Withington Community Hospital, with services also being delivered from a number of ‘spoke’ sites across Manchester and Trafford. However there has not been any commitment to revenue funding beyond year 1 as part of this award.

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:	Darren Banks, Group Executive Director of Strategy
Paper prepared by:	Caroline Davidson, Director of Strategy
Date of paper:	September 2021
Subject:	Trafford Locality Plan
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 confirm MFT support and commitment to delivering the refreshed Trafford Locality Plan.
Contact:	Name: Darren Banks, Group Executive Director of Strategy Tel: 0161 276 5676

1. Introduction

Clinical Commissioning Groups (CCG) across Greater Manchester have recently refreshed their Locality Plans. The purpose of this paper is, as a key partner in the Trafford health and care system, to seek confirmation of our commitment to the aims and to playing our part in the delivery of the updated plan.

2. Background

Each CCG area in Greater Manchester has a locality plan in place. These plans were first developed as part of 'Taking Charge', the original plan to improve the health and well-being of people living in Greater Manchester, and since then have formed the bedrock of the GM Health and Care Strategy.

Following the pandemic and in preparation for the transition to an Integrated Care System, CCGs have refreshed their plans to document their journey to date and to set out their vision and approach to transforming the health of their residents, including how they will meet the key challenges of:

- Creating and improving health – tackling the social determinants, addressing inequality, inspiring and supporting community action
- Creating more consistent evidence based preventive and proactive primary care
- Completing the integration of services and removing the historic barriers between primary, social, community, VCSE and secondary care services, across physical and mental health
- Addressing variation in standards, access and quality of care.

3. Trafford Locality Plan

MFT members of staff have been involved in the refresh of both the Manchester and Trafford plans and are content that there is alignment across the plans and MFT aims and strategic direction.

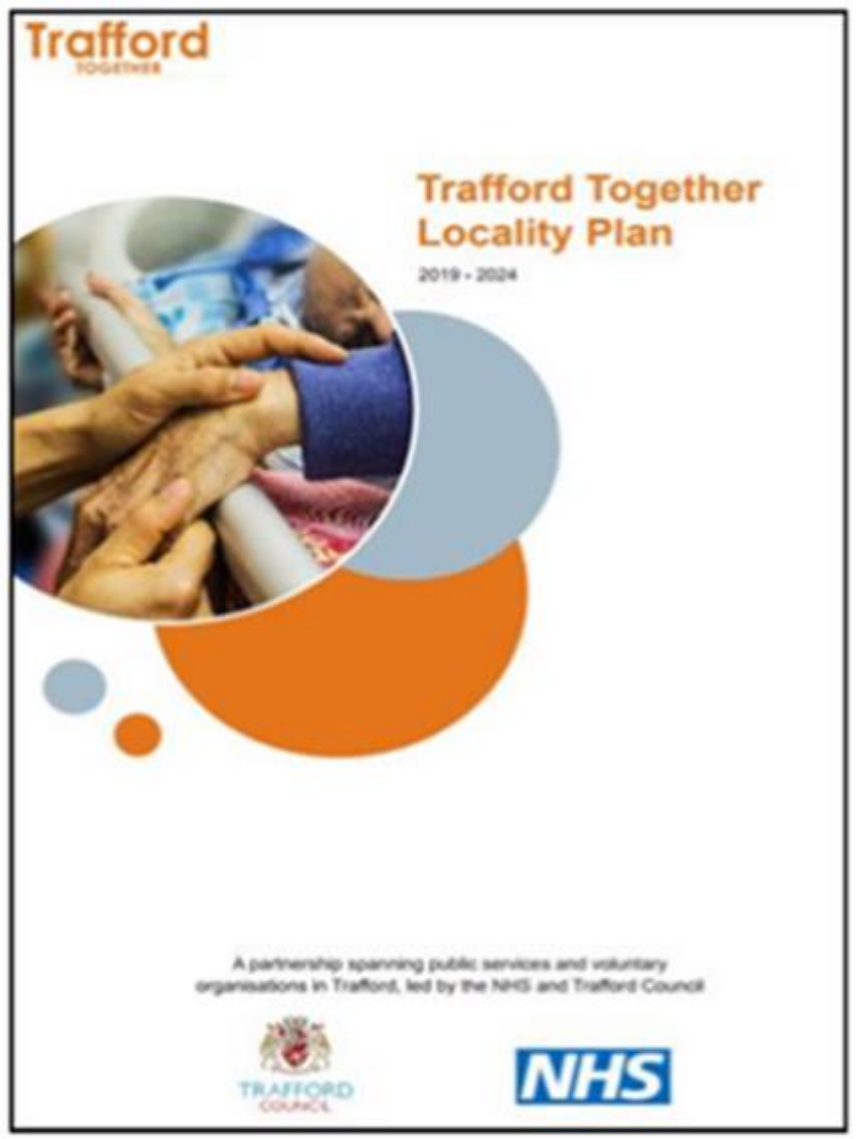
Attachment A is the refreshed locality plan for Trafford. As a key partner, we now need to formally confirm that we are signed up to the aims and committed to playing our part in delivering on the plans set out in the document.

The Manchester Plan is currently being finalised and will be brought to the Board in due course.

4. Action / Recommendations

The Board of Directors is asked to confirm MFT support and commitment to delivering the refreshed Trafford Locality Plan.

TRAFFORD TOGETHER LOCALITY PLAN REFRESH 2021



Trafford
TOGETHER

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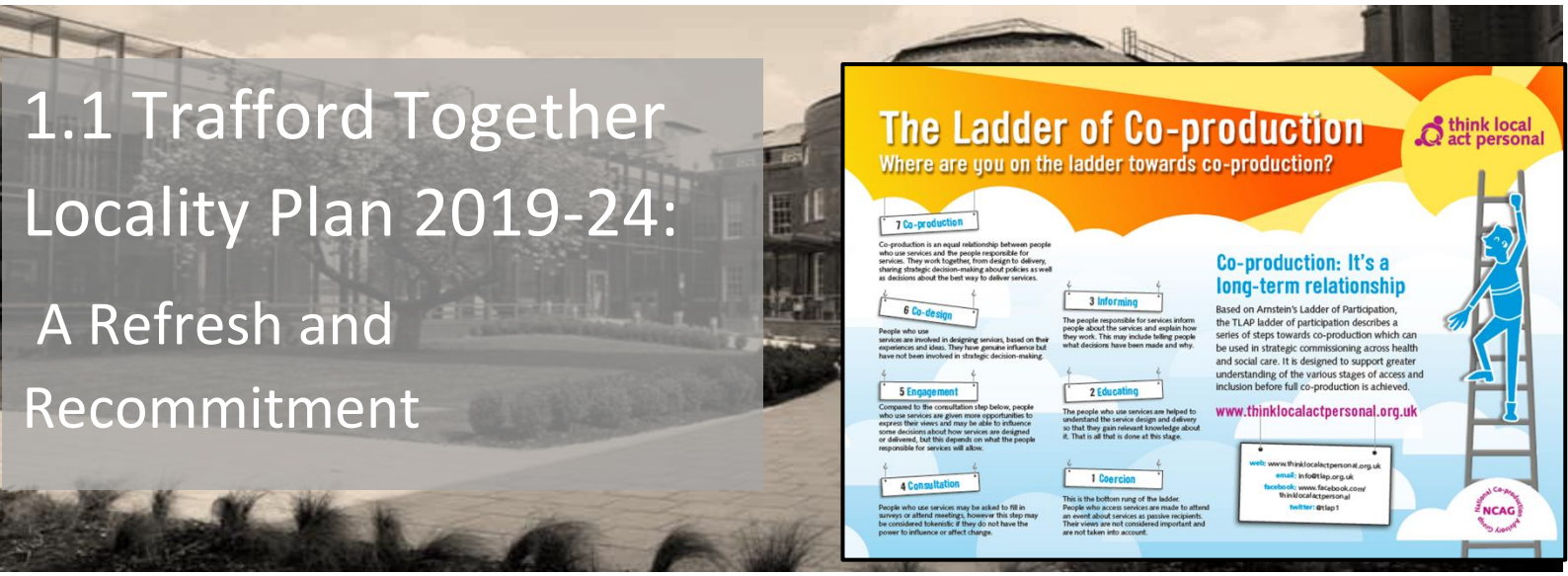
Foreword from the Trafford One System Board

This is a refresh of our Trafford Together Locality Plan 2019-24. The plan was first agreed in November 2019, having been developed and owned by the partners in the Trafford Local Care Alliance. The plan was built on a collaborative approach that had at its heart the principles of place, people, population and partnership, to ensure that we developed and delivered our services for Trafford people together. This was Trafford's second locality plan, the first having been written in 2016, when the GM devolution was agreed. Therefore we were learning from the first plan and continuing to build on the work that had gone before us.

We have also seen at the end of 2020 the publication of the integrated care white paper and subsequent bill, which means the role of CCGs will disappear and the establishment of Integrated Care Systems, across England, established. This will culminate in a new health and social care system by April 2022.

In light of this changing context we have refreshed the locality plan, so that the above journey is documented and that there is a plan, that the Trafford system can take forward into 2022. This refresh should be read in conjunction with other strategies and plans across the system.



The Trafford Together Locality Plan 2019-24 was published in 2019 and remains our blueprint for the transformation of health and social care. The plan was developed and strategically owned by the Trafford Local Care Alliance (LCA) and its constituent members in statutory health and social care providers and partner sectors. The LCA has been the driving force behind recent changes and been involved in creating the system architecture as it has evolved over the past 18 months. The LCA will continue to play a pivotal role in shaping the refresh. The collective commitment to our **Locality Plan Refresh is in light of the publication of the White Paper and Health and Care Bill and therefore the imminent national reform of health and social care.** This is an opportunity to collectively reinforce the aspirations of our original Locality Plan whilst reframing and refocussing our efforts where required, so as a Trafford system we take forward our joint plan together into 2022.

Prevention	Living Well at Home	Urgent Care
Planned Care	Children's Services	Mental Health

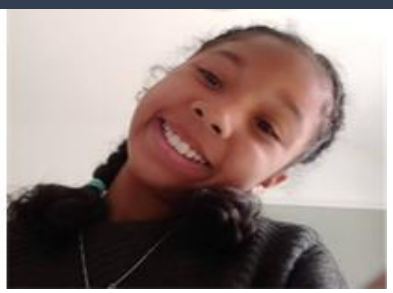
The system reform areas agreed in the 2019 plan (above) had the ultimate aim to move our resources to where they will have the biggest benefit for long term health and wellbeing for Trafford people, with each area underpinned by reform of key system enablers; digital strategy, finance and contracting, people and engagement. A full list of deliverables can be found in Appendix A.

Over the course of the pandemic we have had to implement rapid changes to the ways we support people in their community, in their own home, in acute care and across all of our health and social care services. We have experienced new pressures to support the most vulnerable to self-isolate at home for extended periods of time, on our funding to deliver this and on our staff resource and capacity due to sickness, self-isolation and shielding measures. New health inequalities have emerged nationally and in our Trafford population as a result of the pandemic, and existing inequalities intensified. But Trafford has risen to the challenge and adapted approaches and ways of working to ensure we place our resources where they will have the biggest benefit for long term health and wellbeing for Trafford people, such as the rapid deployment of digital solutions in Primary Care to enable people to access medical support and advice throughout the pandemic. Over time we see this as a move to prevention and being able to live well with appropriate support in our neighbourhoods.

We have built on the 2019 Plan and have reflected on what we have achieved and learnt over this period of time. The health and social care landscape within the UK, Greater Manchester and Trafford has changed within this period and we have had to address issues as well as build on our successes. Our key six areas of system reform above remain key commitments across the health and social care system, and now form the basis of our three Strategic Design Groups, Living Well in My Community, Living Well At Home and Short Stay In Hospital, which bring together partners and colleagues in a shared space to deliver the ambitions of the Locality Plan and design how we do this together.

1.2 Implementation of the Locality Plan Refresh



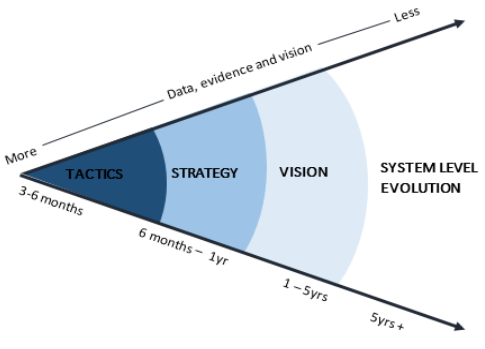



A critical issue that the Covid-19 pandemic has taught us is that we have significantly changed the way we work. The ability for organisations to **flex and be agile** will be crucial in the future especially as we embrace the changes that the Health and Care Bill will bring with the creation of Integrated Care Systems.

The Trafford system has worked together to plan and implement effectively, and we must be willing to accept more uncertainty as we continue on our journey of reforming the system. We cannot include every detail in this plan, as there continues to be a significant level of unknowns, but we will be open to continued iteration of our strategy and tactics with the ambition of improving services for the residents of Trafford. This approach we believe will enable flexibility for the local organisations to respond to external factors.

An example of how this has been achieved in Trafford is through the acceleration of the digital transformation programme across the health and social care system. Without this change we would not have been able to function and deliver services during the emergency.

We are now working and living with uncertainty about the future, so it is likely we will need to change how we **implement and plan our work on the Locality Plan** into the future. We will identify highly probable events which are backed up by data and evidence and continue to work in 12 week sprints to achieve these probable events / actions. The framework for planning will be in four stages; (1) tactics; (2) strategy; (3) vision and (4) system-level evolution or change.

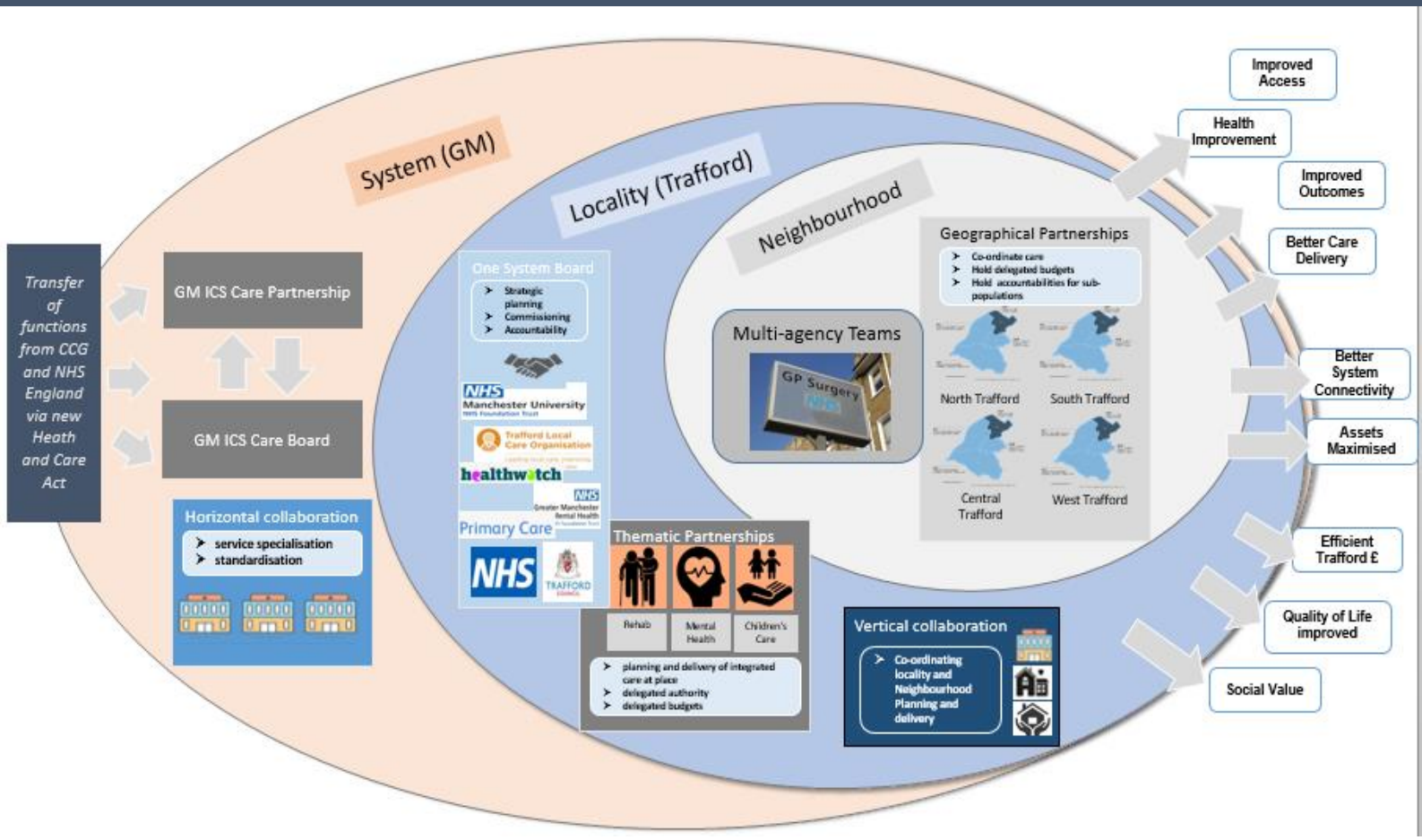


1.3 An Integrated Care System

1.3.1 White Paper and ICS changes ahead -

In February 2021 the Government published 'Integration and Innovation: working together to improve Health and Social Care for all', a White Paper setting out legislative proposals for a Health and Care Bill with a focus on removing barriers that stop the system from being truly integrated.

The new legislation will aim to resolve the tensions between the formal rules for the NHS and how the system wants to actually work in practice, by making changes including removing competitive tendering requirements for clinical services and setting out that NHS and local authority have a duty to collaborate in an Integrated Care System (ICS).



Trafford Locality Operating Model

1.3.2 Our structured approach to transition

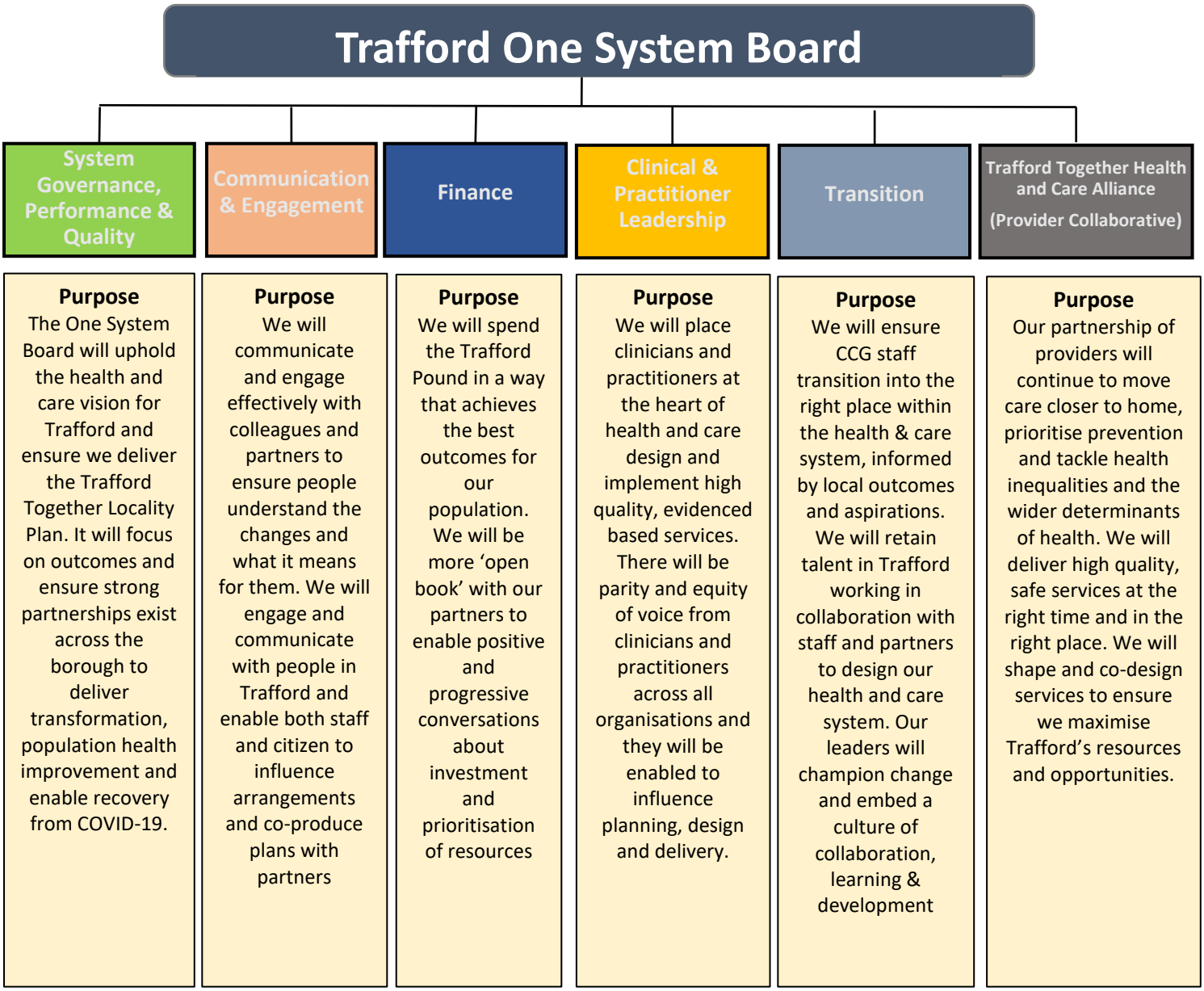
Trafford have mobilised a locality programme approach to develop Trafford's locality arrangements. We have mobilised a dynamic programme structure with work programmes that enable partners to shape our locality construct, these focus on: system governance – performance and quality, finance, provider collaboration, transition, clinical and practitioner leadership and communications and engagement

Along with other GM localities we have worked to implement a shadow ICS architecture for October 2020. In Trafford our established Joint Commissioning Board has been reconfigured to be our locality board which we call our One System Board. A Trafford 'Provider Collaborative' will be built from our established Local Care Alliance. Trafford will be moving into shadow arrangements on **1st October 2021.**

The One System Board, which is jointly chaired by the Leader of the Council and CCG Chair and includes senior leaders across the breadth of health and social care, has been mobilised with a fundamental aim of improving health and care for our Trafford population.

The development of the Greater Manchester Integrated Care System will require the redesign of our current operating model and ways of working. Our key focus areas for our workforce to ensure successful transformation to include:

- **Engagement** of our colleagues to ensure we base decisions about how we integrate on the thoughts and views of workforce
- **Development** to build knowledge and understand as we progress into our new Integrated Care System model
- **Consultation** with colleagues whose roles are impacted by proposed changes, ensuring fairness, transparency and fulfilment of legal obligations
- **Support** for our workforce throughout the organisational change process, whether this be with health and wellbeing, adoption of new ways of working, transition into new roles – our focus will be on providing the right support at the right time



1.4 TRAFFORD PRIORITIES, PRINCIPLES AND BEHAVIOURS

ONE PLAN FOR THE TRAFFORD HEALTH AND SOCIAL CARE SYSTEM

1.4.1 Trafford Priorities

This Refresh, like the 2019 Plan, is based on our 4 main principles. These remain our population, the people we serve, the place where we live and work and the partnerships we create. In doing so we have three main aspirations for this plan: better lives for our most vulnerable people, better wellbeing for our population and better connections across our communities. We have built our plan around our place and in Trafford this is our four neighbourhoods, our locality and working with other localities in Greater Manchester.

1.4.2 Trafford Principles

We remain committed in Trafford to ways of working that put into practice our principles and the difference these make to the people we serve. The principles in our 2019-4 Plan remain a key focus as we recover from the pandemic;

- Together as **Partners** – co-ordinating across our health and social care system, thinking bigger and doing better using our combined resources to improve outcomes for residents.
- In a **Place** – being positive about our places and spaces, bringing people who live and work in an area together to build stronger communities.
- With **People** – putting residents at the heart of what we do, listening and working with people.
- Focusing on **Prevention** – commitment to taking action early and making every contact count.
- **Continually improving** – making the most of technology and using data and information to make shared decisions. We will continue to learn and develop our workforce and make the best use of our combined assets

1.4.3 Trafford Behaviours

Throughout the pandemic, it has become clearer than ever that empowered system leadership and behaviours are essential to transform the way we deliver services for the better. Working closely with our partners across Trafford, we will work in collaboration to deliver the Trafford Principles which describe the shift needed towards improving the health and wellbeing of the Trafford population.

Together, we continue to believe in Trafford that effective leadership behaviours are about being **courageous, curious and clear.**

In doing this, we have a shared set of ideas and actions. By doing this together we will be working to distribute our leadership and decisions across the health and social care system. We will encourage diverse perspectives, making connections, and investing in and promoting our shared values. We will continue to commit to **lead, listen and learn** from each other as we move forward.

Co-production and working closely together has enabled us to rapidly design services together during the pandemic such as;

- **Rapid Discharge**
- **Rapid Homecare**
- **Crisis Intervention Service**
- **Establishment of Community Hubs**
- **Long Covid Pathway**

TLCO Operational Plan
The Plan focuses on developing **collaborative neighbourhood plans** with our key partners to support local communities. The plan is embedded via an **integrated workforce** (health and social care) that delivers person-centred and holistic care. The principles of these new ways of working are to ensure that: Residents are at the centre of what we do, receive the right care, at the right time, as close to home as possible.

The diagram, used throughout the 2019 plan represents Trafford locality, with our **4 neighbourhoods** which encompass our **5 Primary care networks** and **our 6 community hubs** in our towns

1.4.4 Co-production

We committed in the 2019 Locality Plan to work with our partners on how we create together a culture of co-production that becomes the way of working to design and commission services (section 3.15 in the 2019 Plan).

The Covid-19 pandemic has enabled us work together closer than ever before, designing, commissioning and mobilising services rapidly in order to serve the people of Trafford. The Locality Plan remains a 'living' document that will need to be regularly reviewed as new information comes to light. This will be done by continuing to engage in Refresh document reviews, engaging with all our stakeholders throughout the lifespan of the plan.

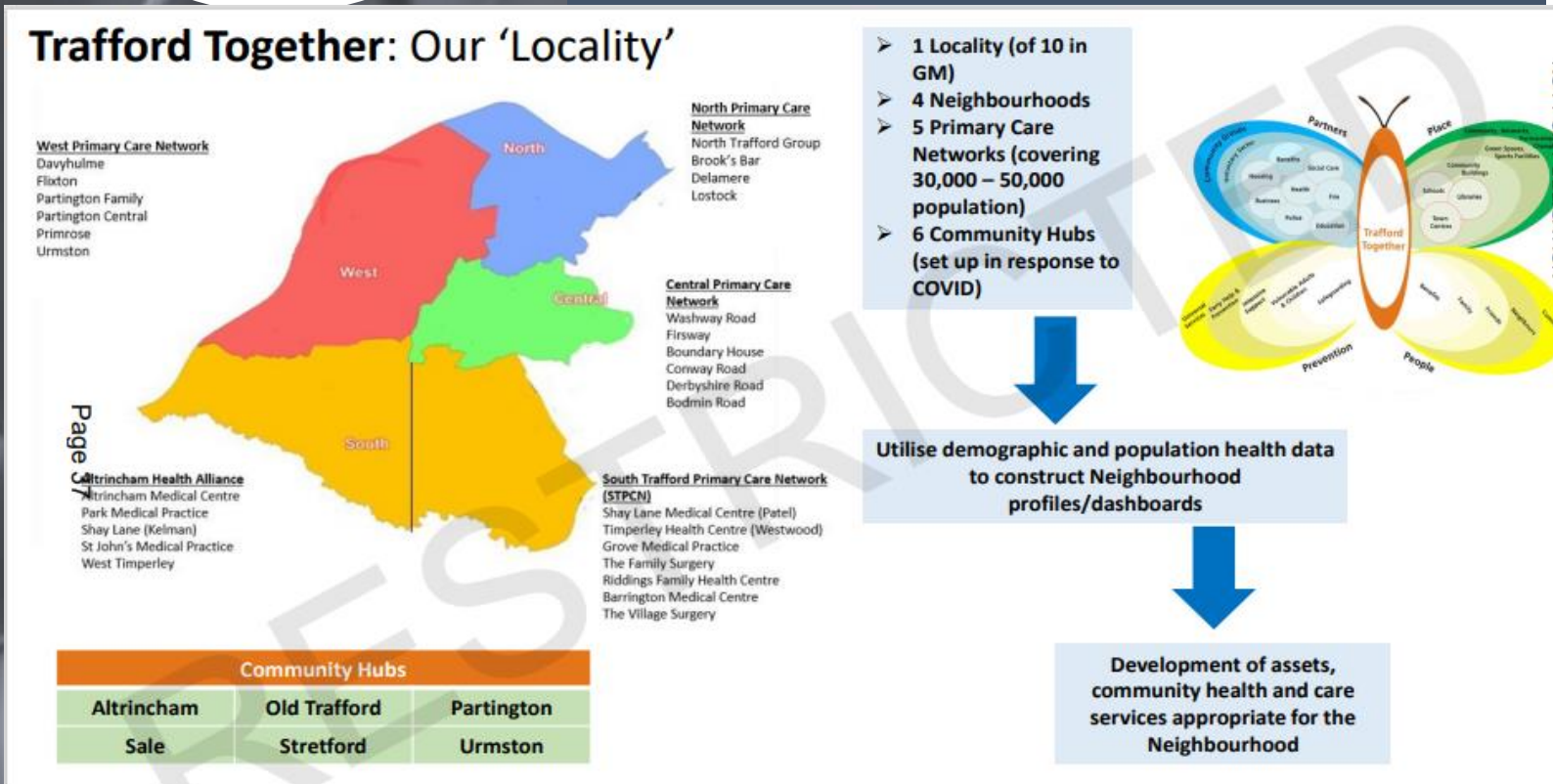
We continue to adopt the ladder of participation as in the 2019 Plan, and will continue to engage, co-design and where possible shift towards true co-production.

1.4.5 Neighbourhood Working

Trafford has a strong history of neighbourhood working, across sectors, organisations and professions and we are committed to building on these embedded ways of working which have been developed and driven through the LCA. Our focus on people, place, partners and prevention, with people 'living well at home' epitomises our Locality Plan

Our Locality Plan is what drives our collaboration and we take a lead from the Integrated Care System Design Framework and our learning from the Covid response that places the utmost importance on working to the principle of subsidiarity. – doing everything locally can be done locally.

Together we will explore the opportunities we have to improve connections in our communities through closer integrated 'on the ground' working. We will further develop our plans on multi-disciplinary working that is befitting of our different communities assets and needs.



1.5 TRAFFORD HEALTH AND SOCIAL CARE SYSTEM:

OUR SERVICES DURING THE PANDEMIC

Across the Health and Social Care system, services have had to adapt and implement new ways of working during the Covid-19 pandemic. Organisations have been enabled to work more closely together to make rapid joint decisions to best serve the people of Trafford. The 2019 Locality Plan set out an ambition to coproduce and jointly deliver services, and it is evident that this ambition has been embraced throughout the pandemic and we have begun to work more closely together as a system, with many services and solutions jointly designed and delivered.

Voluntary, Community, Faith and Social Enterprise (VCFSE)

The VCFSE Strategy remains a firm commitment as set out in the original Locality Plan. Through the last year the sector has been organising itself by developing **the Trafford Community Collective,** which became a registered CIO (Charitable Incorporated Organisation) Associate Model in March 2021. Another key achievement in the VCFSE sector is the rapid development and implementation of our six **Community Hubs** to support the most vulnerable throughout the pandemic.

Primary Care Networks (PCNs)

Our **Primary Care Networks** have continued to deliver outstanding support to the people of Trafford, **co-designing and supporting the development of services** in addition to delivering a huge scale vaccination programme across the borough. As of April 2021, **117,361** registered Trafford residents received the 1st dose of their COVID-19 vaccination, with **52,432** having had both doses of a vaccine. Our PCN colleagues will be a key driver in developing a Neighbourhood Working model for Trafford, which is a priority over the next year in our Health and Social Care system.

Health and Social Care Services

Our **Health and Social Care services** have remained resilient and relentless in delivering support to the people of Trafford throughout the Covid-19 pandemic throughout significant pressure and challenge

In March 2020, we significantly reconfigured Trafford's **homecare offer** to respond to the pandemic. The new service offer includes the development of a **Rapid Homecare service** to support same day hospital discharge and support to avoid a hospital admission, a focus on **Stabilise and Make Safe Reablement** supporting people to return home, **Long Term Homecare** and utilisation of the **British Red Cross** to support hospital discharge, reduce social isolation during the pandemic and ensure people attend planned medical appointments. More recently the Red Cross' support offer has been expanded to include **support for the COVID-19 vaccination programme**, providing transport for vulnerable households to attend vaccination, emotional support, sitting service (where carers need to attend for vaccinations), and support at the vaccination sites.

We have made changes to our ways of working, with our social care teams across the system undertaking virtual and phone assessments and conversations with residents to support them through the pandemic. At the start of the pandemic, we developed a **Unique Operating Procedure** to support people to return home from hospital as quickly and safely as possible. We have also established **Medicines Management** support to **Discharge to Assess (D2A) beds** as well as Structured Medication Review conversations initiated with Primary Care Networks to support our residents to return and live well at home safely.

Acute and Urgent Care

Changes to ways of working can also be seen in our urgent and acute settings. In response to the nation-wide increase of people struggling with mental health during the pandemic and presenting at A&E, a **Mental Health Urgent Care Unit** has been established to deliver crisis support, **diverting 20% of A&E patients** with mental health issues (replacing interim COVID-19 response model). The successful implementation of **Direct Booking** into Emergency Departments and Urgent Treatment Centres has also been a key achievement during the pandemic. Longer term, Trafford can now offer long term support for residents suffering from **Long Covid** with a range of support, from a local level in the community through GPs and local groups, all the way up to a multidisciplinary service at a GM level for the most severe cases. All Trafford residents suffering from Long Covid can now be referred by their own GP and will receive the **right support to help them recover and manage their condition.**

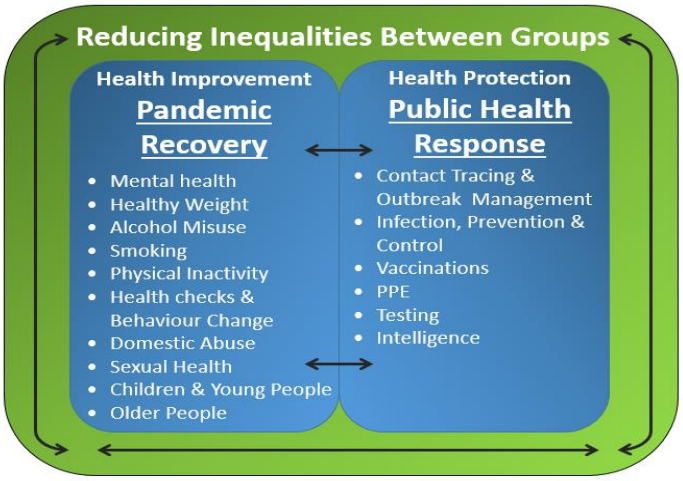
Public Health

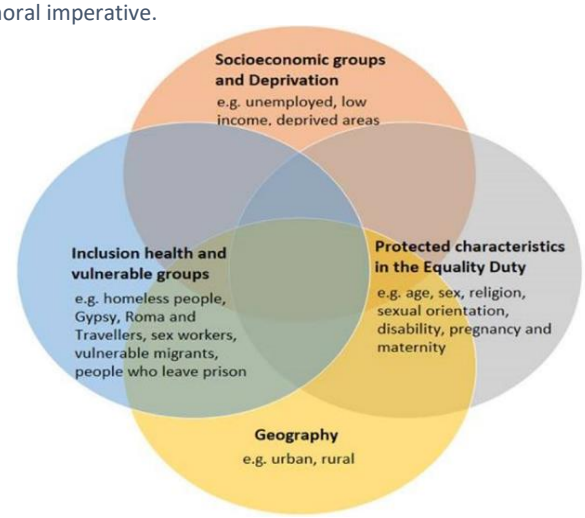
Our **Public Health** colleagues have worked closely with partners across the Health and Social Care system to keep both staff and the people of Trafford safe and healthy, and to identify and reduce health inequalities as a result of the pandemic. **35,305** tests have been carried out in our Local Testing Centres, **35,386** tests in our Mobile Testing Unit and **9,930** tests via Business Outbreak Testing to date.




1.6 INEQUALITIES

Nationally and within Trafford the impact of Covid-19 pandemic has not been evenly spread with risk increasing when more than one factor is present, with the greatest impact falling on those with poorer health and well-being. This has amplified existing health inequalities, particularly with older people, our deprived communities and those from a black or ethnic minority background. The virus is moving from a pandemic to an endemic (likely to be a constant present in our country and under control). Failure to address health inequality drives up health and social care costs. Addressing health inequalities is therefore as much an economic as a moral imperative.





As we recover from the Covid-19 pandemic, our key focus in responding to Covid-19 will be on enduring transmission and variants of concern (VoC). Public Health programmes will concentrate on:

- **Intelligence** – monitoring key demographics and targeting programmes in those areas where there is a high Covid impact and/or risk.
- **Testing** – providing full access to everyone to access tests to allow for self-isolation and reduce the spread of Covid.
- **Contact Tracing & Outbreak Management** – providing prevention advice, responding to outbreaks.
- **Vaccinations** – supporting the equitable delivery and uptake of the programme.
- **Personal Protective Equipment (PPE)** – continue providing PPE to key settings.
- **Infection Prevention & Control** – provision of professional advice, training and support to key settings.

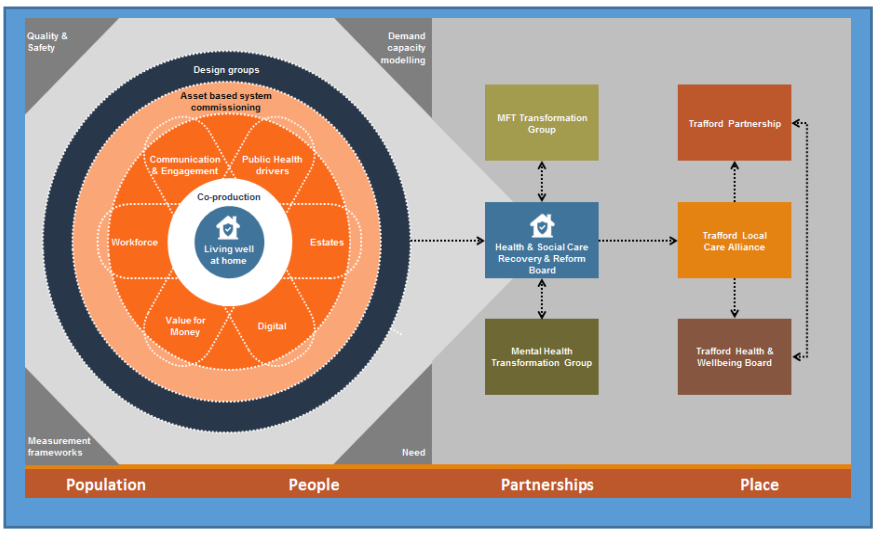
Trafford's Public Health Recovery Plan will link in with the Trafford Health & Wellbeing Strategy and the Public Health Annual Report, as well as the Public Health Poverty Strategy. It will also utilise Trafford's Joint Strategic Needs Assessment (JSNA).

2 Working Together

Trafford TOGETHER

2.1 DEVELOPING WAYS OF WORKING

Working together over the past 18 months under the stewardship of the LCA we have established our three **Strategic Design Groups** (SDGs) to support the delivery of the Locality Plan through our LCA members. The groups have taken the six key areas of system reform in the original 2019 Plan, and focused these areas into three key groups, with a commitment to **design services and solutions in a shared space through co-production**. The groups are focused on delivering a wide range of work-streams, including but not limited to the six original Locality Plan reform areas, to support our residents in the community, at home and throughout primary and secondary care. They are also supported by a range of expert enablers in Public Health, Digital, Workforce, Estates, Finance and Communications and Engagement, **expanding the role and remit of enablers** in the original 2019 Plan to bring these colleagues into the design space to embrace our inclusive approach.



Our contributors and delivery partners:

- Trafford Council Adult Social Care, All Age Commissioning,
- Communications and Engagement Teams
- Trafford Clinical Commissioning Group (CCG) – All Age Commissioning
- Trafford Local Care Alliance
- Trafford Local Care Organisation (TLCO)
- Trafford Community Collective
- Manchester Foundation Trust (MFT)
- Mastercall
- Greater Manchester Mental Health (GMMH)
- Trafford Primary Care Networks (PCNs)
- Trafford Community Hubs (x6)

2.2 STRATEGIC DESIGN GROUPS AND THEIR RECOVERY PRIORITIES

Our three Strategic Design Groups, curated from the learning of the pandemic and mobilised to move us closer towards the aspirations of our 2019 Locality Plan, have been overseen by the LCA for the past 12 months and continue to mature into a pivotal design function as we look to transform health and care services

2.2.1 Living Well in My Community

Our vision is that Trafford is a kind and compassionate place to live. All residents and communities in Trafford are able to live their best lives and be given help and support if and when they need it in the community in which they live.

The LWiMC group is made up of a wide range of stakeholders and is also the only strategic design group that is jointly led by community leaders and reports through both the One System Board and the Trafford Partnership Board.

In order to achieve the vision there are 4 key areas of work to progress:

1. Developing a community based working model with a network of hubs

The strategic design group was born out of the success of the Covid-19 community response hubs, as we started to see a reduction in demand due to lockdown and self-isolation easing, we see that the community hub model played a significant role in making sure that residents had a place to go when they needed support. The importance of a virtual network of hubs is key, as is the support from partner agencies to the hubs, so that we can respond to people at the earliest opportunity.

2. Promoting equality by reducing health inequalities

Trafford has a wide range of outcomes in terms of health and wellbeing and this varies greatly according to where you live. The more deprived areas tend to see poorer outcomes, as do areas where there is a high number of people that are from black and ethnic minority communities. Trafford recognise that health and wellbeing factors are influenced by things like education, employment, deprivation, poverty, community assets, environment, and air quality. This is why the priorities that we will concentrate on include helping people to maximise their income, plus access training and skills to improve employment rates, as set out in the Trafford Poverty Strategy.

3. Developing a consistent information and advice offer across Trafford

One of the main purposes for the hubs will be sign posting, plus giving residents information and advice to help them with their health and wellbeing. The group recognises that there are many organisations across Trafford giving advice and will aim to create consistency across the system.

4. Nurturing a strong and healthy voluntary sector so that people can access the support they need at the earliest opportunity.

In order to help people at the earliest opportunity, we know the value of the voluntary and faith sector and the numerous organisations across Trafford that help people on a day to day basis, from national organisations through to small charities and mutual aid groups. Having a strong voluntary and faith sector is vital for Trafford to achieve the ambitions set out in the Locality Plan

2.2.2 Living Well at Home

Our vision is that people in Trafford are supported to live fulfilling, independent lives in their own homes (and other home-settings) for as long as possible. Where our residents need additional temporary support because they are leaving hospital or their normal support system breaks down, we will wrap additional independence-building support around them so that they are able remain i - or return to - their normal place of residence, wherever possible.

All our support will build on personal **strengths**, natural supports (such as support from family and friends), and community **assets**, so that people are kept connected to family, friends and the wider community. People will plan their support **collaboratively** with their family and social support circle, and health and social care community services.

The Living Well at Home Strategic Design Group is made up of a variety of partners from across the health and social care system, working together to make our vision a reality. The group is responsible for a wide range of activity, with 14 key areas of focus

2.2.3 Short Stay in Hospital

The Short Stay in Hospital Strategic Design group will facilitate the delivery of programmes that will aim to address a number of challenges which will need to be managed at a locality, system and national level in order to run an efficient and safe service that does not create health inequalities.

Urgent Care	**Transform community services to avoid unnecessary hospital admissions and improve flow, in particular on the emergency pathway. This will be achieved through work on:** • Front door triage and streaming • Development of Clinical Assessment Services • Establish Direct Booking • Establish Clinical Hub Model • Development and mobilisation of urgent treatment centres • Development of same day emergency care models • Community Rapid Response
Planned Care	**Maximise elective activity, taking full advantage of the opportunities to transform the delivery of services. This will include the following:** • Virtual Wards and Pulse Oximetry At Home • Advice and Guidance • Evidence –Based Interventions/Effective Use of Resources Compliance • Outpatient reform by speciality • Patient initiated follow up (PIFU) roll-out • AQP Audiology re-tender • Muscular skeletal Local Pathway • Phlebotomy • Community Diagnostics Hubs
Long Term Conditions	**To reduce variation in access and outcomes and implement whole pathway transformation to improve Long Term condition management through continued work on:** • Risk Stratification and Population Health Management • Long Covid • Long Term Condition Management
Mental Health	**Through the implementation of the Trafford Mental Health Transformation Strategy, we will:** • Ensure Trafford's core mental health services, community and inpatient are resilient and fit for purpose • Reform and redesign our mental health and wellbeing offer to Trafford's citizens • Establish early intervention and preventative approaches • Reduce mental health inequalities
Living Well at Home	**We will transform pathways to support reablement and improve access to therapy through the redesign of:** • Discharge to assess clinical model • Specialist Rehab (Community Neuro Rehab Team) • Generalist Rehab including OPAL House, Ascot House, Intermediate Care at Home, and community rehabilitation • Equipment and Adaptations • Access to Therapies • In Hospital rehab
Cancer	**Improve the inequality in access to early cancer diagnosis** • Screening Programmes • Performance monitoring linked to Primary Care Network early cancer diagnosis (Directed Enhanced Service - DES) • Inequality of access linked to Primary Care Network early cancer diagnosis (Directed Enhanced Service –DES)
Maternity Services	**Deliver improvements in maternity care, including responding to the recommendations of the Ockenden review through:** • Continuity of Care • Saving Babies Lives V2 • Maternity Services: Choice/Experience • Community midwife access to community facilities
Primary Care	**Deliver the Trafford Primary Care Health Inequalities Plan to see improvements in:** • Access • Digital Transformation • Data Quality • LTC Management • Screening & Immunisation • Annual Health Checks for people with severe mental illness or a learning disability
Childrens	**Maximise each opportunity to improve child health by prioritising the transformation of the following services and seeing increased performance:** • Children's urgent care • Children's Mental Health • Special Education Needs and Disabilities • Early Help • Placements

2.3 ENABLERS AND THEIR PRIORITIES

2.3.1 Finance

Trafford as a system has a combined resource for health and social care of **c£512 million** for 2021/2022. This is a resource that as a system we need to be able to spend in the most effective and efficient way possible to get high quality, safe services, that provide value for money and provide the people of Trafford with the best possible outcomes. This is the current estimated budget figure but as we move towards the Greater Manchester Integrated Care System and the system becomes clearer regarding the planning and delivery model this may change.

All providers across the system face unprecedented challenges as we emerge from the pandemic, with a significant system deficit gap. It is ever more important we embody our agreed financial principles:

1. Have a shared vision of a financial model for the system.
2. Work within a financial framework that has a more mature collaborative approach across partner agencies that is open, transparent and fair.
3. Deliver financial balance and sustainability for the health and social care system.
4. Use resources effectively for our vision of care closer to home.
5. We will be guided by clinical and professional leadership.

We will do this by:

- Developing an Integrated Partnership Agreement to support the reform of the system.
- Continuing to review and respond to Government guidance.
- Enacting changes to financial systems in agreement with the Greater Manchester Integrated Care System
- Ensuring effective co-ordination of financial planning across the system
- Being data led and intelligence driven in our financial approach.
- Continuing to monitor the financial impact of the covid-19 pandemic on our services.
- Allocate any discretionary funding to the areas that need it the most

It is imperative that our Locality Plan and its stakeholders recognise the level of financial challenge we will need to address together to bring our system finance into balance and make our system sustainable. This will require open and honest conversations and a shift towards open book accounting as referred to in the ICS Design Framework. This will enable a better understanding of our organisational and system risks and gains and enable us to work up solutions – we will route this through our One System Board and future Trafford Together Health and Care Alliance (currently the LCA).

2.3.2 Quality and Performance

Throughout 20/21 the Business Intelligence and Performance Teams across health and care have been working together to develop a suite of performance dashboards to support the delivery of the Locality Plan. The dashboards are focused on identifying opportunities and demonstrating the impact of health and social care reform and recovery plans. A 'Tableau' landing page (performance data) is now in place giving desktop access to the workforce across Trafford CCG and Council and also wider stakeholders. The landing page contains:
Local Care Alliance Dashboard – this contains metrics that talks to the 3 aspirations of this plan. The Recovery of Commissioned Services Dashboard focuses on delivering the plans set out in NHS guidance, and our Strategic Design Group Dashboards link directly to our LWAH, SSIH and LWiMC design groups.
Thematic Dashboards have also been developed as required e.g. children's and mental health.

In 21/22 the team will focus on co-producing robust data to support the on-going work to reduce inequalities, targeted improvement activities in our neighbourhoods and demonstrating the impact of delivery of the plan to our residents and patients. Also, we will develop:

- An Inequalities Dashboard
- Four Neighbourhood Dashboards
- We will be bringing these products into a single space which will improve our approach to continuous improvement and the data led approach we strive for.

2.3.4 Workforce

Our Trafford Together Health and Social Care Workforce are our most critical asset in enabling the success of the Trafford Together Locality Plan. Our ambition is to achieve:

'One workforce across Trafford, enabling, better lives for our most vulnerable people, better wellbeing for our population and better connections through our communities'

We are faced with national drivers for change through the NHS Long Term Plan, local drivers through Greater Manchester plans and the current review and reform of the way on which Clinical Commissioning operates across the whole of GM. Global turbulence caused by the COVID-19 pandemic has placed the workforce under unprecedented pressure, driving instant changes to working practices and system operations. If we are to achieve our aspirations we must place our workforce at the heart of our Health & Social Care strategy, as working together is critical in delivering those aspirations Trafford has set out to achieve.

Our workforce strategy sets out our approach to ensuring we have a health & social care workforce that is: Engaged, Effective and Inclusive. The workforce priorities (2021-202) have been co-produced through discussion with a wide range of stakeholders across Trafford, including discussion with partners at the Trafford Locality Workforce Group.

2.3.5 Digital

The digital agenda has rapidly progressed during the Covid pandemic. Trafford's Health and Care organisations are increasingly using digital solutions to interact with the public and to deliver new models of care, such as the use of digital solutions to undertake consultations and provide care and advice to the people of Trafford. Employees are now more dependent on digital as most are currently working from remote locations and high levels of home and hybrid working are expected to continue now national restrictions have been lifted. Trafford Together is changing how it operates with digital at its core, but the increased dependency on digital has placed resourcing challenges on IT teams. Demand for digital solutions has increased and support is more complex and time consuming. We aim to deliver in an inclusive way to cater for all.

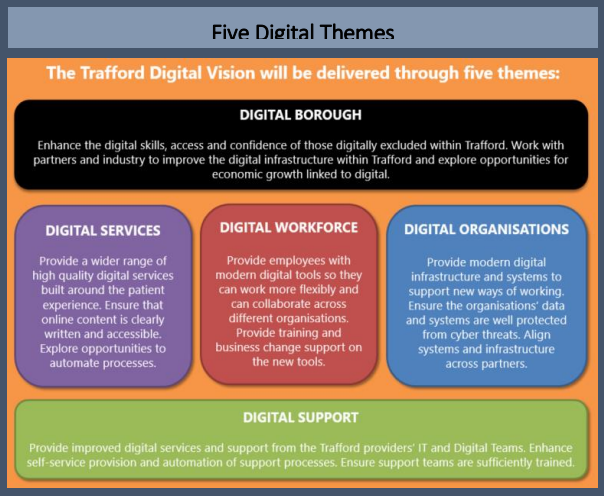
Several of the key digital activities listed in the Locality Plan and Digital Roadmap have been delivered. The original work plan remains in place but some initiatives will be enhanced and developed, with some needing expediting. These include:

- Implement EMIS Community Electronic Patient Record
- Implement EMIS GP to EMIS Community Workflow and Referrals
- Implement Integrated Care Plan (Graphnet)

The creation of the Integrated Care System in Greater Manchester will change how digital is planned and delivered in Trafford. The future form and function of digital is currently being considered and Trafford is proposing retaining a locality based digital leadership function while embracing greater strategic alignment at the ICS level.

2.3.6 Estates

The Infrastructure, Environment and Physical Activity Group has been established to ensure the restarting of the local economy / society. This is to be achieved through a focus on the Trafford Estate, transport and infrastructure. There will be a focus on access to our Green space and leisure estate to provide physical and mental health benefits for all will also link into the wider climate change programme



2.3.7 Communication and Engagement

Before the pandemic we had a year of engagement planned for 2019/20. Upon publication of the original Locality Plan we established a multi-agency Communications and Engagement Steering Group which started to pull together what our year of engagement would look like. We were just about ready to publish the practical things we would do when Covid-19 hit us.

As we move into Recovery we are now keen to develop a longer term communications and engagement strategy
a) Covid-19 recovery and outbreak management and
b) The longer term strategy for Health and social Care reform.

The Covid-19 pandemic has enabled levels of innovation and collaboration unprecedented within the NHS and wider social care system. This emergency has provided us with an opportunity to develop, redesign and reset how we work as a system and individual organisations to deliver health care and social care moving forward.

2.4 Key challenges for our services

1. The health and care system both in Trafford and nationally faces significant challenges to restoring services across Social Care, Primary Care, Hospitals, Mental Health and Community-based services.

2. Health and Social Care services must remain fully prepared for any future waves of Covid-19 and for the potential need for further mass vaccination against new variants.

3. Practical challenges to delivering 'business as usual' services while Covid-19 remains a risk. We recognise that enhanced infection control measures are likely to slow the pace at which we can support our residents via appointments and treatments, which results in increased waiting times and potential impacts on people's outcomes and experiences of care.

4. Our Health and Social Care system must prioritise and address backlogs of demand for health and care services to reduce waiting times and potential impacts on people's health and wellbeing. We must examine our resource and ensure we have the staff available to deliver care; remaining sensitive to risks such as staff burnout and exhaustion from a prolonged period of responding to the pressures of the Covid-19 pandemic.

5. Addressing significant increases in mental health needs over the coming years as a result of the pandemic, particularly due to the impact of social restrictions and lockdown measures, anticipating that demand for adult mental health services and child and young people services to rise.

6. We must as a system continue the co-production and joint ways of working we have committed to in the 2019 Locality Plan and strengthened by the pandemic, to deliver a whole-system response spanning acute hospitals, primary care, community, mental health and social care services. Whole system must encompass our VCFSE sector, which has offered both us and our residents invaluable and critical support during the pandemic.

7. We face significant financial challenges as we could potentially move into another period of austerity nationally

LOOKING FORWARD:

Both Andrew Western (Leader of Trafford Council) and Dr Muhammed Imran (Chair of NHS Trafford CCG) as the Joint Chairs of the Trafford One System Board are fully committed to establishing the key steps outlined in this plan to define the future of Trafford's health and social care system and see it thrive in the new ICS arrangements. The White Paper produced by the Government can help pave the way towards new opportunities for collaboration, greater public voice and the ability for our system to address our known challenges and inequalities to ultimately deliver against our aspirations of: Better connected communities; Better wellbeing for our population; Better lives for our most vulnerable people.

We have already seen the fruit of collaboration in the shape of national vaccination program for COVID and many other exemplar programmes of work since the initial launch of the Locality Plan back in 2019 which have been expedited. We will continue to work openly and honestly with partners, and with integrity to fulfil our systems ambitions. With the cessation of the CCG in March 2022 and the formal standing up of the GM ICS on April 1st 2022 the strategic role of the Trafford One System Board and the Trafford Together Health and Care Alliance becomes critical and collectively along with other forums and its constituent organisations it will drive forward the intent of the Trafford Together Locality Plan.

In addition and on the horizon there are a number of other key national reform programmes such as 'Delivering Carbon Neutral' and further legislative changes in Public Health and particularly in Adult Social Care with the imminent introduction of the Liberty Protection Safeguards. More can be found on these areas of work and national reforms in the appendix. Needless to say these will form key areas of focus for the Trafford One System Board and the Trafford Together Health and Care Alliance (currently LCA) as we work together to address some of our biggest challenges which can only be met with a comprehensive and collaborative response from all of Trafford health and social care, and wider system partners.

Andrew Western,
Leader of the Council and Joint Chair of the Trafford One System Board

Muhammed Imran,
CCG Chair and Joint Chair of the Trafford One System Board

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce and Corporate Business
Paper prepared by:	Stephen Gardner, Director – Single Hospital Service Programme
Date of paper:	September 2021
Subject:	Update on the NMGH transaction and integration processes
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:	This Paper should be considered against the strategic aim of completing 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 ongoing work on the SLA/disaggregation and integration processes. • Note the ongoing work to deliver the SRFT statutory transaction and the dissolution of PAHT.
Contact:	Name: Peter Blythin, Group Executive Director of Workforce and Corporate Business Tel: 0161 701 0190

1. Introduction

1.1 The Board has previously received reports on the acquisition of North Manchester General Hospital (NMGH), and the post-transaction management arrangements. The acquisition of NMGH was successfully completed by a Prior Commercial Transfer at 1st April 2021 and good progress is being made on integrating NMGH in to MFT.

1.2 This paper describes the continued integration planning and implementation processes, the management of the Service Level Agreements and associated work on service disaggregation, the arrangements for the proposed Salford Royal NHS FT (SRFT) statutory transaction, and the finalisation of the future bi-lateral governance arrangements.

2. Integration Planning and Delivery

A third and final version of the NMGH Post-Transaction Integration Plan (PTIP) has been produced and approved by North Manchester Programme Board. The document provides an update on the integration work that has been completed in the first 100 days since the NMGH acquisition and offers assurance that all relevant milestones and integration plans have been completed. The PTIP also describes the plans for future disaggregation/integration and articulates how oversight of related plans will be transferred into 'business as usual' processes going forward.

3. Disaggregation and Service Level Agreements

3.1 As previously reported, one of the consequences of the transaction process is that a number of services are operated under Service Level Agreements (SLAs). There is an on-going process to review these SLAs and determine how and when the parties might withdraw from them. There is a total of 87 SLAs between MFT and Pennine Acute Hospitals NHS Trust (PAHT).

3.2 MFT, PAHT and SRFT have agreed that, over the coming months and years, the SLA arrangements should be wound down and so a number of services, including special imaging services and medical device management, will disaggregate at the end September 2021. MFT and SRFT have also signalled their intentions to stand down a number of SLA arrangements in April 2022 and 'exit plans' are being developed that set out how these changes will be safely and effectively managed.

3.3 September 2022 is likely to represent a significant milestone in the process to reduce the number/value of the SLAs in place as it is expected that the SLA arrangements will cease in Informatics, Pathology and Pharmacy. Formal notice on these SLAs will be served in September 2021 and plans to deliver this disaggregation are currently being developed.

3.4 There are a number of clinical service areas where, because of the complexity of existing service delivery and/or a range of strategic issues, the precise nature of disaggregation has not yet been agreed. These clinical areas include General Surgery, Urology, ENT, Trauma and Orthopaedics and Cardiology. PAHT asked MFT and SRFT to develop a high-level 'statement of intent' for each of these services in order to aid transparency and to foster a collaborative approach to planning. Following discussions, an agreed position was reached, and this was signed off at a meeting of the key MFT/SRFT Executive Directors on 25th August. The PAHT Board will consider this statement as part of its transaction due diligence.

4 Statutory transaction

4.1 As the Board is aware, the intention is for SRFT to acquire the Bury, Oldham and Rochdale sites and services on 1st October 2021. The Provider Oversight Committee of NHS Improvement/NHS England (NHS E/I) will formally consider the proposal at its meeting on 14th September 2021, and the SRFT Board will then confirm its intention to complete the acquisition. At the same time, the PAHT Board will formally ask the Secretary of State (SoS) to dissolve the Trust.

4.2 It is expected that SoS will make three orders under his powers arising from the NHS Act 2006. In addition to the Dissolution Order, two separate Transfer Orders will transfer PAHT assets and liabilities to SRFT and MFT. Clearly the majority of the transfer associated with the NMGH Undertaking has already been achieved through the Prior Commercial Transfer completed by MFT at the 1st April 2021.

4.3 The MFT Transfer Order will serve to transfer i) the services covered in SLAs which are being discontinued at 1st October 2021, and ii) residual assets and liabilities which could not be transferred through the commercial transaction. In combination with the SRFT Transfer Order, this will ensure that there is an equitable alignment of all assets and liabilities of PAHT to either MFT or SRFT.

4.4 The transaction documentation agreed by the Board of Directors at end March 2021 included drafts of the Transfer and Dissolution Orders, and the associated schedules. The finalised versions of these documents will be approved under the delegated authority to the Chair and Chief Executive agreed by the Board.

4.5 The Council of Governors has also been kept fully briefed on the transaction processes throughout.

5 Recommendations

5.1 The Board of Directors is asked to:

- Note the ongoing work on the SLA/disaggregation and integration processes.
- Note the ongoing work to deliver the SRFT statutory transaction and the dissolution of PAHT.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Sue Ward, Group Deputy Chief Nurse Alison Lynch, Corporate Director of Nursing Barbara Mitchell, Assistant Chief Nurse Safeguarding, Quality & Patient Experience Claire Horsefield, Head of Customer Services
Date of paper:	September 2021
Subject:	Complaints & PALS Report: Quarter 2021/22
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 staff experience Patient safety
Recommendations:	The Board of Directors is asked to note the content of the Report
Contact:	Name: Barbara Mitchell, Assistant Chief Nurse Safeguarding, Quality & Patient Experience. Tel: 0161 276 4738

1. Executive Summary

1.1 This report relates to Patient Advice & Liaison Service (PALS) and Complaints activity across Manchester University NHS Foundation Trust (MFT) during Q1 2021/22. For the first time, data and information are included from services at North Manchester General Hospital (NMGH), who joined MFT from 1st April 2021. This has contributed to a proportionate increase in complaints and PALS activity. Our aim is to provide timely resolutions to complaints when people raise concerns about their experience of care and treatment received to remedy the situation as quickly as possible and ensure that the individual is satisfied with the response that they receive. Findings and learning from complaints are used to improve services for the people who use them, as well as for staff working in them.

1.2 The report provides:

- A summary of activity for Complaints and Patient Advice & Liaison Service (PALS) across the Trust
- An overview and brief thematic analysis of concerns raised
- A summary of feedback received through Care Opinion and NHS Websites.
- A summary of improvements achieved, and those planned to ensure learning from complaints is embedded in practice
- Improvements made, and future developments
- Complainants' satisfaction survey
- Equality and Diversity information

1.3 A range of supporting information referred to throughout the report is included in tables and graphs presented at Appendix 1.

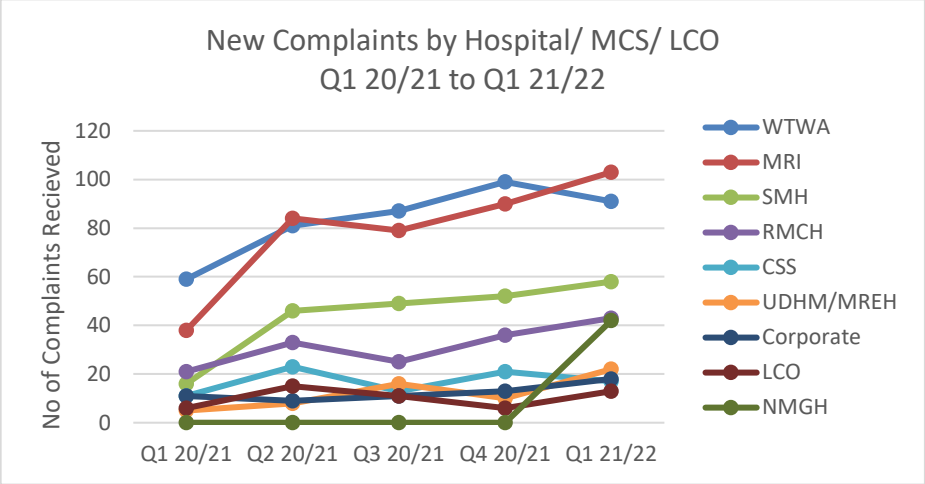
2. Q1 2021/22 summary of activity for PALS and Complaints Services

- 1,833 PALS concerns were received in comparison to 1,496 received in the previous quarter[1]
- 407 new complaints were received in comparison to 327 received in the previous quarter[2]
- 100% of complaints were acknowledged within 3 working days; this position was maintained throughout all the previous quarters of 2020/21
- 359 complaints were closed in comparison to 289 closed in the previous quarter[3]
- 92.5% of complaints were closed within the agreed timescale compared to 93.8% in the previous quarter. This is the fourth quarter in which the Trust has achieved or exceeded the 90% target
- 34 (9.47%) complaints investigated were upheld, 64 (18.0%) were not upheld and 248 (69.0%) were partially upheld
- 5 cases were being investigated by the Parliamentary Health Service Ombudsman (PHSO)
- An increase in complaints relating to outpatient and inpatient services was noted across the Trust and an increase in re-opened complaints.
- The PHSO closed 4 cases, 2 were partially upheld[4], and 2[5] were upheld. In one case, the Trust was required to pay £200 redress in recognition of minor injuries caused. Details of the 'live' PHSO investigations are set out in Table 1, Appendix 1.
- 17 virtual or face to face complaint local resolution meetings were held.

- 15 in-house Complaints Letter Writing Training Educational Sessions were held, with 152 number of staff attending.
- The Complaints Review and Scrutiny Group (CRSG), chaired by a Non-Executive Director, met during Q1. Two cases were presented by the Manchester Royal Eye Hospital (MREH) and University Dental Hospital Manchester (UDHM) senior teams. The learning identified from these cases is detailed in Section 6 of this report.

3.0 An overview and brief thematic analysis of complaints contacts

3.1 The Trust received 407 new complaints Q1, as described previously in this paper this is an increase compared to the previous quarter. **Graph 4** below shows the number of complaints received by each Hospital/MCS/LCO each quarter. MRI and WTWA receive the greatest number of complaints, this is not unexpected as they are larger hospital sites than others. Further detail is provided in **Table 6**, **Appendix 1**.



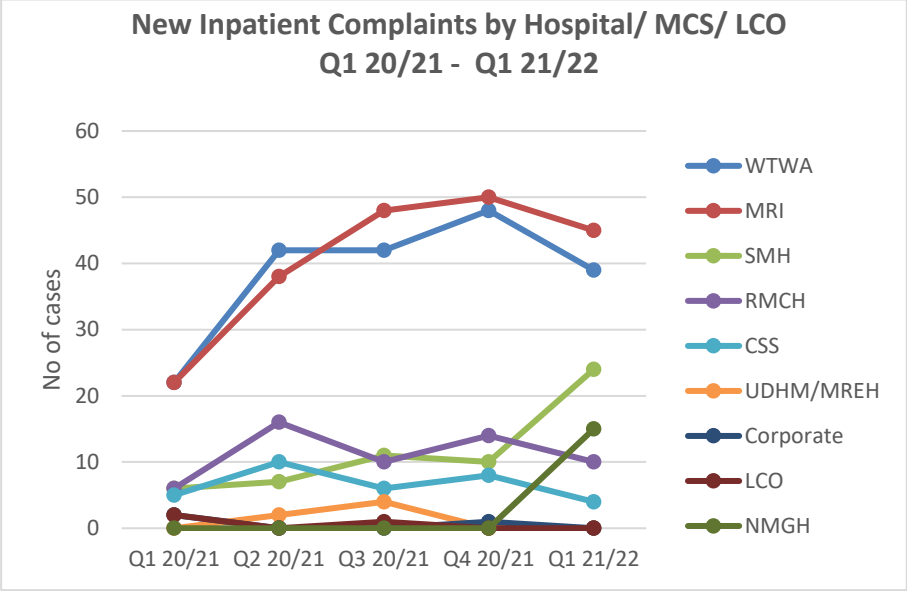
Graph 4: New Complaints Received by Hospital/MCS/LCO

3.2 **Graphs 5 and 6** below illustrate the number of new complaints relating to inpatient and outpatient services during Q1 2020/21 - Q1 2021/22.

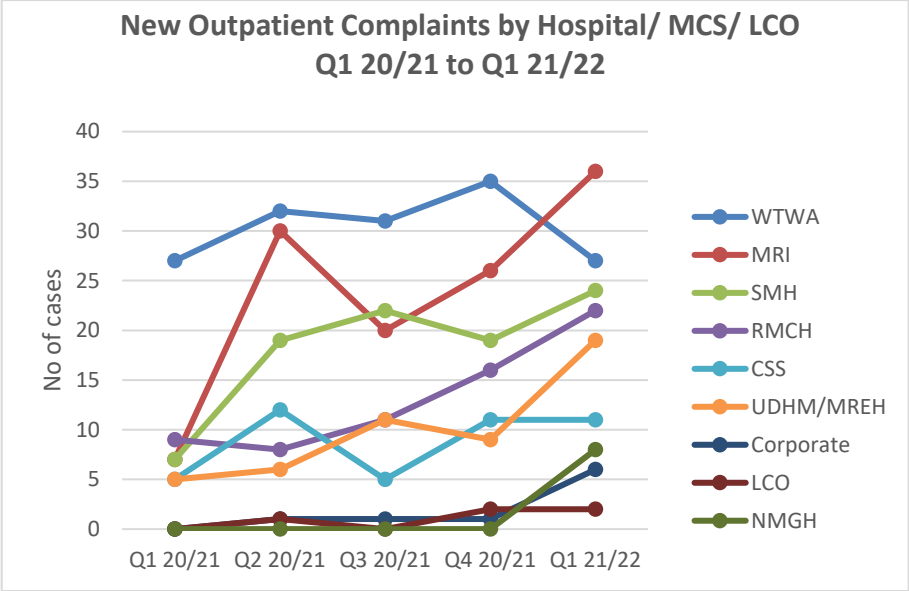
3.3 Overall, the greatest increase in complaints relates to outpatients, with a slight increase relating to in-patient services.

3.4 It is considered that the increase noted should be viewed in the context of NMGH joining the Trust, activity increasing in outpatient departments and an increase in waiting times for elective work as the NHS works toward recovering from the pandemic.

[1] Contributed to by NMGH joining from 1st April 2021
[2] Contributed to by NMGH joining from 1st April 2021
[3] Contributed to by NMGH joining from 1st April 2021
[4] Definitions of fully upheld, partially upheld and not upheld relate to K014a return, and are expanded on at point 3.9 of this report
[5] Definitions of fully upheld, partially upheld and not upheld relate to K014a return, and are expanded on at point 3.9 of this report



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

3.3 Under the NHS Complaints Regulations (2009) there is a requirement that all new complaints are acknowledged within 3 working days of receipt of the complaint, MFT are committed to achieving this in 100% of cases. This quarter, as in all previous quarters, the Trust met this indicator. **Table 7**, Appendix 1 demonstrates the complaints acknowledgment performance.

3.4 Complaints resolved within agreed timescales

3.5 92.5% of complaints were closed within the agreed timescale. This is the 4th quarter that the Trust has achieved above the agreed 90% target, however it must be noted that this represents a continual decrease of 1.3% compared to the previous 2 quarters. Table 8, Appendix 1, provides the comparison of complaints resolved within agreed timeframe during the last 5 quarters.

3.6 The oldest complaint case closed during Q1 was registered within WTWA on 11th November 2020 and was 135 days old when it closed on 27th May 2021. The complaint also involved 3 other NHS organisations, delays in receiving outcomes of some

external investigations impacted the overall response time. The complainant was kept updated and was fully supported throughout this process.

3.7 Outcomes from Complaint Investigations

3.8 All NHS organisations and those delivering NHS services are required to submit information on a quarterly basis to NHS Digital through the Hospital and Community Health Services Complaints Collection (KO41a) report. The K014a report includes a range of data in respect of complaints, including demographics, and also in relation to whether a complaint is fully upheld, partially upheld, or not upheld.

3.9 Often complaints relate to more than one issue. In conjunction with the Hospital/ MCS/LCO investigating team, the Corporate Complaints team 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. Where are complaint is withdrawn, or consent to investigate not received, no outcome can be recorded.

3.10 During Q1, 34 (9.47%) of the complaints investigated and resolved were fully upheld, a slight increase from the previous quarter, whilst 249 (69.3%) were partially upheld. Table 9, Appendix 1 demonstrates the outcome status of all complaints between Q1 2020/21 and Q1 2021/22.

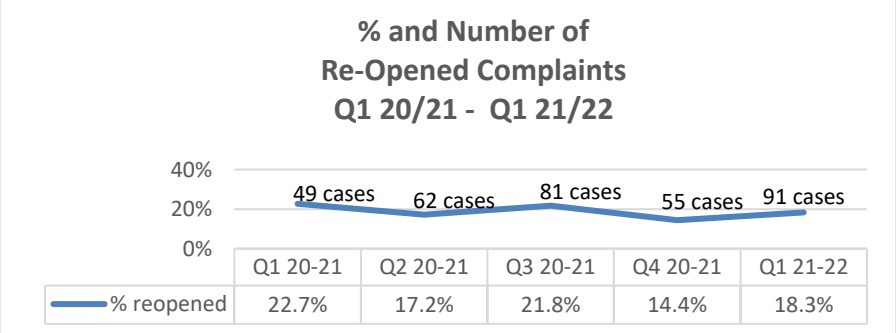
3.11 Re-opened complaints

3.12 The number of re-opened complaints is used as a proxy indicator to measure the quality of the initial response. A tolerance threshold of 20% has been agreed; during Q1, 18.3% of complaints were open (91 cases in total). In the previous quarter, 14.4% of complaints were reopened.

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

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

3.14 **Graph 7** demonstrates the number of complaints re-opened from Q1 2020/21 - Q1 2021/22. Table 10, Appendix 1 provides an overview of the predominant reasons for the complaint being re-opened by Hospital/MCS/LCO during Q1.



Graph 7: Total Re-opened complaints Quarter 1, 2020/21 to Quarter 1, 2021/22

3.15 In 51 of the 91 complaints requiring re-opening, the predominant reason for was due to the complainant being 'dissatisfied with the response', with WTWA and MRI receiving the greatest number.

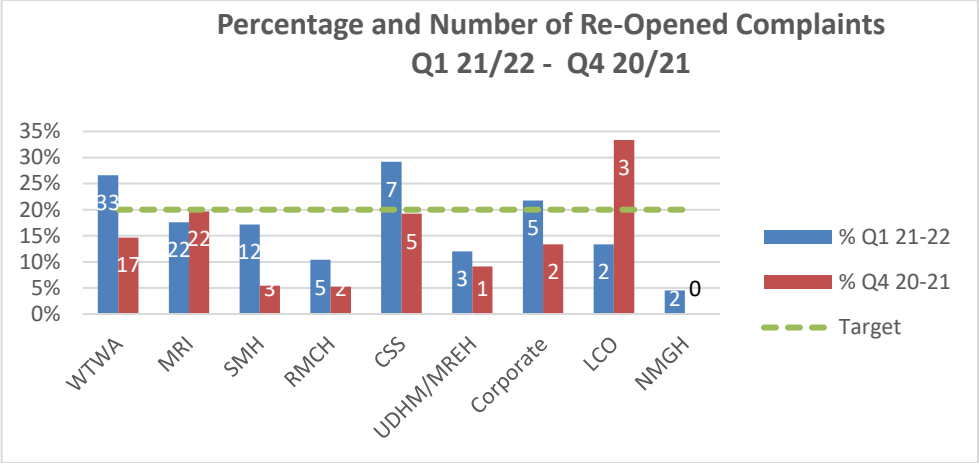
3.16 The 20% threshold was exceeded is as follows:

- WTWA - 26.6%
- Clinical Scientific Services (CSS) - 29.2%
- Corporate - 21.7%

3.17 **Graph 8** below shows re-opened complaints for MRI, Saint Mary's Hospital (SMH), Royal Manchester Children's Hospital (RMCH), UDHM/MREH, Local Care Organisation (LCO) and NMGH, which all fell below the 20% threshold.

3.18 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 CSS and Corporate.

3.19 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 and number of re-opened complaints, Quarter 1, 2021/22

3.20 Brief thematic overview of complaints

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

3.22 During Q1, the top 5 categories remain unchanged from previous reports. 'Treatment/ Procedure' remained the top category. The categories 'Discharge/Transfer', 'Access' have not been in the top 5 categories in the previous 2 quarters, reflecting the hard work and recovery strategies in place in to address the backlog of care following pauses in activity in response to the COVID-19 pandemic.

3.23 The top themes in Q1 from complaints are shown in Table 1 below. Themes from previous quarters are included to enable comparison.

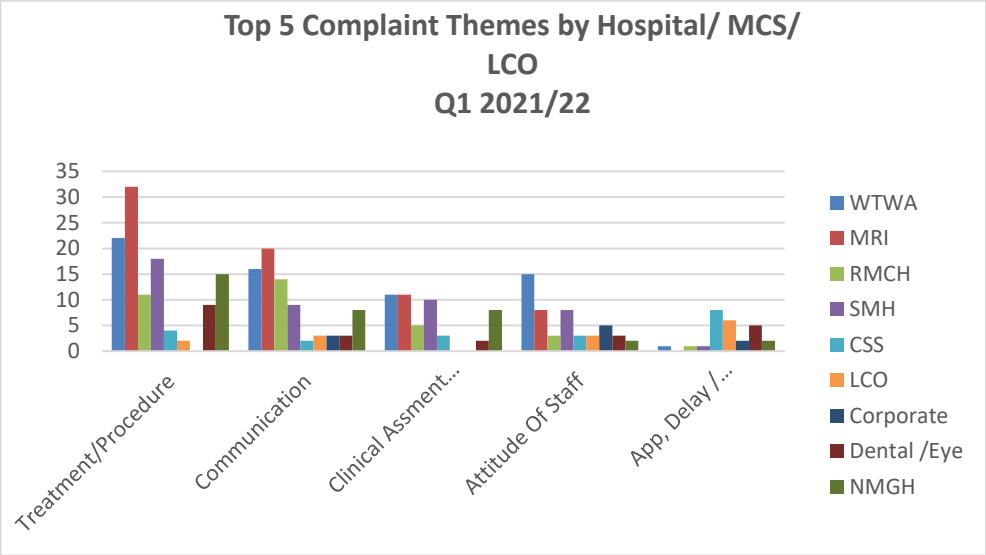
	Q1,20/21	Q2,20/21	Q3,20/21	Q4,20/21	Q1,21/22
1	Treatment/ Procedure	Treatment/ Procedure	Treatment/ Procedure	Treatment/ Procedure	Treatment/ Procedure
2	Communication	Communication	Clinical Assessment (Diag,Scan)	Communication	Communication
3	Clinical Assessment (Diag,Scan)	Clinical Assessment (Diag,Scan)	Communication	Clinical Assessment (Diag,Scan)	Clinical Assessment (Diag,Scan)
4	Attitude of Staff	Attitude of Staff	Discharge/ Transfer	Attitude of Staff	Attitude of Staff
5	Discharge/ Transfer	Access	Access	App, Delay / Cancellation (OP)	App, Delay / Cancellation (OP)

Table 1: Top Complaint Themes Q1, 2020/21 to Q1, 2021/22

3.24 The MRI received the most complaints relating to 'treatment/procedure'. As previously described, most of the new complaints relate to inpatient and outpatient services. Some examples include:

- a patient experiencing an unexpected clinical outcome following outpatient angioplasty treatment
- a family member, on behalf of a patient, seeking an explanation regarding the delay in the patient's procedure being performed

3.25 **Graph 9** below shows the distribution of the top 5 themes by Hospital/MCS/LCO in Q1 2021/22.



Graph 9 Top 5 themes by Hospital/MCS/LCO in Q1 2021/22.

3.26 Work continued during this quarter to align identified themes from complaints to the MFT What Matters to Me (WMTM) categories.

3.27 The themes identified from Q1 2020/21 to Q1, 2021/22 are shown in Table 12 below. In this report, as in the previous reports, Positive Communication and Professional Excellence are noted as the top 2 WMTM themes. Some examples of complaints received relating to Positive Communication and Professional Excellence include:

- a patient receiving poor communication in relation to their treatment plan
- patient documentation not being completed appropriately by nursing staff

3.28 Table 2 below shows themes of complaints mapped to MFT WMTM categories, Q1 2020/21 - Q1, 2021/22

WMTM themes	Q1,20/21	Q2,20/21	Q3,20/21	Q4,20/21	Q1,21/22
Positive Communication	84	78	47	97	196
Environment	11	17	6	8	20
Organisational Culture	85	59	24	44	93
Professional Excellence	71	65	48	78	164
Leadership	18	22	11	10	10
Employee Wellbeing	1	3	0	1	1
Grand Total	**270**	**244**	**136**	**238**	**484**

Table 2: Themes of complaints mapped to MFT WMTM cateogories, Q1 2020/21 - Q1, 2021/22

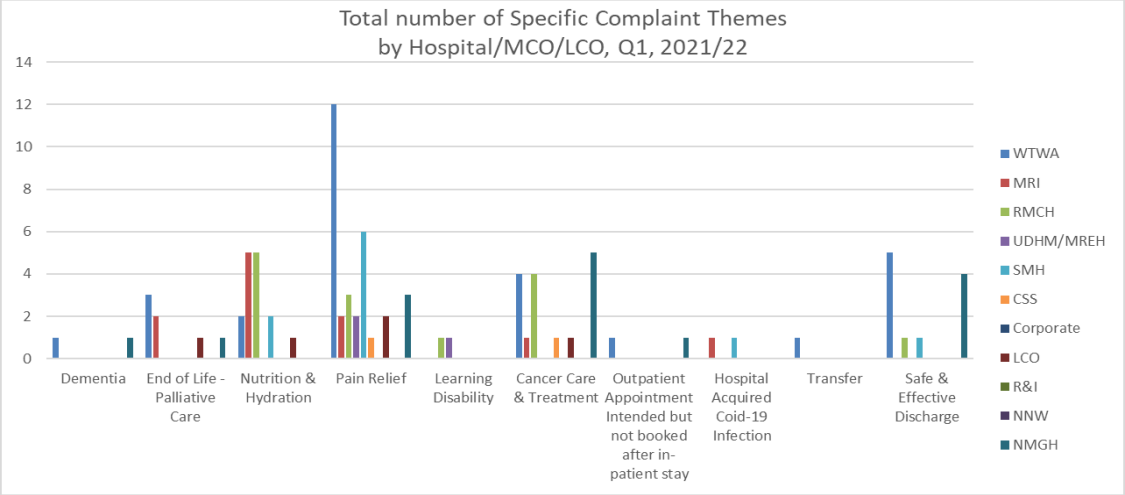
3.29 The themes identified from Q1 2020/21 - Q1, 2021/22 are shown in Table 3 below. This quarter, as in the previous 3 quarters, pain relief is illustrated as the top specific theme. Further detail is provided in Table 14, Appendix 1 of this report.

Specific themes	Q1,20/21	Q2,20/21	Q3,20/21	Q4,20/21	Q1,21/22
Dementia	1	1	1	1	2
End of Life – Palliative Care	11	4	4	11	7
Nutrition & Hydration	5	5	5	11	15
Pain Relief	7	7	8	14	31
Learning Disability	1	3	0	1	1
Cancer Care & treatment	0	0	1	2	2
Outpatient Appointment intended but not booked after in-patient stay	0	0	4	5	16
Hospital Acquired Covid-19 Infection	0	0	0	0	2
Transfer	0	0	0	2	2
Safe & Effective Discharge	0	0	0	1	1
Grand Total	**25**	**20**	**23**	**48**	**79**

Table 3: Total number of New Complaints by specific themes, Q1 2020/21 - Q1, 2021/22

3.30 **Graph 10** below shows the themes identified from complaints received in Q1 2021/22. WTWA received the most complaints relating to Pain Relief. Some examples of complaints received relating to Pain Relief include:

- a patient experiencing a lack of pain control.
- a patient not being provided with pain relief.



Graph 10: Total number of Specific Complaint Themes by Hospital/MCO/LCO, Q1 2021/22

3.31 In Q1, the Corporate Complaints Team attended the Trust's Risk Management's Daily Safety Huddles. This Daily Safety Huddles provide the Trust's Risk Management's team and the Hospitals/MCS/LCO with an overview of themes possibly impacting the safety of service users and in turn identifies the specific areas across the Trust where there are hot spots and trends. Examples of areas where there is specific action in place include:

- nutrition and hydration collaborative
- re-focus on the dementia care strategy
- development of the Trusts End of Life Care Strategy
- development of the Trusts Cancer Strategy
- safe & effective discharge collaborative
- pain management collaborative

4.0 Care Opinion and NHS Website feedback

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

4.2 All NHS Website and Care Opinion comments are received by the Patient Experience Team (PET) and shared with the relevant Hospital/MCS/LCO. Responses are required for publication within 5 working days. Designated senior staff within each Hospital/MCS/LCO review the comments and provide a response for publication. Table 4 below provides 2 examples of the feedback received and the subsequent responses posted on Care Opinion and NHS Website during Q1.

Quarter 1, 2021/22
Manchester Royal Infirmary
"Amazing staff -thank you!" *My mum had to attend the Manchester Royal Infirmary A&E Department on Tuesday night. We would like to thank each and every member of staff we had contact with from the security lady and gentleman who were professional and supportive in their very difficult role on the door; the 2 triage staff who were so welcoming, efficient and made it feel as though they had all the time to listen and care then the 2 staff at reception after triage again so caring and reassuring and then the wonderfully patient, caring, calm nurses, particularly the lead nurse who dealt with a particularly loud and disgruntled patient with dignity and such professionalism, and eventually the caring and efficient doctor who saw my mum. I cannot imagine the immense pressure that they were all under, but the way they all treated every single person who came through their care with the same level of support and help was truly wonderful. We want to thank them for making such a huge difference to what was, a very traumatic experience. Please pass on our deep appreciation and thanks.*

Response
Thank you for your positive comments posted on the NHS Website regarding your experience at Manchester Royal Infirmary in Accident and Emergency. It was very kind of you to take the time to write and compliment the staff as it is always good to receive excellent feedback which reflects their hard work and dedication. It was reassuring to read that from the moment you arrived, all staff were professional and that the care your mum received was efficient. It is wonderful for us to know that you felt everyone was so welcoming and overall, you had a positive experience throughout. We are sincerely grateful for your kind words and we have passed on your appreciation and gratitude to the Head of Nursing, who will share with all the staff involved.
Corporate Services (Estates and Facilities)
"Heavy handed tactics" *Having made an appointment to visit my father in ICU, along with mum and my sister, all authorised, I was disgusted by the attitude of the security guard today. I've been visiting without issues until today where I was made to feel like I was lying to enter the hospital. The security man was very rude, asking if I had an appointment and what time and where! He then told me he would have to check to make sure I had! I'd just told him. This was in front of other visitors and was highly embarrassing as upsetting. There are ways of speaking to people and making them feel like liars is not one of them. I'm going to enter through a different entrance tomorrow as I HAVE made another appointment to visit my father. He almost lost his life last week and luckily every other member of staff has been wonderful.*
Response
Thank you for your feedback regarding the experience you had whilst visiting Wythenshawe Hospital, Intensive Care Unit. The Security Officers are positioned at the doors to manage the flow of patients and visitors across site, in order to manage the risks relating to Covid-19 transmission. The Trust would like to apologise that you felt that your interaction with the Security Officer was embarrassing and upsetting. Whilst the Security team are tasked with ensuring traffic on site is managed, it is essential that this is carried out in a professional and courteous manner. Your feedback has been shared with the Security Management Team and the importance of customer care will be reiterated to the team. It is difficult to respond to all posts in a full way often because of a lack of detailed information, therefore if you would like to discuss your experience with us in more detail, please do not hesitate to contact our Patient Advice and Liaison Service (PALS) on 0161 276 8686 or by e-mailing pals@mft.nhs.uk
North Manchester General Hospital
"Sympathetic caring attitude" *Had to liaise via telephone with respect to my back problem. A very professional caring male doctor gave me clear helpful advice and exercises and followed up regularly with phone calls and email to my doctor to ensure they completely understood my problem and really listened to me and my concerns. Really impressed with him.*
Response
Thank you for taking the time to share your positive feedback on the NHS Website regarding your care at North Manchester General Hospital in Physiotherapy. We are pleased to read that you were fully listened to, and the advice you received was in a professional and caring manner. We are sincerely grateful for your kind words and we have passed on your message to the Head of Nursing, who will share with the staff involved.
Clinical Scientific Services – Wythenshawe Hospital
"Outstanding Hospital" *My Dad is currently in CTICU. I cannot commend this unit highly enough. The staff are amazing, all of them. We were there all-night last night and despite the nursing staff and the healthcare assistant being extremely busy, they kept us informed all through the night and the lovely Healthcare provided refreshments etc all night. Nothing was too much trouble. The staff were extremely vigilant regarding PPE and the unit was spotless and calm despite being busy. At one point my dad had 4 people working on him at once calmly but efficiently. You are all angels and no matter what the outcome ends up as he could not be in a better place.*
Response
Thank you for your positive comments posted on the NHS Website regarding the care your dad is receiving at Wythenshawe Hospital in CTCCU, for what must be a difficult time for you and your family. It was very kind of you to take the time to write and compliment all the staff as it is always good to receive positive feedback which reflects the hard work, dedication, and caring nature of our staff. It was reassuring to read that you were kept informed throughout your visit, and felt that the ward was spotless, calm and nothing felt like too much trouble. We really appreciate your positive words and can assure you that we have passed these onto the Head of Nursing who will share your comments with the staff on CTCCU.

Table 4: Examples of Care Opinion/ NHS Website Postings and Reponses Q1 2021/22

4.3 This quarter a total of 40 comments were received via the websites, of which 30 (75.0%) were positive. 8 negative comments were received (20.0%). The number of Care Opinion and NHS Website comments by category; positive, negative and mixed, are detailed in Table 15, Appendix 1.

5.0 Learning from Complaints

5.1 This section of the report provides examples of improvements made in response to feedback via complaints.

5.2 The Complaints Review Scrutiny Group, chaired by a Non-Executive Director, met during Q1 2021/22. The management teams from MREH/UDHM presented 2 cases in May 2021. Learning and associate actions identified from the 2 cases were discussed and assurance provided that complaints are investigated, and appropriate action taken when needed. Outcomes from the 2 cases discussed are provided in **Table 5** below..

Hospital/MCS/LCO	Learning	Actions
MREH	We learned the impact of unacceptable behaviour displayed from patients	• Via MREH's 'mural' (creative engagement/dialogue with staff) explore in detail and establish any key facts and important issues surrounding racist attacks/unacceptable patient behaviour. • Ensure staff have the correct tools they need to deal with an issue when a patient is demonstrating unacceptable behaviour. • Increase staff awareness to help staff to recognise the problem when it occurs. • Encourage staff to incident report any instances of unacceptable behaviour.
UDHM	We learned that there was poor communication with the Surgical team at the Christie Hospital	• Development of an MDT Head and Neck Oncology Service
	We learned the impact of the lack of communication regarding the taking of long-term antibiotic cover and the severe associated side effects	• Development of a protocol for the use of long-term antibiotics for the management of post radiotherapy patients
	We learned the impact of patient's outpatient appointments cancelled on several occasions - patient not fully informed of appointment cancellations in a timely manner - clinics overbooked and reduced in capacity	• Development of a departmental Standard Operational Policy (SOP) to provide a clear understanding in the management of multiple outpatient appointment cancellations • Undertaking of audit monitoring cancelled appointments • In order to enhance the patient, experience a Business Case supporting additional clinic provision has been submitted and is awaiting approval

Table 5: Actions identified at the Trust Complaints Scrutiny Group during Q1 2021/22.

5.3 Detailed below, in **Table 6**, are some examples of how learning from complaints has led to changes that have been applied in practice.

Hospital/ MCS/LCO	Reason for complaint	Action Taken
MREH	Concerns regarding clinician not having followed correct measures regarding the wearing of Personal Protection Equipment (PPE).	Clinician retrained in the correct use of PPE and undertaken additional Infection Prevention and Control training.

UDHM	Impact on patient regarding clinician's assumptions of the patient's family unit.	Concern shared and clinician supported in reflecting on the events leading to the complaint. LGBTQ+ awareness session delivered at MREH/UDHM ACE day in June 2021. Concern shared and discussed with the Paediatric team at the departmental specific training session held in June 2021.
WTWA (Heart & Lung)	Poor nursing care, lack of recognition regarding patient's mental health condition, poor communication and hospital acquired infections.	Complaint to be shared and discussed with the On Call Medical team for wider learning. Formal review of patient's clinical care completed and shared with all staff within the Respiratory Directorate and the Respiratory Directorate Governance meeting. Junior doctor supported in reflecting on communication provided and the cause of death recorded on the death certificate. Ward 'Patient Hygiene Check List' developed and introduced on the ward. Matrons to be based in all clinical areas.
MRI (Theatres & Elective In-Reach)	Patient unable to communicate with staff due to patient's hearing aids not being in-situ; This resulted in staff advising the patient's family that the patient was confused.	Enhance process of implementation of a 'Prompt Sheet' for staff undertaking 'patient focused rounding', to enable aid requirement checks to take place.
MRI (Head & Neck Specialties)	Deterioration in patient's hearing, absence of retesting/monitoring and assessment of a second cochlear implant prior to patient reaching the age of 18, resulting in the patient no longer being eligible for a second implant.	Second implant offered and made available to the patient should the patient wish to accept this course of treatment. Immediate change in practice ensuring all children with unilateral cochlear implants are provided with a contralateral ear review at every review appointment. Review to be undertaken of all 'unilateral' children's case notes and early review appointments to be scheduled where necessary.
SMH	Impact of the provision of misleading/inaccurate information on completion of social care documentation - labelling the patient as 'single supported' rather than 'married' - confirming parents visiting patterns without checking the accuracy or reason for these	Recruitment of a Specialist Nurse in New-born Services to support communication and other identified competencies, such as accurate record keeping of individual family composition and needs. An addition to be placed on the infant's paper medical records to ensure clarity is provided. Complaint shared anonymously and discussed at core huddles. All staff to be reminded via the Safeguarding Newsletter of the importance of documenting discussions and the process of concerns relating to parental attendance Matron to support the nursing staff in the checking of correct patient/family information and ensure records are kept accurate.
RMCH	Poor communication with the patient's parent regarding transition planning to adult services.	Concerns and lessons learned to be shared at the Transition Champion's Meeting.

Table 6: Examples of the application of learning from complaints to improve services, Q1 2021/22

6.0 Quality Improvements during Q1 202/21 included

6.1 NMGH PALS Reception

- During Q1, work commenced and re-opening of the PALS office at NMGH took place at the end of May 2021.
- The re-opened PALS facility will enable patients and members of the public to make face to face enquiries and book appointments to see a PALS Team Leader, Facilitator or Officer.

6.2 Implementation of the formal restructure of the Trust's Corporate PALS and Complaints Service

- Following a formal restructure, changes to the PALS and Complaints service were implemented this quarter. Through the development of a team approach, the reorganisation offers a more responsive service to all of the Hospital's/MCS's/LCO's and provides greater service resilience, as well as supporting the development of a career pathway for the Corporate PALS and Complaints staff members.

- Led by the Head of Customer Services and the PALS and Complaints Manager, as of 5th April 2021, the MFT Corporate Complaints staff now work within one of three teams, based at Cobbett House. Each team is led by a Team Leader who are supported by Facilitators and Officers.

- The Trust's Corporate PALS team also consists of three teams, based at the PALS offices/Receptions in MRI, Wythenshawe Hospital, and NMGH. Each PALS team is led by a Team Leader, supported by Facilitators, Officers and Receptionists.

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

- Module 1 of the Trust's e-learning Customer Service & PALS and Complaints package was launched in Q1 for staff wishing to access training created to help them understand why good customer service is so important.

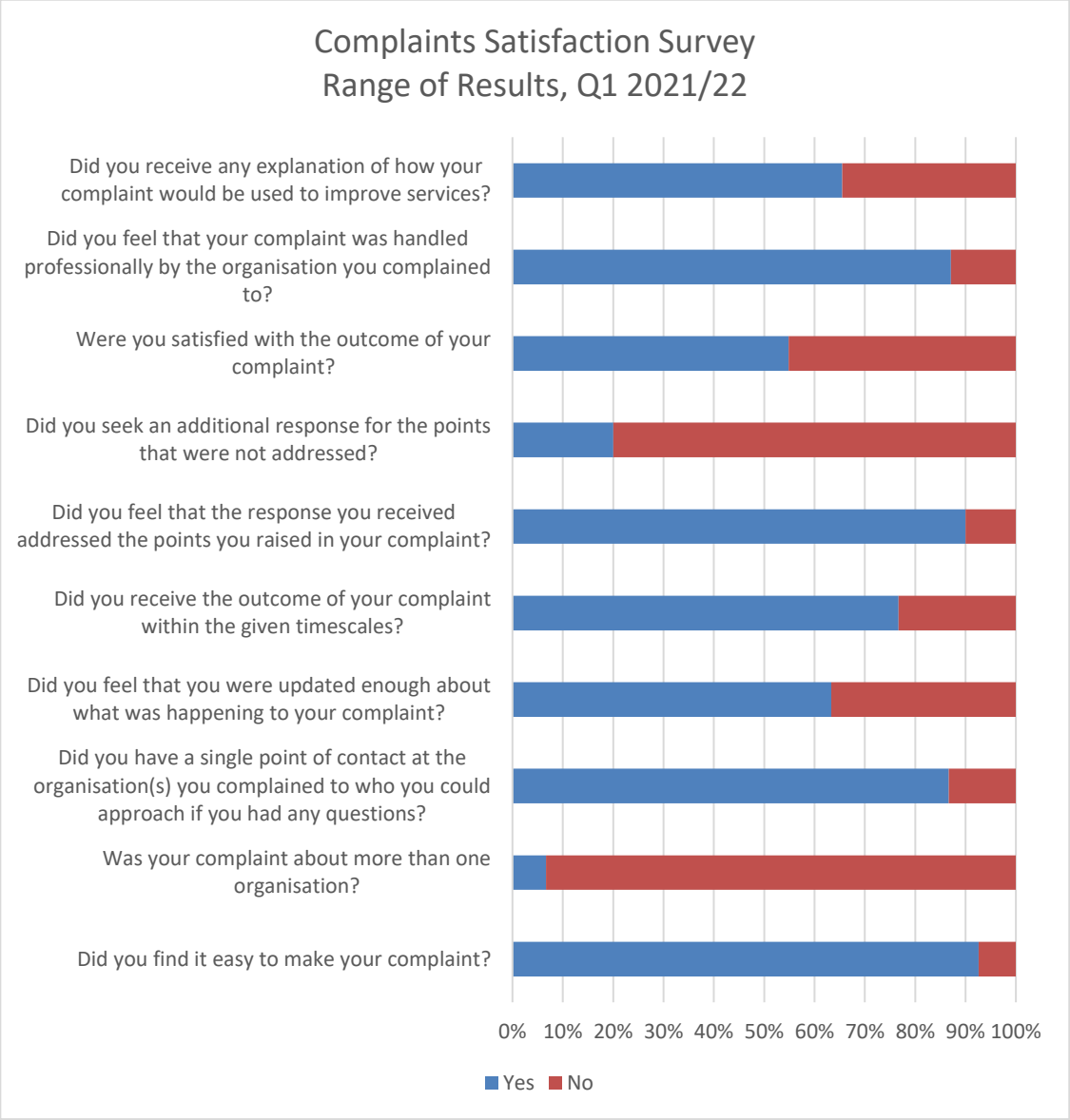
- Further development of the PALS and Complaints Customer Service Advanced Module is underway, with a launch date planned for Q2 2021/22.

7.0 Complainant's Satisfaction Survey

7.1 A satisfaction survey, based on the 'My Expectations'[6] paper, is sent to complainants across all MFT Hospital's/MCS's/LCO's once the complaint is closed. In Q1, 261 surveys were distributed, with 31 questionnaires returned; the results are shown in **Graph 10** below. There is a decrease in satisfaction in respect of complainants the

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

outcome of their complaint within the given timescales, which correlates to the noted decrease in achieving the 90% target.



Graph 10: Complaints satisfaction survey results for Q1 2021/22

7.2 The following are examples of feedback from provides staff with opportunities to improve the standard of care and service provided. Comments received during Q1 2021/22 include the following:

"I felt that my complaint had been investigated well & the response was thorough"

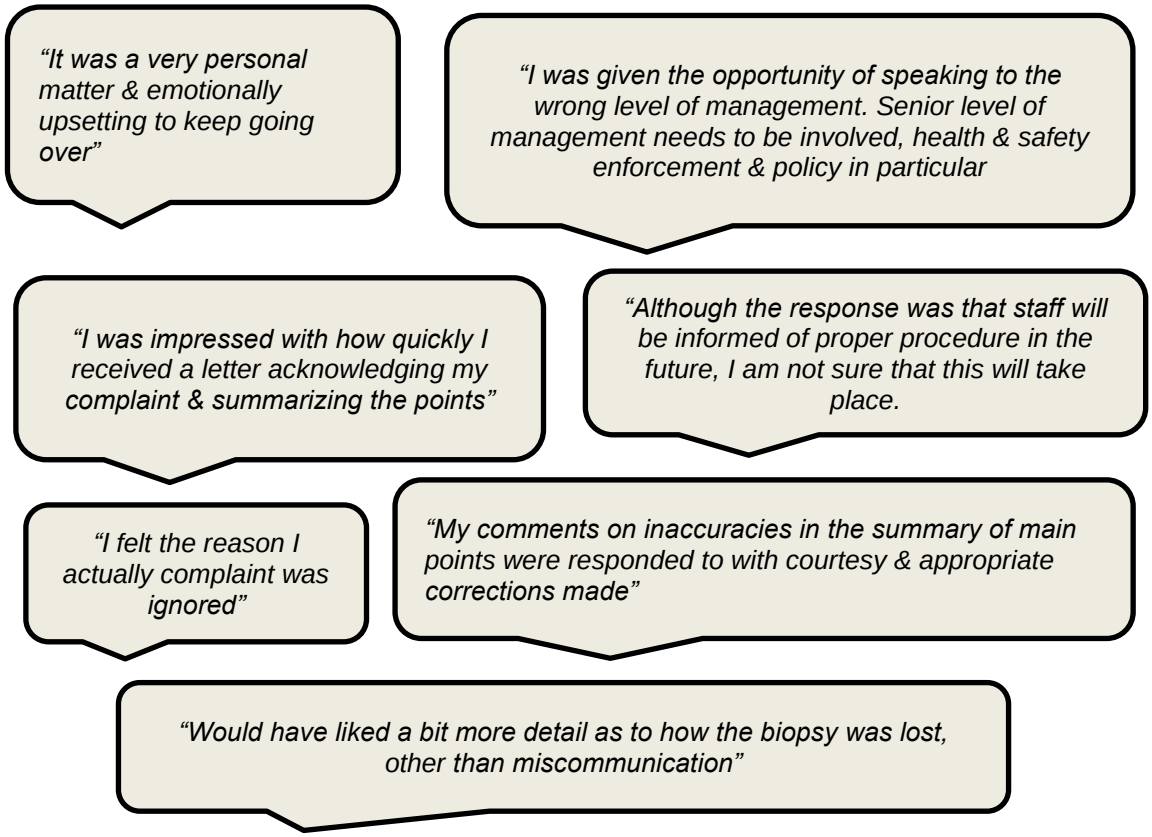
"Speed, courtesy & professionalism of acknowledgement, investigation & outcome"

"I was encouraged to make the complaint by staff"

"The main point was not settled to my satisfaction"

"Didn't get the answer to the main point"

"The reasons for someone failing to do their job were insufficient"



8.0 Planned Improvements

8.1 Several areas for improvement and development have been identified for Q2, including: include the following activities:

- Revision of Trust Concerns and Complaints Policy
- Implementation of the Complaints Audit Action Plan
- Implementation of assurance principles in relation to action plans developed following investigation into concerns raised through the complaints process
- Exploration of methods of sharing the Complainant Satisfaction Survey feedback across MFT, including feedback mechanisms in respect of actions taken
- Development of the PALS and Complaints Customer Service Advanced Module
- Identify ways to improve collection of Equality and Diversity Data in respect of recording 'disability' and 'religion' and overall consistency through use of audit

9.0 Equality and Diversity Monitoring Information

9.1 The collection of equality and diversity data is shown in **Table 19,** Appendix 1. As in previous quarters, collection of this information remains inconsistent.

9.2 This quarter, as in previous quarters, good compliance was found with regard to 'gender' data (97.5%) and 'ethnicity' data (67.3%). However, the need to improve 'disability' and 'religion' has been identified; only 7.3% and 20.1% being received respectively.

9.3 Supported by the newly developed departmental Equality and Diversity Checklist the Corporate PALS and Complaints team continue to ensure complainants are informed of their right to support with their 'religion' and/or 'disability' status. Findings and actions to undertake from the additional audit measuring the outcome of the checklist will be published in Q2's report.

10.0 Conclusion and recommendations

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

10.2 Members of the Board of Directors are asked to note the content of this Q1 Complaints Report and the on-going work of the Corporate and Hospital/MCS/LCO teams to ensure that MFT is responsive to concerns raised and learns from patient feedback 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
MRI (2)		
Cardiovascular Specialty	1	Awaiting Provisional Report
GI Medicine & Surgical Specialty	1	Awaiting Provisional Report
WTWA (3)		
Surgery (Orthopaedics)	1	Awaiting Provisional Report
Heart & Lung (Cardiology)	1	Awaiting Provisional Report
Surgery	1	Awaiting Provisional Report
TOTAL	**5**	

Table 2: Number of PALS concerns received by Hospital/ MCS/ LCO Q1 2020/21 - Q1, 2021/22

	Q1,20/21	Q2,20/21	Q3,20/21	Q4,20/21	Q1,21/22
WTWA	220	359	389	396	465
MRI	220	365	433	445	404
RMCH	52	115	128	139	172
UDHM/MREH	70	104	84	128	131
SMH	98	148	203	233	254
CSS	36	94	100	79	119
Corporate	49	50	58	57	60
LCO	10	34	24	14	25
R&I	0	2	3	1	0
Nightingale NW (NNW)	0	0	2	4	0
NMGH	0	0	0	0	203
Grand Total	**755**	**1271**	**1424**	**1496**	**1833**

Table 3: Closure of PALS concerns within timeframe Q1 2020/21 - Q1, 2021/22

	Q1,20/21	Q2,20/21	Q3,20/21	Q4,20/21	Q1,21/22
Resolved in 0-10 days	697	1094	1340	1310	1617
Resolved in 11+ days	57	97	112	152	188
% Resolved in 10 working days	**92.4%**	**91.9%**	**92.3%**	**89.6%**	**89.6%**

Table 4: Number of PALS concerns taking longer than 10 days to close by Hospital/MCS/LCO Q1 2020/21 - Q1, 2021/22

	Q1,20/21	Q2,20/21	Q3,20/21	Q4,20/21	Q1,21/22
WTWA	22	26	18	27	35
MRI	16	31	41	45	40
RMCH	1	5	7	16	20
UDHM/MREH	3	5	7	5	15
SMH	9	16	22	38	31
CSS	3	3	9	9	9
Corporate	3	5	7	6	21
LCO	0	6	1	5	2
R&I	0	0	0	0	0
NNW	0	0	0	1	0
NMGH	0	0	0	0	15
Grand Total	**57**	**97**	**112**	**152**	**188**

Table 5: Number of PALS concerns escalated to formal investigation Q1 2020/21 - Q1 2021/22

	Q1,20/21	Q2,20/21	Q3,20/21	Q4,20/21	Q1,21/22
No of cases escalated	3	8	10	17	3

Table 6: Number of Complaints received by Hospital/ MCS / LCO Q1 2020/21 - Q1 2021/22

	Q1,20/21	Q2,20/21	Q3,20/21	Q4,20/21	Q1, 21/22
WTWA	59	81	87	99	91
MRI	38	84	79	90	103
SMH	16	46	49	52	58
RMCH	21	33	25	36	43
CSS	11	23	13	21	17
UDHM/MREH	5	8	16	10	22
Corporate	11	9	11	13	18
LCO	6	15	11	6	13
NMGH	0	0	0	0	42
Grand Total	**167**	**299**	**291**	**327**	**407**

Table 7: Complaints Acknowledgement Performance

3 Day Target	Q1, 20/21	Q2, 20/21	Q3, 20/21	Q4, 20/21	Q1, 21/22
100% acknowledgement	100%	100%	100%	100%	100%

Table 8: Comparison of complaints resolved by timeframe: Q1 2020/21 - Q1 2021/22

	Q1,20/21	Q2,20/21	Q3,20/21	Q4,20/21	Q1,21/22
Resolved in 0-25 days	120	178	270	244	285
Resolved in 26-40 days	49	20	22	17	30
Resolved in 41+ days	77	51	49	40	44
Total resolved	**246**	**249**	**341**	**301**	**359**
Total resolved in timescale	171	227	322	282	332
% Resolved in agreed timescale	**69.5%**	**91.2%**	**95.3%**	**93.7%**	**92.5%**

Table 9: Outcome of Complaints, Q1 2020/21 - Q1 2021/22

Number of Closed Complaints		Upheld	Partially Upheld	Not Upheld	Information Request	Consent Not Received	Complaint Withdrawn	Out of Time
Q1,21/22	359	34	249	64	3	7	1	1
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

Table 10: Re-opened Complaints by Hospital/MCS/LCO Q1 2021/22

	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	3	6	4	20	33
MRI	2	6	0	14	22
SMH	0	1	2	9	12
CSS	1	2	1	3	7
RMCH	0	1	4	0	5
UDHM/MREH	0	0	1	2	3
Corporate	1	2	1	1	5
LCO	0	0	1	1	2
NMGH	0	0	1	1	2
Grand Total	**7**	**18**	**15**	**51**	**91**

Table 14: Specific themes by Hospital/MCS/LCO, Q1 2020/21 - Q1 2021/22

	WTWA	MRI	SMH	RMCH	CSS	UDHM /MREH	Corp-orate	LCO	NMGH	Total
Dementia	0	2	0	0	3	0	0	0	1	6
End of Life – Palliative Care	13	16	0	2	0	0	0	5	1	37
Nutrition & Hydration	6	20	2	9	1	0	2	1	0	41
Pain Relief	19	22	7	3	3	2	0		3	59
Learning Disability	0	2	0	2	0	1	0	0	0	5
Cancer Care & Treatment	7	5	0	5	1	0	0	2	5	25
Outpatient Apt intended & not booked after in-patient stay	1	0	0	0	0	0	0	0	1	2
Hospital Acquired Covid-19 Infection	2	1	1	0	0	0	0	0	0	4
Transfer	2	0	0	0	0	0	0	0	0	2
Safe & Effective Discharge	8	0	1	1	0	0	0	0	4	14
Grand Total	**58**	**68**	**11**	**22**	**8**	**3**	**2**	**8**	**15**	**195**

Table 15: Care Opinion/NHS website postings by Hospital/ MCS / LCO in Q1 2021/22

Number of Postings received by Hospital/MCS/LCO/Corporate Service Q1 21/22			
Hospital/ MCS /LCO	**Positive**	**Negative**	**Mixed**
MRI	**5**	**0**	**0**
WTWA	**7**	**1**	**2**
CSS	**2**	**0**	**0**
Corporate	**0**	**1**	**0**
UHDM/MREH	**2**	**1**	**0**
LCO	**0**	**0**	**0**
RMCH	**1**	**0**	**0**
SMH	**5**	**3**	**0**
NMGH	**8**	**2**	**0**
Grand Total	**20 (75.0%)**	**6 (20.0%)**	**5 (05.0%)**

Table 19: Equality and Diversity Monitoring Information

	Q1,20/21	Q2,20/21	Q3,20/21	Q4,20/21	Q1,21/22
Disability					
Yes	12	21	12	13	26
No	18	6	8	9	8

Not Disclosed	137	272	271	305	373
Total	**167**	**299**	**291**	**327**	**407**
Disability Type					
Learning Difficulty/Disability	0	1	0	1	0
Long-Standing Illness or Health Condition	7	10	15	18	16
Mental Health Condition	0	0	5	3	6
No Disability	0	0	0	0	0
Other Disability	0	2	0	3	5
Physical Disability	3	4	3	2	1
Sensory Impairment	1	1	2	1	2
Not Disclosed	156	281	265	299	377
Total	**167**	**299**	**291**	**327**	**407**
Gender					
Man (Inc Trans Man)	74	123	115	133	147
Woman (Inc Trans Woman)	90	172	168	190	250
Non-Binary	0	0	0	0	0
Other Gender	0	0	1	0	0
Not Specified	3	4	7	4	9
Not Disclosed	0	0	0	0	1
Total	**167**	**299**	**291**	**327**	**407**
Sexual Orientation					
Heterosexual	28	65	64	92	75
Lesbian / Gay/Bi-sexual	0	2	2	4	4
Other	0	0	0	0	0
Do not wish to answer	0	2	0	5	3
Not disclosed	139	230	225	226	325
Total	**167**	**299**	**291**	**327**	**407**
Religion/Belief					
Buddhist	0	0	0	1	0
Christianity (All Denominations)	17	39	36	40	48
Do Not Wish to Answer	0	3	3	1	0
Muslim	1	1	3	6	5
No Religion	10	24	18	13	25
Other	2	1	2	0	0
Sikh	0	1	0	0	1
Jewish	1	0	2	0	3
Hindu	0	0	1	1	0
Not disclosed	136	228	234	240	325
Humanism	0	1	1	1	0
Paganism	0	1	0	0	0
Total	**167**	**299**	**291**	**327**	**407**
Ethnic Group					
Asian Or Asian British - Bangladeshi	0	0	1	1	1

Asian Or Asian British - Indian	1	4	4	6	6
Asian Or Asian British - Other Asian	1	2	2	0	3
Asian Or Asian British - Pakistani	3	9	6	17	3
Black or Black British – Black African	6	2	4	5	6
Black or Black British – Black Caribbean	3	5	2	3	0
Black or Black British – other Black	1	0	1	1	1
Chinese Or Other Ethnic Group - Chinese	0	1	1	1	0
Mixed - Other Mixed	0	0	5	3	0
Mixed - White & Asian	1	1	2	1	2
Mixed - White and Black African	0	1	0	1	0
Mixed - White and Black Caribbean	2	2	1	3	1
Not Stated	28	48	54	58	79
Other Ethnic Category - Other Ethnic	1	2	2	4	5
White - British	75	121	117	147	160
White - Irish	4	3	7	3	5
White - Other White	4	11	5	4	2
Not disclosed	37	87	77	69	133
Total	**167**	**299**	**291**	**327**	**407**

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Sue Ward, Deputy Chief Nurse Barbara Mitchell, Assistant Chief Nurse Safeguarding, Quality & Patient Experience Emma Orton, Head of Nursing Quality, Patient Experience & Professional Practice Melanie Maclean, Patient Experience
Date of paper:	September 2021
Subject:	**Patient Experience Annual Report:** Presentation of the findings of National Patient Surveys, the Friends and Family Test and local patient feedback, and update on continuous improvement in the context of the MFT Patient Experience Programme **'What Matters to Me'**
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support ✓ • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Delivering an excellent experience for patients, their families and their significant others.
Recommendations:	Patient staff experience Patient safety
Contact:	Name: Emma Orton, Head of Nursing Quality & Patient Experience Tel: 0161 256 5061

Contents

1. Executive Summary

1.1 Patient Experience is recognised as a core element of Quality[1] (DOH, 2008). Patients' experiences of care and treatment provide key information about the quality of services provided, which can be used to drive improvements both nationally and locally.

1.2 Patient Experience feedback provides a rich source of data to support continuous improvement of the services provided by Manchester University NHS Foundation Trust (MFT). Patient feedback is sought continuously through a range of formats. These findings inform improvement activity at both strategic and local levels.

1.3 This annual report would usually provide a summary of the MFT results of the mandatory national surveys that have been published throughout 2020, however the mandatory national surveys have been affected by the Coronavirus pandemic, which has resulted in national decisions to delay or stand down implementation of the survey schedule. No mandatory survey results are therefore available to include in this report.

1.4 The 2020 Maternity Survey was stood down by the Care Quality Commission and Trusts were offered the opportunity to participate in the optional National New Mothers' Experience of Care Survey 2020 instead. MFT elected to participate in this survey, which is therefore the only national survey that is included in this annual report. As this is the first time this survey has been used and as only 12 Trusts nationally agreed to participate, no national comparison data is available, however the analysis includes a comparison of local data between MFT's maternity sites.

1.5 The Trust has a well-established quality and patient experience programme. For some periods during the Coronavirus pandemic, all non-essential activity was stood down to enable clinical staff to focus on direct care delivery, and to release members of the corporate workforce to support the Trust's response to the pandemic. This included the suspension of data collection from electronic devices and paper surveys in line with the NHS England (NHSE) guidance between March and May 2020. This temporary pause in quality and patient experience data collection is reflected in this report.

1.6 An update is provided on the positive progress undertaken during 2020/21 in relation to the MFT What Matters to Me (**WMTM**) Patient Experience Programme. This includes an overview of the Trust's NHSE Always Events® [2] pilot and also an update on the delivery of the MFT Experience and Involvement Strategy: Our Commitment to patients, families and Carers 2021-2023[3].

1.7 The MFT WMTM Patient Experience Framework supports the triangulation of results from annual national surveys with the Trust's local Quality of Care Round and the WMTM patient experience survey data in order to identify areas of best practice and priorities for improvement at both Trust-wide and ward/department/team level. The pause in the national patient survey programme has meant that the organisation has been unable to

[1] DOH (2008) High Quality Care for All

[2] NHSE (2016) Always Events Toolkit

[3] MFT Experience and Involvement Strategy: Our Commitment to patients, families and Carers 2021-2023

triangulate the data in the usual way but has continued to utilise a range of data sources to monitor quality and continue to drive improvement.

1.8 Continuous improvement activity at all levels is underpinned by MFT's Improving Quality Programme (IQP) methodology. The Trust's clinical accreditation programme, which monitors key quality and practice standards across clinical areas and examines how quality and patient experience data is used to drive improvement for the benefit of patients was temporarily replaced for this year with an alternative assurance process undertaken by the Deputy Chief Nurse with Directors of Nursing/Midwifery. This process included consideration of quality, safety, patient and staff experience and leadership in every ward and clinical area, ensuring that although it has not been possible to undertake the usual analysis and triangulation of data, standards across these areas continued to be monitored.

1.9 The Patient Experience Team and Voluntary Services Team supported the pandemic response in a number of ways, including implementing a Family Liaison service and developing COVID-19 safe volunteer roles, for example entrance way finding, patient dining and virtual visiting. This report describes these patient experience initiatives in more detail.

1.10 A summary of some of the improvement work that has been undertaken across the hospitals/MCS and LCOs informed by patients' and relatives' feedback regarding their experience during the pandemic response is included in this report along with an update on the activity and improvements aligned to the Trust's WMTM patient experience framework.

1.11 Finally, two patient stories are presented, which demonstrate the impact of the Trust's quality and patient experience initiatives on the patient experience and outcome.

1.12 Members of the Board of Directors are asked to note that despite the impact of the pandemic, improvement activity has continued, using creative approaches when the Trust's established work programmes could not be delivered in the usual way.

2. Introduction

2.1 This report demonstrates the on-going focus on patient experience activity for the year April 2020 to March 2021. The NHS National Patient Survey Programme, which is overseen by the Care Quality Commission (CQC), is a key source of patient feedback. It covers a range of NHS settings on a rolling programme of surveys, the results of which are published on the CQC website. In 2020/21, the National Survey Programme was impacted by the COVID-19 pandemic resulting in survey timeframes being rescheduled or surveys being offered as "optional".

2.2 For this reason, the only national survey outcome available for inclusion in this annual report is the National New Mothers 'Experience of Care Survey 2020, which MFT opted to continue. As this is the first time this survey has been used, and as only 12 Trusts nationally agreed to participate, there is no opportunity to undertake a national comparison: for this reason the analysis provides a comparison of local data between MFT's maternity sites. Triangulation of the results of the New Mothers Experience of

Care Survey 2020 with the MFT 'What Matters to Me Patient Experience' survey findings is also presented within this report.

2.3 The Friends and Family Test (FFT) is a further mechanism by which the Trust receives feedback on Patient Experience. This report provides details of FFT performance, with comparisons provided against the other Shelford Trusts. These surveys were stood down between March and May 2020 in response to the pandemic, which is reflected in the data presented.

2.4 An update is provided on the Trust's Patient Experience Programme, What Matters to Me, which focuses on the delivery of personalised care for every patient or service user with a view to improving care outcomes across all quality domains. Examples are provided of improvement work undertaken across MFT hospitals/MCS/LCOs based on feedback from patients and relatives along with an update on the activity and improvements aligned to the Trust's WMTM Patient Experience Framework.

2.5 Finally, two patient stories ground the report in what matters to patients, demonstrating the value of the continued focus on quality and patient experience on patient outcomes.

3. New mothers experience of care survey 2020

3.1 The NHS Maternity Survey 2020 was stood down by the CQC due to the COVID-19 pandemic. The Picker Institute developed the New Mothers' Experience of Care Survey 2020 to help Trusts reach out to mothers who would have been eligible for the NHS Maternity Survey. Participation in this survey was offered to trusts as an optional alternative. MFT opted to commission the survey.

3.2 This is the first time this survey has been used and as only 12 other NHS trusts agreed to participate, no national comparison data is available, therefore the analysis can only include a local comparison of data between the MFT maternity sites.

3.3 The New Mothers Experience of Care Survey 2020 is derived from the NHS Maternity Survey 2020. Amendments were made to the survey by the survey provider based upon feedback from new mothers, which reflect the changes in service delivery as a result of the COVID-19 pandemic.

3.4 The New Mothers Experience of Care Survey 2020 included 68 questions about experience and a further 9 demographic questions. A total of 47 comparable questions were asked within the New Mothers Experience of Care Survey 2020 NHS and Maternity Survey 2019, which allows a level of comparison to be made between the findings of the two surveys.

3.5 A postal questionnaire that was aligned to different aspects of the maternity pathway including antenatal care, labour and birth and postnatal care, was sent to 949 eligible women, aged 16 years and over. Respondents were required to indicate the standard of care they received by selecting one of the options provided. Positive scoring was applied to responses where applicable, with a positive score indicating a more positive patient experience.

The survey was structured into the following categories relating to the maternity pathway:

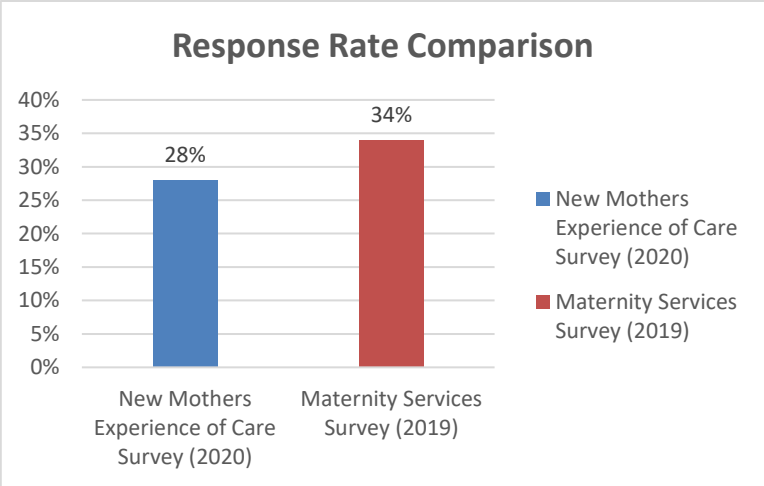
Antenatal Care	Labour and Birth	Postnatal Care
The start of your care in pregnancy	Labour	Care in the ward after birth
Antenatal check-ups	The birth of your baby	Feeding your baby
During your pregnancy	Staff	Care at home after the birth

New Mothers Experience of Care Survey Results

Response rate

3.6 In total 949 individuals were invited to respond to the New Mothers Experience of Care Survey 2020 with 261 (28%) responses received. **Graph 1** below compares the 2020 response rate for the New Mothers Experience of Care Survey to the 2019 response rate for the Maternity Services Survey.

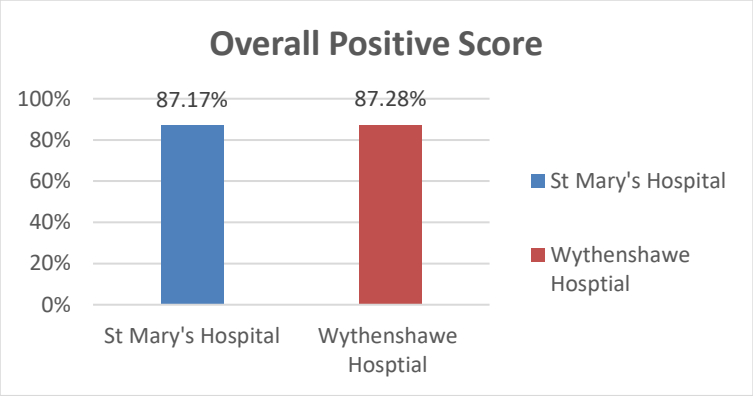
Graph 1: MFT Response rate comparison between New Mother's Experience of Care Survey and Maternity Services Survey



Survey Analysis

3.7 Whilst there is an overall score for each question within the New Mothers Experience of Care Survey 2020, there was no question relating to the overall experience. An overall positive score is provided for each site within St Mary's Managed Clinical Service (MCS), but a combined, Trust-wide positive score is not provided. **Graph 2** below compares the overall positive score between the St Mary's Hospital Oxford Road Campus and Wythenshawe Hospital sites and demonstrates very similar scores, suggesting consistency in care standards.

Graph 2: Comparison between St Mary's Hospital and Wythenshawe Hospital for overall positive score



Notably High Scores

3.8 The results of 5 of the questions asked indicated improvement when compared to the scores in the Maternity Survey (2019), as per **Table 1** below. These improvements provide a level of validation regarding the impact of activity undertaken by the Trust through the '**What Matters to Me'** Patient Experience programme, which involves staff at all levels providing personalised care to an individual's needs.

Table 1: Improved Areas highlighted within the New Mothers Experience of Care Survey 2020 questions compared to the NHS Maternity Survey 2019 questions.

Question	MFT Score 2019	MFT Score 2020
Antenatal Care		
B13. Given the help needed by midwives (antenatal)	93%	97%
Labour and Birth		
C21. Able to ask questions afterwards about labour and birth	80%	84%
Postnatal Care		
D2. Discharged without delay	54%	61%
D5. Given enough information	91%	93%
Care at home after the birth		
F1. Given a choice about where to have check-ups	41%	46%

Notably Low Scores

3.9 The results of 5 questions indicated notably low scores (a percentage decrease of more than 5%) which are presented in **Table 2** below. The results of all 5 of the questions indicate areas where improvement is required.

Table 2: New Mothers Experience of Care Survey 2020 questions with a percentage decrease of more than 5%

Question	MFT Score 2019	MFT Score 2020
Labour and Birth		
C2. Staff created comfortable atmosphere during labour	95%	87%
C15. Felt concerns were taken seriously	90%	82%
Care at home after the birth		
F16. Received help and advice about feeding their baby	91%	86%
F17. Received support or advice about feeding their baby during evenings, nights, or weekends	71%	65%
F18. Received help and advice from health professionals about their baby's health and progress	98%	89%

Improvement plan

3.10 Saint Mary's Hospital MCS have developed a local improvement plan in response to the findings **(Appendix 1),** underpinned by the following principles laid out by Picker Institute:

- **Identify any key questions where you wish to highlight the results.** 'The positive score summary identifies questions where the results are significantly different to the Picker average. This allows organisations who are performing better than the average to feed back these results.'
- **Review your organisation's performance over time.** 'The report highlights significant changes from the Trust's previous survey and longer-term trends over the last several years. Are there particular areas which have being improving or declining over time?'
- **Compare areas within your organisation**. 'Good practice should be shared. Areas requiring further attention can also be highlighted so improvements can be made. Go to the Internal Benchmark section to see where this is the case.'

Summary

3.11 Overall, the results of the New Mothers Experience of Care Survey (2020) show that women reported positive experiences of care, with notable improvement in 5 questions. However, areas for improvement were also identified where there was some deterioration when compared to specific questions within the Maternity Services Survey (2019) and these have formed the basis for the improvement action plan.

4. MFT Quality and Patient Experience Feedback

4.1 As the National Patient Survey programme was paused during 2020, it has not been possible for MFT to compare local patient experience feedback with a national data set as would usually be undertaken. However, MFT collects real time patient feedback via **'What Matters to Me'** patient experience surveys, which are administered using a hand-

held electronic device and on bed-side screens. Patients are asked a series of questions about their recent experience with questions based on the themed category questions set out in national patient experience surveys, including:

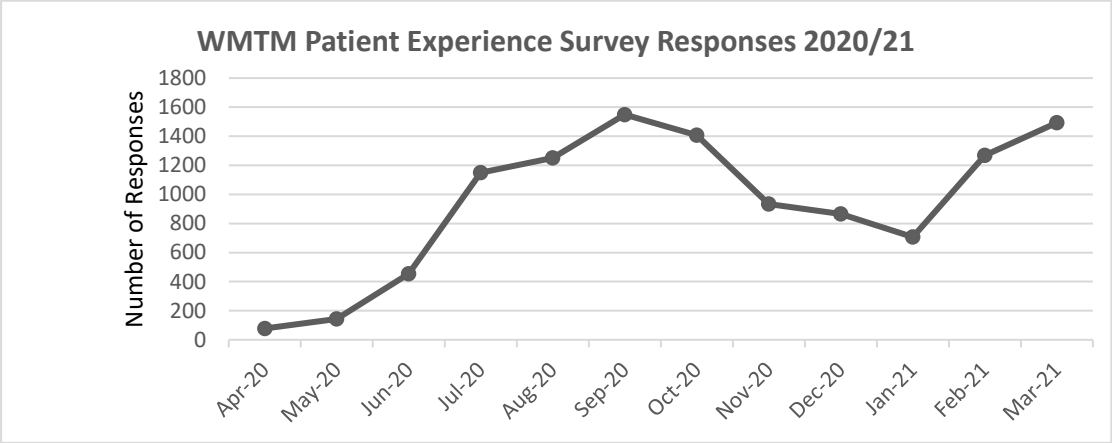
- Clean environment
- Infection control
- Patient Safety
- Pain Management
- Privacy and Dignity
- Equality and Diversity
- Involving Patients and Carers
- Patient Satisfaction
- Clinic Organisation
- Staff Communication

4.2 In addition to the Trust's WMTM patient experience surveys, Quality of Care Rounds (QCR) are undertaken, which include capturing patient feedback. The QCR is a MFT designed self-assessment audit tool completed monthly by either the Ward Manager or the Matron. The assessment is completed in all hospital-based clinical areas; inpatient; day case areas; outpatients; theatres and urgent care areas and includes the same domains as the WMTM patient experience survey.

4.3 The internal baseline target for the WMTM survey and QCR is set at 85% for all domains. Responses are triangulated with quality, safety and patient experience data (Quality Care Round (QCR), Friends and Family Test, Workforce data, Complaints and Incidents) to provide teams with an overall view of an area's performance. This enables the identification of areas of improvement and highlights areas of strength and outstanding practice. This information then guides the improvement agenda within the area, supported by MFT Improving Quality Programme (IQP) methodology. Importantly it also provides the opportunity to identify, celebrate and share successes and good practice.

4.4 A decision was taken with the Trust to make patient feedback data collection optional for clinical areas periodically between March 2020 and March 2021 in order to release nursing time to support the Trust's response to the COVID-19 pandemic, resulting in an anticipated reduction in response rates compared to the previous year. **Graph 3** below shows that between April 2020 and March 2021, despite staff being offered the option to stand down the surveys, a total of **11,300 WMTM** patient experience surveys were completed compared to 24,062 in 2019/20; a decrease of 12,762 responses. Achieving this total, albeit reduced, during the pandemic response demonstrates the commitment of Trust staff to seeking feedback from patients to inform continuous improvement of services.

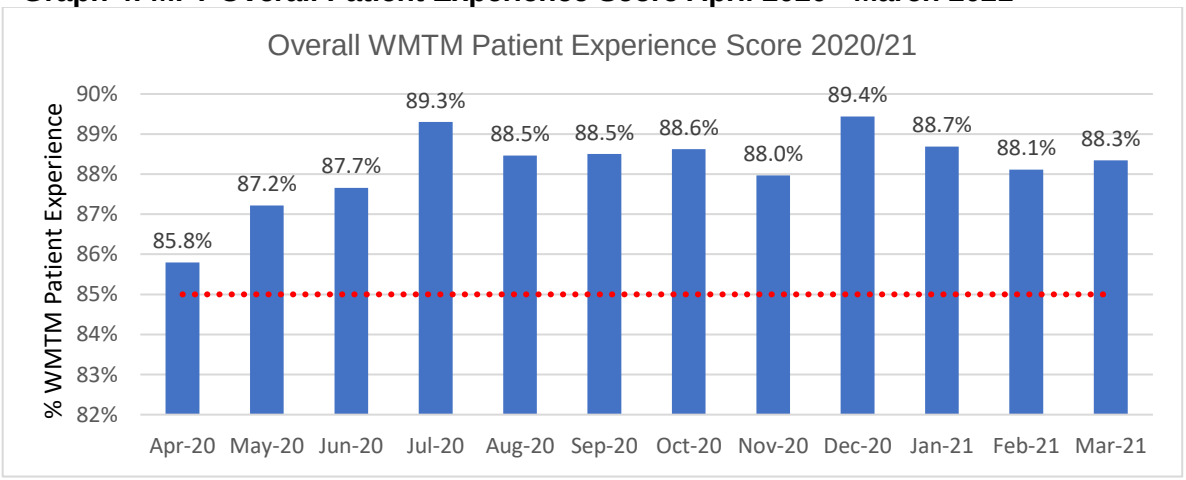
Graph 3: Number of WMTM Patient Experience Survey Responses 2020/21



4.5 The Trust's electronic system allows analysis to be undertaken at ward, Hospital/MCS/LCO and Trust level and provides overall patient experience satisfaction for each of the themed categories. Since the introduction of a new electronic system on 1st April 2018 to capture and report **'What Matters to Me'** patient experience survey and QCR data; frontline teams have had access to real-time quality and patient experience feedback data including comments provided by patients, which enables a real time response.

4.6 Analysis of '**What Matters to Me'** survey data shows a very slight decrease in the average overall patient experience score for 2020/21, with a score of **88.20%** compared to **88.25%** in 2019/20. Over the year there was month by month variation, with the lowest score in 2020/21 being **85.8%** compared to a lowest score of **87.56%** in 2019/20. The highest score in 2020/21 was slightly higher at **89.4%** compared to the highest score in 2019/20 of **88.86%. Graph 4** below shows the overall Patient Experience score for April 2020 to March 2021. Notably, despite the challenges of the pandemic, the score never fell below the Trust's baseline target score of 85%.

Graph 4: MFT Overall Patient Experience Score April 2020 - March 2021

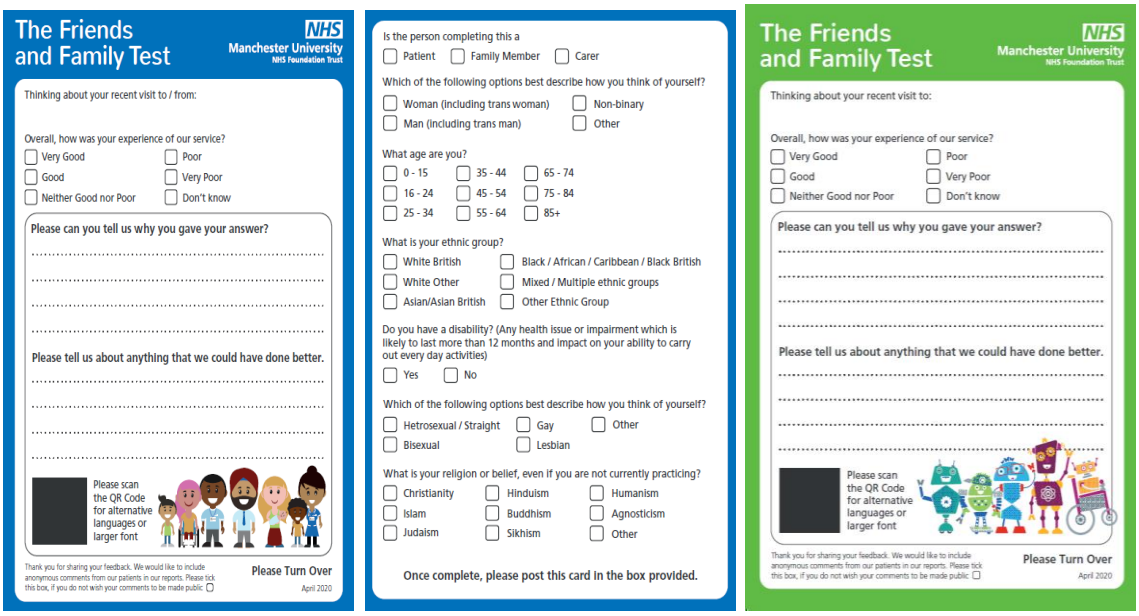


5. The Friends and Family Test

5.1 The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service that they have experienced to friends and family who may need similar treatment or care[4]. FFT results are published monthly on the NHSE website and monitored by the Care Quality Commission (CQC) as part of their inspection process. FFT results are included in the Trust's Board Assurance reports. FFT performance including qualitative comments provided by patients is accessible via the IQVIA Patient Experience Portal, which is the Trust's current electronic patient experience platform.

5.2 FFT is an important source of information that provides information about **What Matters to Patients** in respect of the care and treatment that they receive. It is important that patients are given the opportunity to complete the FFT question so that they can add comments about their experience. The feedback informs continuous improvements and transformation of services to provide a high-quality patient experience. To maximise feedback from the FFT, responses are captured through a variety of different methods including FFT cards, tablet devices, Hospedia bedside entertainment screens, online surveys, and SMS text messaging.

Figure 1: FFT Cards



5.3 A bespoke FFT card for children and young people was launched in April 2020. The card was co-produced with the Royal Manchester Children's' Hospital (RMCH) and has colouring and wording suitable for children and young people. This is the green card in **Figure** 1 above.

5.4 During 2018/19 the National FFT Development Project was undertaken, focusing on how the FFT could better collect feedback that can then be used to improve the quality of NHS services.[5] As a result of this review NHSE/I published a series of amendments to

[4] NHS, England **The Friends and Family Test**. Available from: http://www.england.nhs.uk/ourwork/pe/fft/

[5] NHS, England The Friends and Family Test. Available from: www.england.nhs.uk/fft/friends-and-family-test-development-project-2018-19/faqs/

the FFT in September 2019. Roll out was delayed nationally during the pandemic, but MFT rolled out the use of the new question to all services, in combination with a follow-on question to encourage free-text comments on what is working well and what can be improved. The revised question now asks:

"Thinking about your recent visit, overall, how was your experience of our service?"

Patients, carers, or family members can rank their answer by choosing one of the following; Very good; Good; Neither good nor poor; Poor; Very poor; Don't know. Followed by:

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

5.5 The changes were designed to make the FFT more accessible for all patients by using an easier to understand question, and by removing specific timing requirements that were a hindrance to collecting feedback at times that worked best for patients. The revised questions have enabled services to gain a broader understanding of patient views through the collection of quantitative and qualitative data.

5.6 This revised guidance relaxed the requirements regarding when people should be invited to give feedback and removed the mandatory requirements to ask at fixed points in A&E and inpatient services as well as streamlining requirements for maternity services. These changes have brought services in line with other NHS services where patients can give feedback at any time.

MFT FFT Performance

5.7 Following suspension of FFT nationally, guidance received in May 2020 advised that where a provider was confident that any feedback collection method; including tablets and cards, could be implemented safely, it may recommence this method to collect patient feedback. MFT recommenced the collection of FFT data in May 2020 via all methods following consultation with the Infection, Prevention and Control Team. The NHSE Healthcare Leaders update published on 4th September 2020 advised that Acute and Community providers would restart submitting FFT data to NHS Digital from December 2020. Prior to this time data were only reported and used internally. The MFT FFT response rates and results from **May 2020 to March 2021** are detailed in **Table 3** below.

Table 3: MFT FFT response rates and results in 2020/21

Friends and Family Test Response and Results: MFT 2020/21		
Area	**Response Rate**	**Percentage of patients who scored 'very good' and 'good' of our services**
Inpatients	23%	97%
Emergency Departments	9%	92%
Outpatients	N/A	96%
Community	N/A	96%
Maternity	N/A	98%

5.8 There is a continued focus across MFT for each Hospital, MCS and Community Services to demonstrate month on month improvements in response rates, which will improve the validity of the data enabling on-going use of FFT feedback to identify any areas of concern and improve the experience of care for patients.

Shelford Group Comparison

5.9 From January 2021 NHSE no longer calculate and publish response rates as the change to the timing requirements invalidates the rate calculation. However, NHSE continue to publish the number of responses collected and the number of eligible patients. The published data can demonstrate that providers are collecting a reasonable number of responses in the context of other local initiatives.

5.10 There was no national submission data for FFT from April to November 2020 due to the pause in response to the national pandemic. Therefore, there are only four months of submission data for 2020/21. During this four-month period, the percentage of MFT inpatients who scored 'very good' and 'good' about the care they received was **97%**, which compares positively to a range of 92% to 99% across the Shelford Group trusts[6] (**Table 4**). In 2019/20, 96% of MFT inpatients who responded were extremely likely/likely to recommend the Trust to friends and family who need similar treatment or care: this therefore represents an **increase of 1%** in 2020/21.

[6] NHS, England **NHS FFT Analysis site**. Available from: https://fft.england.nhs.uk/

Table 4: MFT Inpatient FFT responses compared to Shelford Group Trusts 2020/21

Friends and Family Test Results: Inpatients 2020/21	
Trust	Percentage of patients who scored 'very good' and 'good'
Newcastle upon Tyne Hospitals NHS Foundation Trust	99%
Manchester University Hospitals NHS Foundation Trust	97%
Imperial College Healthcare NHS Trust	97%
Cambridge University Hospitals NHS Foundation Trust	97%
University Hospitals Birmingham NHS Foundation Trust	97%
University College London Hospitals NHS Foundation Trust	96%
Oxford University Hospitals NHS Foundation Trust	96%
Guy's and St Thomas' NHS Foundation Trust	95%
Kings College Hospital NHS Foundation Trust	94%
Sheffield Teaching Hospitals NHS Foundation Trust	92%

5.11 The overall Emergency Department FFT responses for the Shelford Group trusts for the period Dec 2020 to March 2021 range from 79% to 92%, as demonstrated in **Table 5** below**.** The percentage of patients who rated MFT's Emergency Department Services as very good and good is **92%**, which places MFT in joint top position, which is an improvement from 89% in 2019/20.

Table 5: Comparison of MFT Emergency Department FFT response score compared to Shelford Group Trusts in 2020/21

Friends and Family Test Response and Results: Emergency Departments 2020/21	
Trust	**Percentage of patients who scored 'very good' and 'good'**
Manchester University Hospitals NHS Foundation Trust	92%
Cambridge University Hospitals NHS Foundation Trust	92%
Imperial College Healthcare NHS Trust	92%
University College London Hospitals NHS Foundation Trust	91%
Guy's and St Thomas' NHS Foundation Trust	91%
Oxford University Hospitals NHS Foundation Trust	87%
Sheffield Teaching Hospitals NHS Foundation Trust	85%
Kings College Hospital NHS Foundation Trust	85%
University Hospitals Birmingham NHS Foundation Trust	82%
Newcastle upon Tyne Hospitals NHS Foundation Trust	79%

FFT Improvements

5.12 MFT employed a FFT and NHS website lead in January 2021, which provides a visible presence and offers guidance and support to clinical areas, enabling a continued focus on improving response rates to ensure that FFT feedback informs improvements in the experience of care for patients.

5.13 This year, 109 iPads were allocated to the clinical areas, including new wards and replacement of old devices in order to support increased collection of feedback. Each Hospital/MCS/LCO reviews and monitors their FFT patient feedback and response rates to identify any areas for improvements and act upon the feedback received.

NHS England Same Day Emergency Care Friends and Family Test (FFT) Pilot

5.14 In November 2020, MFT received an invitation as Regional Leads to express interest in participating in a pilot for the National Same Day Emergency Care (SDEC) survey on behalf of NHSE. The Emergency Departments at Wythenshawe Hospital, Royal Manchester Children's Hospital, Manchester Royal Infirmary and St Marys Hospital Emergency Gynaecology Unit at Wythenshawe Hospital all expressed an interest in participating. The purpose of the pilot was to enable a better understanding of the

experience of care for people who use local services for SDEC during the COVID-19 pandemic.
This information was to be collected through a trial of new supplementary questions for the FFT over a 10-day period with data collection taking place during February 2021. The questions were provided by NHSE and covered four key areas:

1. Arrival
2. Experience of Waiting
3. Involvement in Care
4. Environment

5.15 To enable quick and easy data collection, the Patient Experience Team developed an online survey which enabled responses to be recorded via an iPad. Members of the Patient Experience Team and MFT Volunteers engaged with patients following discharge from the above services to ask them to share their experiences of care anonymously. During the 10-day pilot 118 individual responses were received. Key findings included:

When asked overall, how was your experience of our service?

- 96.5% rated the experience of the service as Very Good or Good.

When asked were you informed how long you would have to wait to be assessed/ treated in the SDEC Service?

- 69% said that they were not informed how long they would have to wait to be assessed/treated although 78% felt the waiting time was about right

How much information about your condition or treatment was given to you?

- 93% of those asked said they were given the right amount of information.
- 84% said they were kept informed and updated about steps whilst a further 13% said they were to some extent.

5.16 All analysed feedback was provided to NHSE following completion of the 10-day data collection period to inform national development of FFT, and each hospital received their own individual analysed responses so that these could inform continuous improvements.

Future FFT developments across MFT

5.17 In order to maximise the utilisation of FFT feedback to improve patient experience, the following further actions are planned for 2021/22:

- To continue to publicise the updated FFT guidance and collaborate with each Hospital/MCS/LCO to increase FFT response rates and promote the FFT survey
- To embed FFT standard of practice at North Manchester General Hospital
- To initiate a collaboration with the voluntary Services, by working together and targeting areas that have low response rates in collecting quality FFT feedback
- To deliver a targeted awareness campaign to promote the relaunch of the Patient Experience platform tool and rebrand of the FFT survey design across the trust
- To ensure a successful transition of all ward areas are included in the new platform, inclusive of any new areas and encompassing northern MLCO and TLCO services that are currently excluded from IQVIA

- To continue to promote an emphasis on the Free Text elements of the FFT ensuring that these are prioritised at both ward level and a corporate level as critical feedback can highlight opportunities for improvement
- To continue to roll out new iPads and retire as many old and unreliable tablet devices as possible
- Ensure 'phase out' of old FFT cards is completed
- To continue to publicise the importance of FFT to staff and patients with emphasis around the rebrand and using pop up banners and posters
- If numbers of responses fall too low, focus on a specialty area or a trigger point to promote the FFT or by engaging with users

5.18 Feedback received through the FFT will continue to be triangulated with other quality and patient experience data to ensure focused quality improvement.

6. NHS Website and Care Opinion Feedback

6.1 The NHS Website (formally NHS Choices) was launched in 2007 and is the official website of the NHS in England. It has over 43 million visits per month and visitors can leave their feedback relating to the NHS services from which they have received care. Care Opinion is an independent healthcare feedback platform service whose objective is to promote honest conversations about the patient experience between patients and health service providers. The Care Quality Commission (CQC) utilises information from both websites to help monitor the quality of services provided by trusts.

6.2 For MFT, there has been a 48.7% decrease in the overall number of postings made on these websites during 2020/21: from 201 postings in 2019/20 to 98 postings in 2020/21. The number of posts from these websites are recorded by categories; positive, negative, and mixed comments, as detailed in **Table 6**, below. The data demonstrate that the comments received in 2020/21 were significantly positive; with 73.5% positive comments compared to 64.7% in 2019/20. Just 18.4% of the comments received related to a negative experience of MFT services; this is a decrease of 7% in negative postings when compared to 2019/20 when 25.4% of comments were categorised as negative. Mixed comments account for 8.1% of the overall responses. WTWA received the most positive postings with 48.61% of the total relating to the WTWA hospitals.

Table 6: Number of NHS Website / Care Opinion postings by MFT Hospital/MCS/LCO 2020/21:

Number of NHS Website / Care Opinion Postings received by Hospital/MCS 2020/21			
Hospital/MCS	**Positive**	**Negative**	**Mixed**
Clinical Scientific Services (CSS)	1	0	0
Corporate Services	0	0	0
Manchester Local Care Organisation (MLCO)	0	0	0
Manchester Royal Infirmary (MRI)	15	6	4
Research & Innovation (R&I)	0	0	0
Royal Manchester Children's Hospital (RMCH)	2	1	0
Saint Mary's Hospital (SMH)	14	4	1
University Dental Hospital of Manchester (UDHM) / Manchester Royal Eye Hospital (MREH)	5	3	2
Wythenshawe, Trafford, Withington and Altrincham (WTWA)	35	4	1
Total	**72 (73.5%)**	**18 (18.4%)**	**8 (8.1%)**

6.3 **Table 7** below provides three examples of feedback received and the subsequent responses posted on the Care Opinion and NHS Website that were published in 2020/21.

Table 7: Examples of feedback posted on the Care Opinion and NHS Website

Trafford General Hospital
Emma gave Trafford General Hospital a rating of 5 stars 'Outstanding care - Trafford General Hospital' I arrived at urgent care with my 2-year-old daughter who had hurt her arm at home. From the nurse assessing at the entrance, security, reception staff, triage nurse through to the doctor who fixed her dislocated elbow, all staff we warm, friendly and professional. A wonderful service. Thank you!
Response:
Dear Emma, thank you for your comments posted on the NHS Website regarding the care your daughter received in the Urgent Care Centre, Trafford General Hospital. It was very kind of you to write and compliment all of the staff members as it is always good to receive positive feedback that reflects their professionalism. We were pleased to read that you felt everyone was warm and friendly and you received a wonderful service from arrival to discharge. I can assure you that we have passed on your thoughts to the Director of Nursing who will share your comments with the staff involved. The Patient Experience Team
University Dental Hospital Manchester
Comment posted anonymously with a rating of 4 stars. 'Change of procedure' Visited the hospital with elderly mother. Staff/ service excellent as always. I was

informed at the hospital that I couldn't go in with her due to new procedure to allow patient only to enter -re 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-19 pandemic we have had to implement additional safety measures to keep both our patients and staff safe. Due to 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 quoting reference number PO20/0080. The Patient Experience Team
MRI
Ant gave MRI a rating of 5 stars 'Excellent service in the middle of a pandemic' I spent 5 nights in the MRI last month due to a big internal bleed. Through the experience, I was treated in the A&E department, endoscopy department, acute medical unit and ward 3. All the staff were very courteous and friendly, and I think I got great care too. Another positive was the food, which surprisingly good compared to other hospitals I've been too. The only negative I'd add is that drip stands were often left bleeping for prolonged periods at night once the drug is finished, this can be annoying when trying to sleep. However, overall, with this experience happening at the height of the pandemic, the care was excellent.
Response:
Dear Ant, We are pleased to hear you feel that the care you received during your inpatient stay was excellent, we always strive to provide patients with the highest quality of care, and we hope that your condition is continuing to improve. Patient Experience is very important to us and we want to offer our apologies that you were troubled by the noise of bleeping from the machines being used on the ward at night. We can appreciate this must have been hard for you whilst trying to sleep and we will highlight this with the ward team to ensure particular attention is paid to machines being used during night time hours and that any noise/alerts are dealt with as quickly as possible. We are sincerely grateful for you taking the time to share this feedback and will ensure that it is shared with all the staff in the departments you were treated. The Patient Experience Team

Future development of NHS Website comments

6.4 To celebrate the excellent positive feedback received, the Patient Experience Team will be introducing the inclusion of positive comments in weekly MFT newsletters and communications so that all staff can read the comments posted by patients, carers, and family members.

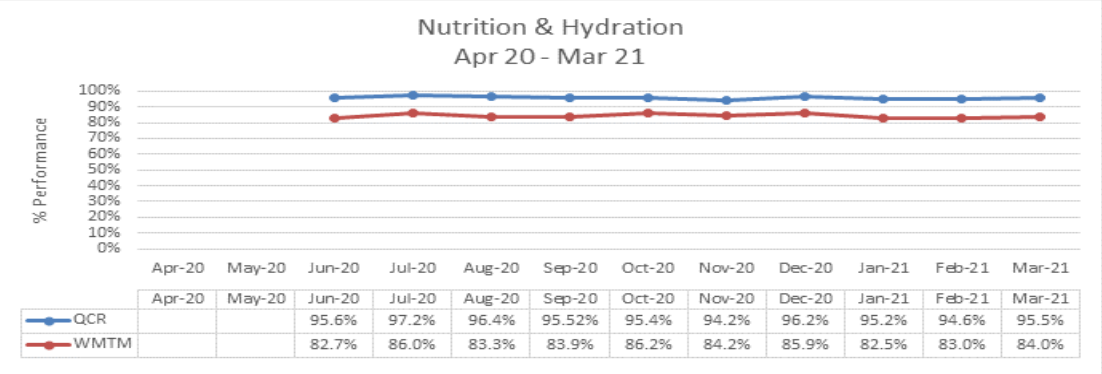
7. Improving Quality Programme (IQP)

7.1 All of the quality and patient experience data collected from the range of sources set out in this report is used to inform local and Trust-wide quality improvement activity, underpinned by the Trust's improving quality methodology, IQP. IQP is embedded across clinical areas and provides a set of tools for teams to identify areas for improvement and implement improvement cycles with a view to aligning change to normal business. In this report improvement activity relating to the patient dining experience is offered as an example of IQP activity.

Improving Food and the Patient Dining Experience

7.2 Triangulation of patient feedback and quality and safety data highlights the need for continued improvement with regard to food, nutrition and the dining experience. **Graph 5** below shows Quality Care Round and **WMTM** patient experience data for food, nutrition and dining for 2020/2021. There is no data for April and May 2020 due to the pause in activity to support the response to the COVID-19 pandemic.

Graph 5: Trust QCR/ WM2M patient experience survey – Providing Good Nutrition



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
QCR			95.6%	97.2%	96.4%	95.52%	95.4%	94.2%	96.2%	95.2%	94.6%	95.5%
WMTM			82.7%	86.0%	83.3%	83.9%	86.2%	84.2%	85.9%	82.5%	83.0%	84.0%

7.3 It is recognised that good nutrition is fundamental to health and wellbeing, especially during periods of illness or frailty. The Trust has placed significant focus on improving the quality of food and the patient's dining experience over many years, however, food was a category identified as still requiring improvement in the 2018 Adult National Inpatient Survey culminating in the development and launch of the MFT Nutrition and Hydration Strategy in 2019. The 2019 Adult National Inpatient Survey results demonstrated positive progress with an improved score of 5.2 compared to 4.7 in the 2018 survey. Improvement work continued in 2020/21.

7.4 The data set out in **Graph 5** demonstrate that patient feedback relating to food and nutrition exceeded the Trust's 85% baseline on three of the ten months recorded and showed an improvement from January to March 2021, but continued work is required to consistently achieve over 85% patient satisfaction. Nutrition and patient dining priorities

were set for 2020/21 and a number of improvement programmes either continued or commenced during the year to deliver these priorities, although these were delayed and impacted by the redirection of staff to support the pandemic response. This section of the report provides a summary of some of the work that has been undertaken to improve this aspect of patient experience and safety.

Food and Dining Improvement Programme: Mealtimes Matter

7.5 The MFT Nutrition and Hydration Strategy sets out the Trust's aims to support patients and staff to achieve good standards of Nutrition and Hydration, underpinned by the Trust's vision, strategic aims and values and the **'What Matters to Me'** Patient Experience Programme with the aim of delivering a high quality, personalised experience for every patient and service user. The Strategy outlines that making mealtimes matter is a crucial component in ensuring patients receive a personalised dining experience which in turn will facilitate the individual's return to health. Collaborative working between Nursing, Midwifery, Allied Health Professionals, Estates and Facilities and the Trust Private Finance Initiative (PFI) Partners, is a fundamental component that drives the MFT Food and Dining Improvement Programme; with the dedicated role of the Facilities Matron being a pivotal driver for improvement.

7.6 'What Does Good Look like' action plans have been developed for the ORC (Oxford Road Campus) and WTWA (Wythenshawe, Trafford, Withington and Altrincham) and Patient Dining Forums are progressing the identified workstreams.

7.7 A key work stream, 'the Model Ward' was established to develop an exemplar ward for patient dining experiences. It was anticipated that following the identification of changes that would deliver the highest impact, these changes would be replicated across the wider Trust. Utilising IQP methodology, the MDT workstream engaged with patients and staff on Ward 12 at Trafford General Hospital to identify key areas to focus improvement and as a result a hot breakfast option and snack rounds were introduced. Wider roll out of this model was delayed due to extensive changes in ward functions during the pandemic response, however, it will be a key element of IQP activity in 2021/22.

Food Safety

7.8 To ensure patient safety in relation to the preparation, service, and storage of food outside the catering services, MFT staff have worked closely with Manchester City Council's Environmental Health Department to develop a Food Safety Management System. This collaboration has led to the development of a suite of new resources to support clinical staff in relation to food safety and a revised 'Food Safety in the Clinical Environment' policy which was launched during Nutrition & Hydration Week, 14th-20th June 2021.

7.9 Mandatory Food Safety on-line Training (Level 1) for clinical staff involved in any aspect of patient food delivery/preparation, was developed in 2020/21 and will be launched in September 2021, once role mapping has been completed with the ODT Learning Hub Team.

Patient Dining Priorities for 2021/22:

7.10 The focus on Nutrition and patient dining will continue in 2021/22; the following priorities have been set to ensure continued improvement:

- To continue to use local data to identify areas that require bespoke interventions that would provide a ***personalised dining experience*** for all patients based on the unique needs of each individual
- To continue to support clinical areas with IQP methodology to enable teams to identify, plan and implement improvements related to the meal service
- To continue to review existing menus to ensure that they remain relevant to the client group
- To finalise and launch the revised Trust Food Safety in the Clinical Environment Policy
- To develop and roll-out the **Food Safety** on-line training for clinical staff involved in any aspect of patient food delivery/ preparation
- To review the outputs of the **Model Ward** and identify improvements to be rolled out across all MFT locations
- To align current practice with national guidelines for hospital food standards
- To deliver key actions from "What does good look like" action plans

7.11 A Group Nutrition and Hydration Committee will be established in 2021, chaired by a Director of Nursing and reporting directly to the Group Quality and Safety Committee to drive improvements in nutrition and hydration. This committee will have terms of reference that enable the correlation between the quality and safety of patient nutrition to be fully understood and improvements made to improve patient outcomes.

8. What Matters to Me: MFT Patient Experience Programme

8.1 **'What Matters to Me' (WMTM)** is the MFT approach to patient experience, aligning closely to core strategies such as the Leadership and Culture Strategy and MFT Values and Behaviours. The programme aims to ensure that MFT staff treat every patient as an individual and encourages them to ask patients **'What Matters'** to them as they travel through MFT services. This requires staff to listen and to respond to those needs. The WMTM programme comprises of six key elements as identified in **Figure 2 below**, which reflect the overarching elements of excellent personalised patient experiences: progress is summarised below.

Figure 2: Six Key Elements to **W**hat **M**atters to **M**e programme

WMTM Patient Experience activity during 2020/21 has included:

8.2 Continued development of a library of **'What Matters to Me'** patient and carer films that can be shared at the commencement of key MFT meetings. Films are also provided to a range of services and hospitals to support staff reflection, and learning. Recent films have included patients and families sharing their experience of MFT services during the pandemic.

8.3 Weekly articles showcasing **'What Matters to Me'** successes and highlighting the underpinning Experience and Involvement Strategy commitment are shared in the MFT internal newsletters to support the continued embedding of What Matters to Me, personalising the patient experience and sharing good practice and learning.

8.4 Regular communications to encourage people to share information and celebrate individual progress by using social media (hashtag **#WMTM)**. During the past year, the Patient Experience team tweeted on **293** separate occasions. Of those tweets there has been over **200,000** impressions and the Patient Experience Team profile has been visited **6,134** times.

8.5 The Patient Experience Team has previously undertaken engagement activity across MFT services to support teams with specific campaign weeks, however due to the pandemic this activity was paused. During April 2020 the Patient Experience Team took a different approach to promote the NHSE Experience of Care week through Twitter. Activity included promotion of the Family Liaison Team, sharing written **WMTM** patient

feedback, undertaking recorded interviews with patients on the wards and sharing images to reflect the contributions that staff make every day to patients, families, and carers.

8.6 The Patient Experience Team manage a survey monkey account to support staff with the development of surveys and reporting processes to enable further opportunities to develop patient and staff feedback mechanisms. During the past year, **41** separate teams have requested advice and support to enable them to develop surveys specific to their areas of work to receive valuable **WMTM** feedback from patients. This local approach was particularly important whilst Trust-wide survey collection was paused to support the pandemic response.

8.7 The Patient Experience Team in partnership with the PALS team have facilitated the telephone Virtual Visiting Helpline. This activity has included providing advice and support to patient's families, booking and co-ordinating visits on their behalf and facilitating virtual visits.

8.8 The Patient Experience and Infection Control Team jointly led on co-production work with representatives from the Hospitals/MCS and LCOs and service users to develop a suite of COVID-19 patient information resources. Patient representatives from the recently established Service User Involvement Group were consulted regarding the patient information resources and provided valuable feedback from a patient focused, non-clinical perspective reflecting Commitment 4 of the Experience and Involvement Strategy " we are committed to listening to, acting on and learning from feedback from all service users and staff".

8.9 The Patient Experience Team has continued to monitor **What Matters to Me** patient experience feedback collected through Hospedia bedside television entertainment units and this has been shared with clinical areas where appropriate to improve the patient experience.

8.10 Members of the Patient Experience Team are accredited tutors in the delivery of the Expert Patient Programme, self-management course and regularly deliver 3-4 six week sessions on behalf of the LCO, on site at Oxford Road Campus (ORC) to patients and carers living with a long term condition. Delivery ceased during the pandemic response, but regular training has continued to support the re-introduction of an online programme.

8.11 From 1st April 2021, North Manchester General Hospital (NMGH) to MFT. In preparation, a Patient Experience Project Manager was appointed to facilitate the implementation of **What Matters to Me** Patient Experience Framework across the hospital**.**

Future development of 'What Matters to Me'

8.12 The Quality and Patient Experience annual work plan 2021/22 includes the following activity:

- To further embed **'What Matters to Me'** across the organisation;
- To further embed the MFT Experience and Involvement Strategy, setting the direction for the inclusion of patients and service users in the co-design of services by 2023;

- To ensure that individual hospitals/MCS/LCOs are responsible for developing and delivering local improvement/implementation plans and progress of this will continue to be monitored via the Group Quality and Patient Experience Forum
- To share learning from NHSE Always Events® across the organisation and develop a toolkit of Always Events® resources for staff to access via the Trust internet webpages and the hub. Resources will include case studies; vlogs; voice over presentations; audit tools; sitting your aim and vision guidance and links to NHSE Always Events Toolkit;
- To complete an EQIA Assessment of the **WMTM** Patient Experience Programme in partnership with Equality and Diversity colleagues;
- To refresh WMTM tools, Masterclasses, and resources to be more accessible;
- To further embed WMTM across non-clinical groups;
- To continue to embed WMTM across North Manchester General Hospital following successful transition from the Northern Care Alliance/Pennine Acute NHS Foundation Trust to MFT

9. MFT Experience and Involvement Strategy 2020 – 2023

9.1 The MFT Experience and Involvement Strategy: Our Commitment to Patients, Families and Carers 2020-2023 was produced in partnership with key stakeholders in 2019 and launched in August 2020 following a delay due to the pandemic. Building on the What Matters to Me Patient Experience Framework, the strategy reflects the Trust's commitment to providing the best possible patient and carer experience whilst aiming to ensure the highest levels of involvement, partnership working and shared leadership. This Strategy sets the direction for the inclusion of patients and service users in the co-design of services by 2023 and outlines the following four commitments:

- Empowering patients and carers to take control of their journey by involving them in every aspect of their care as well as the direction of our organisation
- Communicating with each other in an accessible, friendly and respectful manner
- Creating an inclusive and welcoming community for patients, carers and staff
- Listening to, acting on and learning from feedback from all service users and staff.

9.2 Hospitals/MCS/LCO management teams are responsible for developing and delivering local implementation plans, and progress is monitored via the Group Quality and Patient Experience forum. Activity to support delivery of the strategic commitments has included:

- Ensuring consideration is given to involving patients/service users in the development and pilot of patient feedback surveys
- Email signatures for the Patient Experience Team and Voluntary Services now include promotional information and a link to access the Strategy
- Weekly **What Matters to Me** news articles reference the strategic commitments
- Publication of a MFT iNews article introducing Co-Production and the Trust Strategy
- Development of a Service User Involvement Group
- Building on established links with Manchester Healthwatch
- Updating the Patient Experience Team intranet page
- Regular social media promotion including a Twitter poll asking staff members if they are aware of the strategy

9.3 The RMCH MCS Patient Experience Committee offers an example structures established to deliver the strategy. Led by the RMCH MCS Director of Nursing, the

committee is responsible for providing assurance to the Hospital Management Board that WMTM Patient Experience workstreams are progressing across the hospital with the ultimate objective to support the delivery of the Patient Experience and Involvement Strategy and ensure that the patient's voice is heard at every point of the patient journey. To ensure that this happens, a patient representative and a parent representative are part of the core membership of the committee. Committee responsibilities include monitoring themes from clinical accreditations, monitoring and management of the FFT, What Matters to Me and Quality Care Round performance, reviewing compliments, complaints and PALS and triangulating themes utilising other available data such as incidents. The committee is also responsible for reviewing intelligence from other sources such as Healthwatch and the Child and Young Person Survey and will link closely with partners to ensure national initiatives are supported within the Hospital, such as NHSE Always Events®.

9.4 COVID-19 recovery and redesign activity provide a considerable opportunity for the involvement of patients and service users; it will be important to ensure that this strategy, along with the application of the MFT QIA Policy continues to be integrated into the hospital/MCS/LCO recovery plans.

10. Maintaining the focus on patient and staff experience during the COVID-19 pandemic

10.1 Maintaining the focus on patient experience has been essential during the pandemic response and has required new and different ways of working and engaging with patients to be developed and implemented at pace.

10.2 **Volunteers** played an important part in supporting the Trust to maintain a positive patient experience. At the start of 2020, MFT had approximately 750 volunteers working across all hospital sites. This number included volunteers from the Trust's partnership with national and local charitable organisations, such as The League of Friends; Radio Lollipop; The Ticker Club; Prevent Breast Cancer and Macmillan Cancer. The volunteers ranged in age from 16 to 94 years and came from a wide variety of backgrounds.

10.3 A significant number of volunteers "paused" their volunteering at the start of the pandemic, either due to advice to shield due to their age profile; shielding for underlying health conditions, or those that were students returning home. As a result, MFT suddenly had significantly less volunteering support at a time when it was needed most. The pause in National Patient Experience reporting enabled Voluntary Services and the Patient Experience Team to come together to focus on the recruitment of COVID-19 Response Volunteers.

10.4 During the initial stages of the pandemic the volunteer recruitment campaign resulted in **100** COVID-19 Response Volunteers being recruited to three key roles: Administration Support; Meeting and Greeting; Wayfinding and Laboratory Runners. This year these volunteers gave over **6,000 hours** of their time supporting patients and staff.

10.5 The return to paid employment and education led to a gradual decline in COVID-19 Response Volunteer numbers. In response to this decline, a further recruitment drive

resulted in an additional **50 volunteers** being recruited who gave **4,000 hours** of their time this year.

10.6 Throughout the year four projects have been running within Voluntary Services, all of which have assisted in the development and growth of the service with a view to supporting patient experience:

- **The Youth Volunteering Project:** this is a two-year fixed term project due to end in August 2021. The project is funded by the Pears Foundation, an " independent, family foundation," which strives to "drive engagement in social progress across the UK and globally, particularly in young people"…and supports "organisations focused on wellbeing for everyone, especially those with a tough challenge to face." [7]

  The Youth Volunteering project aims to:
  - increase the number of young volunteers aged between 16 and 23 years
  - improve the volunteering opportunities at MFT for this age group
  - improve the skills and broaden the education and employment prospects for young volunteers

  Whilst the project "slowed" over the course of the pandemic; MFT has still recruited 25 volunteers through this programme. These Volunteers have provided more than **800** hours of their time. **Table 8** below provides examples of feedback received from the volunteers recruited through this programme of work.

Table 8: Young Volunteer feedback in relation to their role and experience volunteering

Volunteer Role	Young Volunteer Feedback
Welcoming Volunteer	'I helped patients who may have been confused as to where they were heading. I answered questions pertaining to directions, and any other questions about the site or the different departments. I led them to the place they were looking for when appropriate'.
Ward Volunteer	'Tasks I was involved with included chatting to the patients, reading cards to them, playing games, setting up calls to their families, assisting with the serving of drinks and the general upkeep of the ward. A high moment was reading greeting cards out to a patient who had dementia and it really seemed to cheer her up!'
Welcoming Volunteer	'I really enjoyed my whole experience volunteering with the team. From the beginning I felt so welcome and supported by all members of the team; and knew that if I had any worries or concerns, they would be happy to help!'
Ward Volunteer	'I've had a great and rewarding time volunteering on Ward F15. The staff are always welcoming and very supportive when I have questions, and I have learned a great deal during my weekly sessions over the past year'.

- **National Volunteering Certificate (NVC)** Following a successful bid to Heath Education England (HEE) in January 2021 the **National Volunteering Certificate**

[7] Pears Foundation: https://pearsfoundation.org.uk/

(NVC) will be available to all volunteers from March 2021**.** The NVC consists of six core standards based on statutory and mandatory topics linked to the NHS Core Skills Training Framework and the Care Certificate[8]. The six modules of the certificate consist of:

- roles and responsibilities
- communication
- safeguarding
- mental health/dementia/learning disabilities
- health and safety
- respect for everyone

The modules aim to enhance the learning that volunteers will have gained and provides a formal qualification related to healthcare for Trust volunteers. In addition to their mandatory training, volunteers are required to contribute a minimum of 60 hours volunteering over 12 months. Benefits to volunteers completing the certificate are:

- It demonstrates to others (internal and external) that the volunteer has undertaken quality assured theoretical training and completed a period of practice to be able to volunteer safely in health and care
- It is nationally recognised (aligned to Care Certificate) – the volunteer can include course completion in their CV or job/course applications
- It is potentially transferable to other trusts/volunteering opportunities

By the end of March 2021, eight volunteers had committed to commence the certificate. Together with HEE, the Trust is assisting in the evaluation of the NVC, both from a qualitative and quantitative perspective, using the Better Impact software package.

- **NHS Winter Volunteering Programme -** following another successful bid in December 2020, MFT was awarded £20K as part of the NHS **Winter Volunteering Programme,** for developing Voluntary Services over the winter period. The funding supported the development of three specific COVID-19 safe volunteering roles: Patient Dining; Virtual Visiting and ECO Bus re-launch, as well as supporting the winter volunteer recruitment campaign. Over the course of this programme, sixty volunteers were successfully recruited, with **Table 9** below highlights the number of volunteers active within these roles and the total hours volunteered.

[8] NHS, Health Education England: https://volunteerlearning.community/what-are-the-national-volunteer-standards/

Table 9: Winter Volunteering Programme – Volunteer Activity

	ORC		Wythenshawe		MFT	
	Number of Volunteers	Hours	Number of Volunteers	Hours	Number of Volunteers	**Hours**
MFT Patient Dining	7	169.41	6	104.7	**13**	**274.11**
SJA Patient Dining	5	252.18	N/A	N/A	**5**	**252.18**
Virtual Visits	14	243.6	6	113.5	**20**	**357.1**

- **Better Impact -** the implementation of the **Better Impact** software administration package commenced in January 2021 at Wythenshawe Hospital, following previous implementation on the ORC. This volunteer database is used by the team to manage all elements of the volunteer recruitment process, including on- line applications, shortlisting candidates, and scheduling interviews. The system also manages the induction and mandatory training of newly appointed volunteers as well as processing ongoing communications, scheduling, and reporting.

10.7 Some of the many examples of volunteer activity during April 2020 to March 2021 to support staff and patient experience are summarised below.

MFT Charities and International Nurses Day

10.8 Several volunteers supported the MFT Charity in its work to assemble and distribute Wellbeing Packs, comprised of items that were donated by local businesses, for MFT staff between April and May 2020. In total, 25,000 wellbeing packs were distributed to individual staff members.

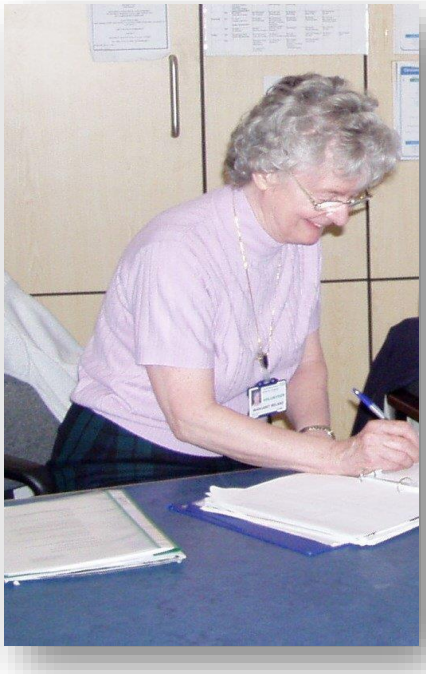
10.9 Volunteers also supported MFT's International Nurses' Day Programme with ten Young Volunteers working as part of a larger team to pack gift bags for nursing and midwifery teams. In total, 10,000 gift bags were distributed to the staff on International Nurse's Day on 12th May 2020.

Figure 3: Volunteers Supporting MFT's International Nurse's Day Programme, May 2020

National Help Force "Wall of Fame Awards"

10.10 November 2020 saw two volunteers awarded a "Wall of Fame" HelpForce Award in their respective nominated categories. For Margaret Ireland, Meet and Greet and Critical Care Volunteer based at Wythenshawe Hospital who has volunteered for 24 years received a **"Going the extra mile"** award and John Carpenter, Chair of Radio Lollipop from 2009-2020 received a **"Teamwork and bringing people together"** award for his work and leadership to deliver the Radio Lollipop service.

Figure 4: Margaret volunteering on the information desk (pre-COVID-19) and John (wearing the hat) with Radio Lollipop Volunteers



St John's Ambulance

10.11 Collaborative working between St John's Ambulance (SJA) and MFT's Corporate Patient Experience and Voluntary Services Team enabled the opportunity for SJA volunteers to work across MFT's hospitals to support the pandemic response. Two new roles were developed in partnership with senior nursing teams across MFT and offered to SJA volunteers. Patient Dining Companions enabled SJA volunteers to support ward areas during mealtimes and a role within Critical Care was later developed, with volunteers undertaking a wide range of duties to support clinical staff including meeting and greeting patients' relatives ahead of planned visits and managing scrubs stocks. Collaborative working between St John's Ambulance, MFT's Corporate Patient Experience Team and Voluntary Services has continued, to further develop the roles available to SJA volunteers capitalising on their unique skill set to provide further support to MFT services.

Family Liaison Service and Virtual Visiting Service

10.12 Following the first wave of the pandemic, MFT established a Family Liaison Team (FLT) to support patients and families to maintain contact and help patients reach out to their loved ones whilst in hospital. The FLT comprised of staff including dental nurses and administrative staff redeployed from their usual roles due to the suspension of elective work. The team was overseen by the Corporate Lead Nurse and Matron for the Single Hospital Service. As Family Liaison Team colleagues returned to their substantive roles as the pandemic response progressed, plans were developed to continue with a Virtual Visiting Service for adult inpatient areas across the Trust, consisting of the Patient Advice and Liaison Service (PALS), Patient Experience Team and volunteers.

10.13 The FLT operated between 10am and 8pm, seven days a week, with additional out of hours visiting arranged if required. Providing this service allowed nursing and medical teams to focus on patient care and treatment. The FLT acted as a link between patients and families, arranging for belongings and messages to be passed regularly between them, helping to keep families connected and to reduce the feelings of loneliness and worry. A newspaper delivery service; the creation of inspirational quotes; posters to support patient wellbeing and large size print crosswords were all included in the service. A kind donation of Lenovo tablets from a local business enabled the FLT to expand their service by enabling each member of the FLT to have their own tablet throughout their shift.

10.14 The FLT was gradually stepped down over July 2020, with the new Virtual Visiting Service, commencing in August 2020. From August 2020 to March 2021, 31 volunteers have helped facilitate over 1,000 calls for patients and families. Over the 2020 festive period a ***12 Days of Christmas Virtual Visiting*** arrangement was scheduled from 23rd December 2020 to 03rd January 2021 and was facilitated by all teams within Patient Services, offering inpatients and nursing teams support with Christmas Virtual Visiting. To ensure continuous development of the Virtual Visiting service, feedback has been anonymously collected from patients' families following their virtual visit. **Graph 6** below summarises the satisfaction expressed with the experience received throughout each stage of the virtual visiting process. Notably over 80% of families described the overall experience of the service as good or excellent and only 3.7% rated the service as poor.

Graph 6: Rating of experience received by families at different elements of the Virtual Visiting Service.

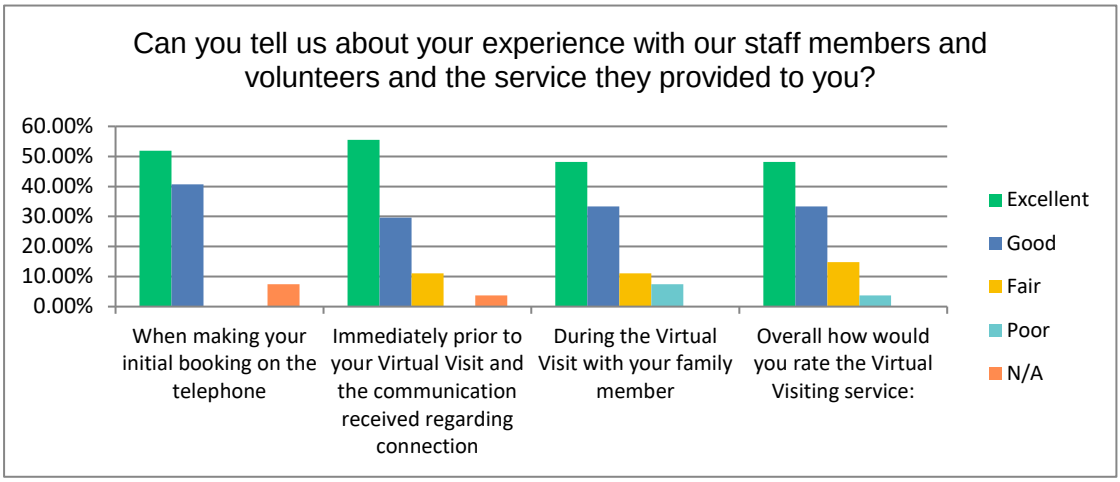
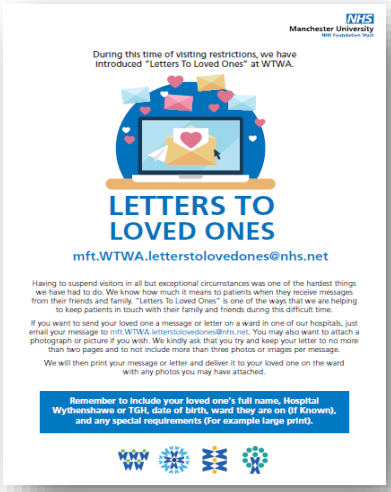


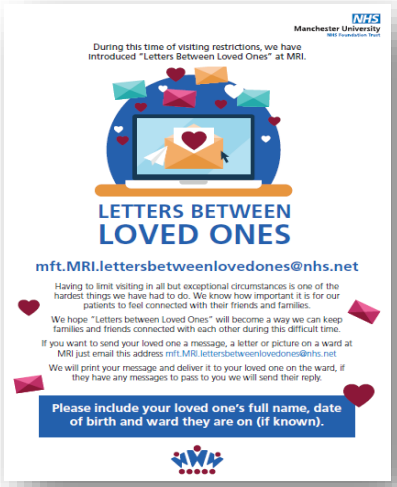
Figure 5: Virtual Visiting Promotional Posters

Letters to/between Loved Ones

10.15 To further improve communication between patients and their relatives at a time when visiting was restricted MRI, Critical Support Services (CSS), Wythenshawe and Trafford Hospitals all established a bespoke mail delivery service. The overall aim of the "Letters to loved ones" service was to enable friends, family and carers to maintain contact with patients during their admission to hospital through the delivery of electronic letters, messages and pictures. Standard Operating Procedures and promotional materials including posters and banners were developed and circulated to widely promote the service. The Patient Experience Team shared details of this initiative with relatives when booking virtual visits.

Figure 6: Letters To / Between Loved Ones resources adapted for different areas





Trust-wide patient experience improvement work

10.16 All MFT hospitals/MCS/LCOs undertook specific work to support patient experience during the pandemic response. Some examples are provided below:

Clinical and Scientific Services (CSS)

What Matters to Your Loved One

10.17 In addition to establishing "Letters between loved ones", CSS, which provides critical services across the Trust, developed an electronic "What Matters to Your Loved One" document that families were asked to complete. The purpose of this document was for families to provide information about the patient to try and individualise their environment. Families were asked the following:

- What does your loved ones like to be called?
- Who are the important people in their lives?
- What do they like?
- What don't they like?
- Do they have any spiritual needs?
- Before they came into hospital what did they like to do?
- What things do they do to help them get to sleep?
- What are their favourite foods and drinks?

10.18 Families were able to provide this information via the dedicated "letters between loved ones" email account. Information about the "What Matters to your loved ones" document was included in the promotional materials and circulated to families.

Supporting Bereaved Families

10.19 The Adult Intensive Care Unit (AICU) team re-introduced cards sent to all bereaved families and carers. Members of the team designed the cards and the name of the team member who created the design is printed on the back. Alongside the card, the family and carer receive 'Forget me knot' flower seeds to plant in memory of their loved one.

Figure 7: Bereaved families personalised cards

WMTM Staff Board – Staff Recognition – Staff Feedback

10.20 CSS staff developed a Team Recognition Board to give messages to colleagues and to show feedback from patients and their families. Communication with families has been particularly challenging throughout the pandemic and staff have introduced several measures to deal with this including:

- Video calling between patients (able to consent) and their families
- Call in, use of passwords and updates from nursing staff
- Consultant calls to families every 48 hours
- Visiting on compassionate grounds
- Development of an electronic **WMTM** proforma for families to complete and return

Figure 8: Staff Wellbeing Board

Saint Marys Hospital MCS

10.21 In June 2020 in response to the emerging evidence from the UK Obstetric Surveillance System (UKOSS), Professor Jacqueline Dunkley-Bent, Chief Midwifery Officer for NHSE, wrote to all maternity units in the country calling on them to increase the support for Black, Asian and minority ethnic women during the pandemic. Maternity Units were asked to take four specific actions which would minimise the additional risk of COVID-19 for Black, Asian, and ethnic minority women and their babies.

1. To Increase the support for at-risk pregnant women
2. To reach out and reassure pregnant Black, Asian and ethnic minority women with tailored communications.
3. To minimise the risk of Vitamin D insufficiency
4. To gather the correct data

10.22 Saint Mary's Hospital MCS cares for over 14,000 women each year across the managed clinical service, of which, 35% are from BAME backgrounds. Therefore, it was important for actions to be taken to mitigate risks as much as possible. A task and finish group, led by the Consultant Midwife and a Professor of Obstetrics, was established, alongside the Local Maternity System Black and Asian Maternity Advisory group, which includes representatives from Saint Mary's Hospital, representatives from the Voluntary, Community and Social Enterprise (VCSE) sector, Higher Education, and other NHS Trusts within the GMEC region. Activity to meet the four actions included:

Increasing support for at-risk pregnant women

10.23 To increase staff knowledge that women from Black Asian and minority ethnic communities were at higher risk of complications, especially from COVID-19 information posters were placed in all clinical areas. Information on the differences in outcomes for these women was also included in all mandatory study days for midwives, doctors, and support workers. Clinicians were encouraged to have a lower threshold to review, admit and consider multidisciplinary escalation in women from a BAME background. The hospital continues to work collaboratively with the three Maternity Voices Partnerships (Wythenshawe, North Manchester, and Oxford Road) along with community organisations to engage with and signpost women to available resources.

Reaching out and reassuring pregnant BAME women with tailored communications

10.24 Maternity service providers in the North West of England have worked with service users and the Universities to co-produce a suite of ten key messages to promote safe maternity care. These messages aim to reassure, support, and inform pregnant women and their families about the risks faced by Black, Asian and ethnic minorities including those who cannot easily access information in English, so that they are able to access services equitably. These messages build on existing COVID-19 specific messages highlighting the need for extra vigilance for complications while pregnant. The most urgent messages have been prioritised, including mental health, domestic abuse and violence, pre-eclampsia, vitamin D deficiency and reduced foetal movements. These messages are available on-line in some of the most frequently spoken languages. A4 posters with the overarching message and a QR code to access the digital resources directly, are being distributed for display in a range of venues in community and clinical settings, recognising that community, faith and cultural networks are important in making sure the information is widely shared with all groups and their families who may not be aware of the recommendations already. MFT midwives have been given a fob with the QR code to ensure that women can

download the resources when they are discussed. The Northwest NHS Maternity Services Safety Information is available digitally at the link below: https://www.england.nhs.uk/north-west/north-west-services/north-west-maternity-services/maternity-safety-information/

10.25 To ensure that digitally isolated women have equal access to these important key messages, a booklet is available in 11 translated languages, for women to take-away when attending clinics and other midwifery appointments. British Sign Language and facilities to support service users with additional communication needs are in place. Local Maternity Services Black and Asian Maternity Advisory Groups have supported research and engagement with service users and are working in partnership with the VCSE sector to undertake further work to explore maternity experiences of women from Black and Asian communities.

10.26 The Role of the Doula: during May 2020. There were several concerns raised regarding the visiting policy, which restricted Doulas from providing support to women during birth. The concern was that a Doula, by her very role, was not able to socially distance so would be excluded from the hospital, however a significant concern for the pregnant women was that their partner may well have to remain at home to provide care for other children leaving the pregnant mother to birth on her own. Midwifery teams across Saint Mary's Hospital MCS sought to provide a safe environment for all women and by making reasonable adjustments, members from the Jewish community who are Doulas were supported to come into the maternity unit to undertake training on PPE and Hand Hygiene.

10.27 in New-born Services, FiCare (Partnership in Care) has continued to be promoted during COVID-19, supporting families to maintain and develop bonds during lockdown. One parent was permitted to visit and provide care. The long-term impact on families of this separation and interruption in parental bonding, learning to care for a preterm infant or one with chronic health issues together as a family may have serious deleterious influences on family relationships in the future. The BadgerNet Baby diary was used to enable virtual communication with families who were self-isolating and unable to attend New-born Services and spend time with their baby. Patient Information Leaflets will also to be shared via this medium, to enhance understanding of treatments and care conditions. Families have been communicated with regularly during the pandemic, in particular concerning visiting to New-born Services. This has been challenging for families and the New-born Services has provided written updates reflecting the changes and restrictions on visiting and have developed options for the care of the bereaved family at this time.

10.28 After the Midwifery-led unit relocated from Ward 47, ORC to Wythenshawe Hospital, it was necessary for the midwifery teams to review the low-risk birthing facilities on the Central Delivery Unit at SMH. Based on **WMTM** feedback, the team identified that the pool room on Ward 64 needed to have a calmer and more inclusive ambience; one that would support women throughout their birthing experience and help them feel supported. Funding was secured through charitable funds, which allowed the department to hire a local, independent artist known as, 'Signed by Jen', to create some beautiful artwork and paint positive birth affirmations in different languages onto the walls. A user-friendly space was created filled with soft furnishings, speakers, cushions, a birthing mat, birthing balls, a large birthing pool, a swing to support women in rhythmical movement and mood-enhancing lighting that projects onto the ceiling with a waterfall effect. The room can, however, easily be converted back to a more "higher-risk" room if required.

Figure 9: Low Risk Birthing Room – Midwifery led Unit, SMH, Oxford Road Site

Manchester Royal Eye Hospital (MREH) and University Dental Hospital of Manchester (UDHM)

MREH

10.29 MREH at Altrincham Hospital is now utilised in a different way for high risk patients with Uveitis who are often on immunosuppressing therapy. At the start of the pandemic many of these patients were shielding, however, still required regular face to face appointments to ensure their sight threatening condition was monitored. It was recognised that patients should have as little direct contact with other people as possible and Altrincham community hospital provided a safe space for these patients and their medical and nursing teams. With less foot fall and reduced clinical activity within the hospital, patients felt safe and have continued to receive their care at Altrincham. To facilitate less face to face contact a questionnaire was devised for patients to complete with information about their current treatment, prescription requirements and any concerns they were having. A courier service was established for shielding patients to receive their medication at home, so they did not have to attend the hospital pharmacy. Positive feedback from patients and parents included:

- "We were greeted with a smiley receptionist and the waiting room was quiet"
- "I would like to continue to come to Altrincham"
- "Good hospital it is quieter than MRI"
- "Distance is a big problem; however, I don't mind because it's really nice and quiet"

10.30 Within MREH OPD a weekly nurse-led Corneal Ectasia clinic was initiated at the end of June 2020 to support the review of patients with this condition. This change was initiated as part of COVID-19 response and has now been adopted into usual activity. The patient pathway in the clinic incudes ophthalmic physiological measurements and imaging as well as the opportunity to discuss any concerns or questions patients have regarding their vison. Questions that cannot be answered on the day by nursing staff are responded to by the medical staff, who after the appointment, have a telephone consultation with the patient that is summarised in a letter. This patient group is predominantly young adults who appreciate the scheduling of the clinic to a Saturday and the smooth flow of this clinic which has a minimal waiting time. Traditionally the DNA rate for this patient group is high and introduction of this bespoke clinic is expected to lead to a reduction.

10.31 During the recalibration of surgical activities, MREH inpatient wards redesigned its cohort of patients to reflect 'Amber' and 'Green' areas providing space and capacity for both planned admissions and urgent cases. A COVID-19 pre-operative swabbing clinic was formed in the outpatient area, ground floor to allow patients to be seen nearer to the entrance thus avoiding any unnecessary footfall into other areas within the hospital, whilst offering the patient a good experience.

10.32 During the pandemic the attendance within the Macular Treatment Centres (MTC) dropped due anxiety and worries about coming into the hospital for treatment. A Nurse Practitioner was allocated to ring patients the day before their treatment to answer any worries and fears. The nurse explained the measures that were in place to ensure that COVID-19 guidelines were followed within the hospital and the department for their safety. Following the implementation of this there was significant improvement in attendance.

10.33 In response to the Pandemic Emergency Eye Department (EED) established a new pre triage service in a separate location at the entrance of MREH Clinic A to pre triage patients that could be signposted to a community service in order to reduce the footfall of patients within EED. The EED Improvement Board has been working with NHS 111 since September 2020 to ensure that pathways are set up to direct the right patients to EED. Since December 2020 patients phoning 111 are redirected to the telephone triage nurse to assess if an EED visit is needed, the timeframe they should be seen within, or to deflect the patient if emergency care is not indicated. The triage nurse also has the option of booking the patient into a rapid access clinic to be reviewed by the advanced clinical Practitioners. This improves the patient experience by ensuring that patients present to the right place first time.

10.34 COVID Urgent Eyecare Service (CUES) across Greater Manchester was established in response to the pandemic. This service enables community optometrists to telephone triage and potentially see and treat patients in the community without the need to attend EED. The MREH EED Improvement Board has created a set of guidance documents for community optometrists based on the College of Optometrists Guidance and Scottish Community Eyecare guidance and produced a formulary for Independent Prescribing optometrists enabling them to treat a wider range of conditions.

UDHM

10.35 The UDHM introduced a Nurse Led Clinic within the Peter Mount Building to provide patients with sleep apnoea devices. Previously, these referrals were reviewed in a Consultant clinic who would take the dental impressions to enable the splint to be made. Within this nurse led clinic, the dental nurse undertakes the review and clinical photography for skin lesions. This new role released capacity of the consultant led clinic and enabled the hospital to increase activity.

10.36 During the pandemic, completion of the **WMTM** questionnaire was not always viable for all patient attendances. A survey monkey was therefore devised incorporating a selection of the WMTM survey questions; key areas covered infection prevention and control, Communication, Safety and Privacy and Dignity. This was sent to a snapshot of patients including those patients having an 'attend anywhere virtual appointment' and enabled UDHM to receive feedback from all patient groups attending the hospital. Patients fed back that the hospital felt 'COVID safe' and the hospital environment was clean.

Royal Manchester Children's Hospital

10.37 Several initiatives have been implemented to support children, young people and families with the challenges of being in hospital during the pandemic. Examples include:

- Roller Banners at every ward/ department entrance explaining infection control, visiting and social distancing guidance
- The development of a staff resource pack, which includes patient information on the most up to date guidance
- Posters placed in all clinical areas to explain PPE to children, young people and their families.
- Child friendly resources to help explain COVID-19 have been made available such as colouring books and story books
- A visiting exceptions process has been implemented to ensure that families individual needs are recognised during this difficult time
- Parents provided with food and drinks while on the ward to reduce footfall through the hospital and reduce the financial burden on families of providing their own food

10.38 In the Paediatric High Dependency, virtual music sessions were organised for patients with the aim of enabling families to spend quality time together, undertaking a fun activity. This initiative was very well received by families who fed back that having access to these sessions helped to normalise their experience and reduce anxiety. Using music therapy to support enhanced recovery will be taken forward as a longer-term project.

Figure 10: Virtual Music Session

10.39 The RMCH MCS Youth Forum meetings moved to a virtual platform using Zoom at which member shared their experiences during lockdown. This feedback supported RMCH staff to understand what mattered to young people during the pandemic. The Youth Forum also co-developed the MFT Transition of Care Young People Strategy into an animation, which is now being shared with transition services across MFT hospitals and will be available on the MFT website alongside the word version[9].

10.40 A core activity of the Youth Forum is to peer review the work of the **You're Welcome** Champions at MFT, which includes reviewing the clinical areas. The Forum provide

[9] C:\Users\marie.marshall\Downloads\NHS Transitions_FINAL.mp4

young people's insights and suggestions on current work and future developments. Their findings are reported to the appropriate manager from the area under review. Representatives from the clinical areas then attend the Forum to feed back any changes that have occurred as a result of their findings. An example of the findings from a Youth Forum review is provided in **Table 10** below.

Table 10: Example of findings from a Youth Forum Review

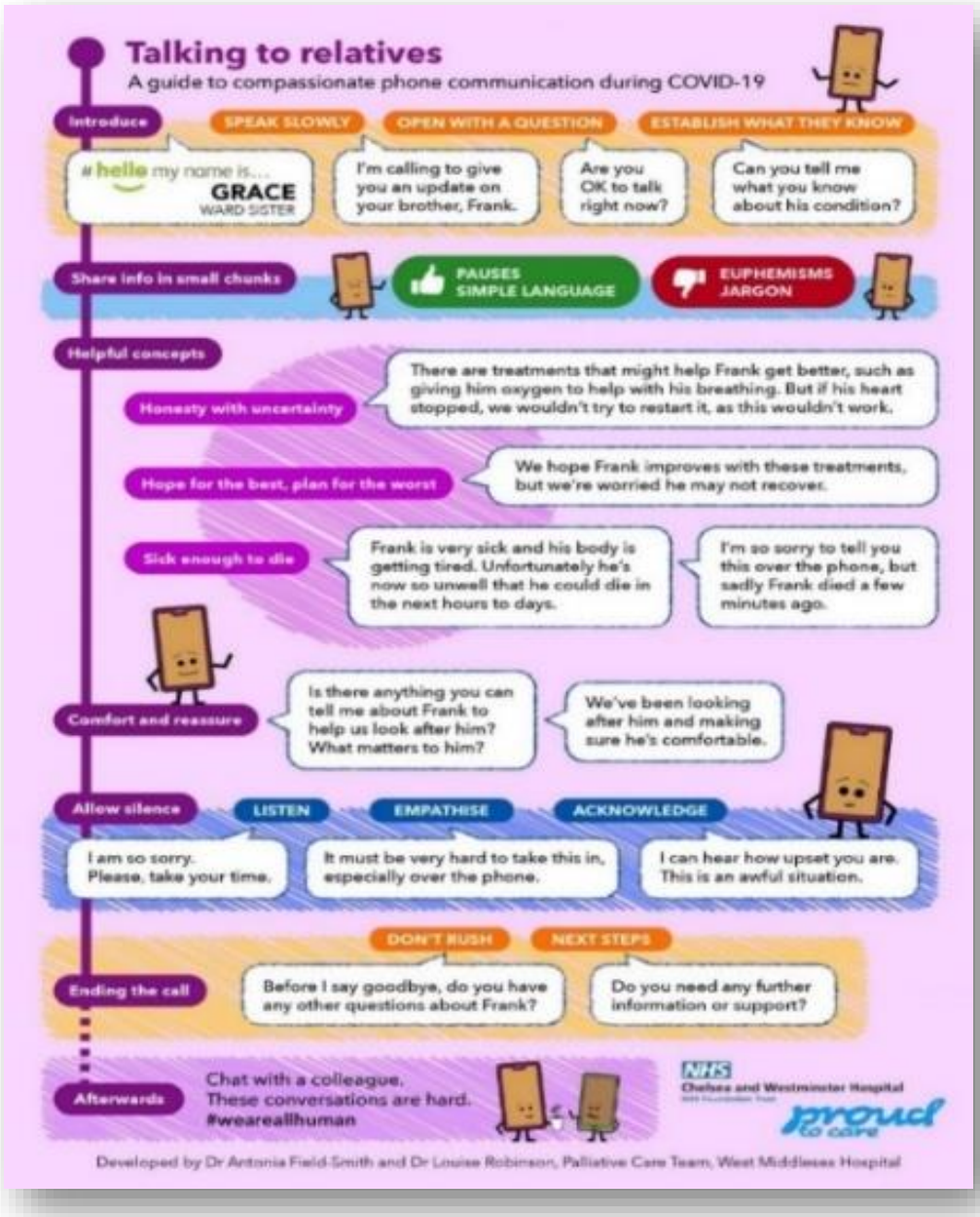
Youth Forum Review findings
What you like about the ward/department? "
• You're Welcome board with information about the You're Welcome Standards and extensive signposting". • "Poster for young people explaining about Rights in Healthcare on You're Welcome Board – NHS YF poster".
Anything you don't like?
• "No – although YF members could not tell where in the department the You're Welcome Board was, is it in an area where easily visible?"
Changes that can be made immediately/inexpensively
• "Can the information leaflets regarding procedures and the personal questions young people are likely to be asked when they arrive be sent in a letter to the young person ahead of their visit?"
Suggested Improvements
• "Liked the space theme, but walls look a bit clinical – maybe brighter painted walls?" • "Could there be a video developed of procedures and machinery used so CYP know what to expect. This could be streamed in the waiting room or use a QR code that can be scanned to a video link."

Figure 11: Youth Forum Poster, RMCH

Manchester Royal Infirmary

10.41 The importance to patients of maintaining contact with family and carers whilst they are in hospital was recognised and, therefore, during the first wave of the pandemic and in addition to the Trust-wide Family Liaison Team (FLT), a separate FLT was established on all COVID-19 wards across the MRI. Initially, a ward communication team pilot project was launched on Wards 45/46 in April 2020 in response to the changes made to the MFT Pandemic Interim Visiting Policy to mitigate challenges in communication with patients' relatives. The pilot demonstrated that this was an extremely valuable resource, providing daily updates to relatives through telephone calls and digital communication methods. The FLT was then established, comprising of redeployed staff, all of whom were provided with training to develop and enhance their skills around communication, holistic care, palliative care and advance care planning conversations. The team worked to a Standard Operating Procedure and used communication models, such as the example shown in **Figure** 12 below, as tools to support interactions with patients and their families.

Figure 12: Talking to relatives Communication Model



10.42 During the second wave of the COVID-19 pandemic, MRI's FLT relaunched with members of staff from the MRI (ward PAs and specialist nurses). The focus of the FLT during this time changed from predominately focusing on COVID-19 areas to non-COVID-19 areas. Activity Co-ordinators on Wards 30, 31 and 32 also adapted their role to incorporate the Family Liaison function within their areas.

10.43 A further improvement programme undertaken by the MRI Team this year was the Complex Patient Programme, which was developed in response to learning from high-level incidents, complaints and coronial recommendations. These data sources highlighted that patients with complex needs, such as those who require the input of multiple specialties require named clinicians (medical and nursing) to be specifically accountable for the continuity of care throughout their stay in hospital. The Complex Patient Work Programme has focused on 3 key principles: to define a criteria for 'complexity' across the hospital; ensure that any patient defined as 'complex' within the hospital has an identified clinical and nursing lead with overall responsibility for the coordination and navigation of care through the hospital and to provide clear expectations and accountability for the medical and nursing lead for identified complex patients. This programme will continue in 2021/22 with a view to improving the patient experience and the quality and safety of care for patients with complex care needs.

Research and Innovation (R&I)

10.44 MFT is at the cutting-edge of research and innovation, enabling the expertise of staff to be utilised in addressing the urgent priorities for research as part of a global, coordinated effort to enhance understanding and develop potential treatments for COVID-19. COVID -19 research studies at MFT, including those designated as Urgent Public Health (UPH) priorities by the National Institute of Health Research (NIHR), were supported and delivered by a multidisciplinary R&I Team, including Clinical and Non-Clinical Research Delivery staff from different research specialities. As of 30th March 2021, 40 COVID -19 studies had opened at MFT with **9,870** participants had been recruited, including coronavirus patients being cared for in MFT hospitals, alongside MFT staff, and adults and children from the wider community.

10.45 UPH studies delivered successfully at MFT include the UK's flagship COVID-19 treatments trial, RECOVERY. Since 4th January 2021, MFT has continuously exceeded the national requirement to recruit a minimum of 10% of patients with coronavirus to the RECOVERY trial – recruiting 14.3% of people admitted to MFT hospitals with COVID-19. Additionally, a leading COVID-19 vaccine study 'ENSEMBLE2', was set-up and coordinated at pace. Colleagues from across R&I came together to deliver the study effectively, exceeding the recruitment target within just eight weeks. In order to deliver the study and following completion of a risk assessment, the team converted a non-clinical area to clinical area, making the necessary arrangements to comply with MFT standards. A member of the R&I team was the first person in the world to be consented to this phase 3 study, which is testament to the efficiency of the entire study.

Figure 13: The MFT ENSEMBLE 2 study team

10.46 The R&I Midwifery Research Team undertook work to enable pregnant women who have raised or borderline blood pressure to continue to be regularly screened for pre-eclampsia without the need for an inpatient admission or visits to hospital up to two or three time per week for blood pressure monitoring. A remote blood pressure monitoring service was introduced enabling the team to triage women's care while they stayed safe at home, and then direct them to come into the hospital as their resulted dictated, or to remain at home with monitoring. Combined with the improved accuracy of diagnosing pre-eclampsia using the placental growth factor (PlGF-based test) meant that fewer women had to be seen in face-to-face clinics, resulting in fewer women being admitted to hospital during the pandemic.

Wythenshawe, Trafford, Withington, and Altrincham Hospitals

10.47 Staff within the Cystic Fibrosis Inpatient unit at Wythenshawe Hospital created a "Sign Language Spelling Bee" to improve patient communication and experience. The idea originated in response to staff **WMTM** feedback. The ward has a group of deaf/hard of hearing patients who usually communicate via lip-reading or an interpreter. Staff emphasised that they wanted to do more to aid communication with these patients as wearing face masks was hindering their ability to lip read. The main aim was to improve patient experience by using the sign language alphabet when communicating with patients who are deaf/hard of hearing, helping to ensure patients feel valued.

10.48 Like other areas, improving communication was pivotal for COVID-19 areas across WTWA. Ward A7 was the first ward at Wythenshawe Hospital to receive patients with COVID-19. Families of these patients were understandably distressed about being unable to visit due to the Trust's Pandemic Interim Visiting policy, which reflected the need to prevent transmission. As a result, Ward A7 received increased telephone calls from families who were worried about their loved ones. Proactively utilising the Family Liaison Team's services to connect patients with their families helped to alleviate worry and concern, and kept families informed of their loved one's health and well-being. In addition, the Ward Clerk established a contact service whereby the nurses attending patients, completed a simple form each morning detailing fundamental aspects of care, such as, if the patient had slept well and what they had eaten for breakfast. The ward clerk then called the patient's next of kin to inform them of these details about their family member. This service helped families to feel more reassured. If the family had any questions, these were returned to the appropriate nurse for clarification.

11. Always Events®

11.1 Always Events® are defined as 'those aspects of the patient and family experience that should always occur when patients interact with healthcare professionals and the health care delivery system'[10]. Always Events® should be reliable processes or behaviours that ensure improvements in the patient experience. As a range of feedback from patients is already collected at MFT the Always Events® process offers a structured methodology to further enhance the MFT **What Matters to Me** Patient Experience Framework and support the Improving Quality Programme with a systematic quality improvement process grounded in service user involvement.

11.2 During December 2019 work was undertaken to establish a framework to support the pilot of Always Events®, laying the groundwork for an initial pilot in three teams/wards/clinical areas within RMCH, the LCO and MRI. An Oversight Group was implemented with membership representatives from stakeholders across each of the hospitals/MCS/LCOs and a representative from Healthwatch. The pilot of Always Events® was scheduled throughout 2020 but was paused on two separate occasions during the Trusts response to the pandemic.

11.3 Ward 84, the pilot area for RMCH, commenced their project in January 2020 with the development of a Point of Care Action Team, including multi-disciplinary representation. Despite being paused on two occasions, this has now progressed to completion. The teenage bay was identified as the first pilot area for the Always Event® on Ward 84 as this patient group and their families already had established relationships with the Teenage Cancer Youth Worker, and regular engagement already took place. The ward worked with patients and their families to consider what improvements could be implemented that mattered to them. 97 responses were provided by families with whom the team engaged, regarding their Experiences of Care. Following analysis of the feedback it was clear that communication was a key element that mattered, and after consideration of further data reflecting the themes it was identified that the provision of daily blood count results, and having a written reminder of their Named Nurse for the day was important. The ward team reflected on the feedback and in partnership with patients and their families, a co-produced vision statement was developed, see **Figure 14 below**. An aim statement was developed to measure the implementation of the Always Event® with measures to sustain an agreed target, see **Figure 15 below**.

Figure 14: Ward 84 Vision Statement

Vision Statement
"I will always receive written daily updates about me/my child's care plan, and this will include information about which Nurse is looking after me/my child each day."

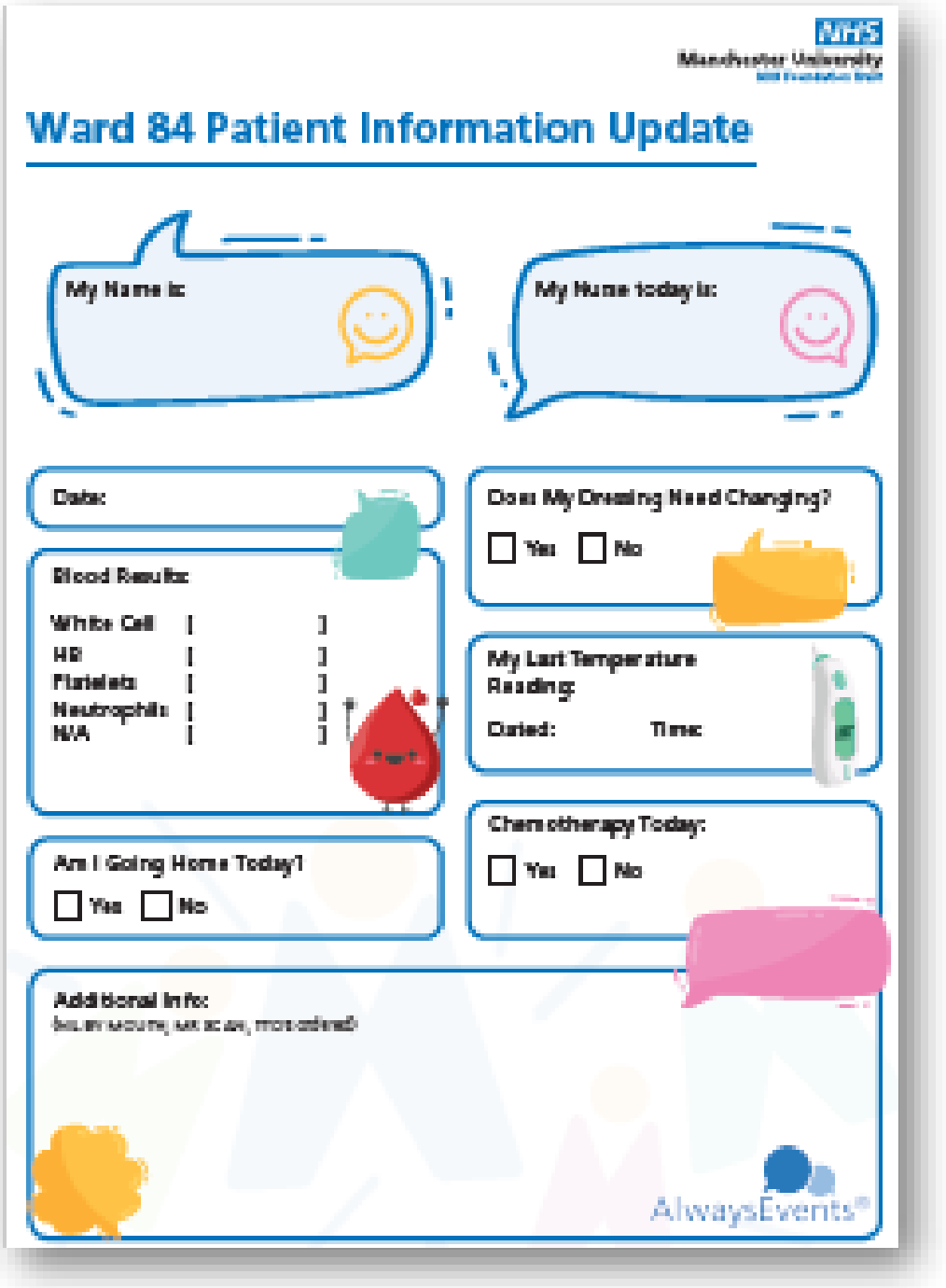
Figure 15: Ward 84 Always Event Aim Statement

An Aim statement was developed to measure if the Always Event was occurring:
By November 2020 90% of patients and parents on Ward 84 will be informed who their named nurse is for the day and we will do this by providing each patient/parent with a Patient Information Update

[10] NHSE (2016) Always Events Toolkit. Available at: https://www.england.nhs.uk/always-events/

11.4 A written communication tool identified as the Patient Information Update (PIU) was developed in partnership with patients, families and staff members in response to Ward 84's vision statement. The PIU outlined key pieces of information patients and families wanted to know daily; this included blood results, dressing and chemotherapy information, as well as any other additional information.

Figure 16: Patient Information Update Communication Tool



11.5 Following its success within the Teenage Bay, the PIU was tested in other areas of the ward before being rolled out to all patients in November 2020. A short experience survey was circulated to all patients, families and staff members to gain their feedback regarding the effectiveness of the tool after implementation. The survey results highlighted the following:

- 99% of patients and their families and 84.5% of staff rated the PIU as excellent or good.
- 80% of patients and their families and 69% of staff said the tool was useful.

11.6 Following the successful implementation of their Always Event®, an NHSE recognition award has been applied for on behalf of Ward 84 and MFT has been selected by the Picker Institute as one of six national case studies for Always Events®. The case study will be launched in July 2021 and will be promoted as a model of good practice on the Picker Institute website and the NHSE Future Collaborations Platform, in addition to being used at future training events by the NHSE Always Events team.

11.7 The second team to commence their Always Event® was the Community Palliative and Supportive Care Team (Central Manchester LCO) in August 2020. The programme engaged with patients and families in their home environment by asking anonymous What Matters to Me questions, in which the team received exceptionally positive feedback, see **Table 11 below.**

Table 11: Community Palliative and Support Care Team patient and family feedback

Feedback received
"The approach of the staff is always outstanding, and they are always at hand and available to visit or phone me. I am treated with great respect and nothing is ever too much for them"
"would find it hard to improve on the care we have had"
"No never had a problem with them. They attended all the appointments and were very helpful with me and my family."

11.8 A Vision statement was developed during telephone discussions with patients and families, with the overall aim being to ensure all patients had contact with a member of the team at least every 28 days. Data was collected prior to and during the pilot period and the patients Always Events Vision was achieved in their first month (December 2020). This programme was subsequently stood down due to the impact of the pandemic until May 2021, but the team remain engaged with the Always Events® programme and have sought to adhere to the aim of their programme. Manchester Royal Infirmary, Ward 45 Haematology, were scheduled to commence their programme in 2020 but due to infection control restrictions as a result of the pandemic, it was agreed by the Oversight Group that this would be postponed and would commence in May 2021, alongside St Mary's Hospital at Wythenshawe, who will be the fourth team to pilot Always Events®.

12. Patient Stories

12.1 In the final section of this annual patient experience report, two patient stories are shared (with the patients' consent), which highlight the ultimate impact of the extensive continuous improvement work that is undertaken across the Trust on patient experience and outcomes.

Jane's Story

12.2 Jane Tasker was initially admitted to Wythenshawe Hospital on 24th March 2021 with COVID-19 and transferred to the Critical Care at MRI on 26th March, where she spent 35 days. During her admission Jane required a tracheostomy and was intubated and ventilated for 17 days. She was stepped down to Ward 46 on 28th April 2021, where she continued her recovery. Jane was very excited to go home and was looking forward to starting to swim again. Her sons Dean and Neil couldn't wait to see her. Jane smiles when she recalls her most vivid hallucination was dancing with Richard Gere wearing a red dress. She planned to watch Pretty Woman with an ice-cold glass of pink gin when she got home. Jane has nothing but praise for all the staff who cared for her throughout her stay. She recalls being called the 'miracle lady' and wants to extend her thanks and gratitude to everyone. In her own words, **'Thank you everybody, I wouldn't be here if it wasn't for you.'** Jane has consented to her information and photographs being shared.

Anthony's Story

12.3 Anthony Lyons was initially admitted on 27th March 2021 with symptoms of COVID-19, after recent travel in Spain. Anthony was intubated and ventilated for 19 days and required critical care for 27 days. Anthony experienced on-going issues with agitation and hyperactive delirium and required a surgical tracheostomy. He was stepped down to Ward 4 on 24th April, where he continued to reach all his rehabilitation goals and was successfully discharged home to his wife Nicki and son Jake on 1st May. Despite initially struggling psychologically to come to terms with his illness and recalling fearful memories of his delirium and of ICU, Anthony is recovering well. He asked the Patient Experience team to pass on his thanks to everyone; '**I am eternally grateful for the hard work and dedication of all the ICU and Ward 14 staff who looked after me at such a difficult time. My family and I are so thankful, and we will never be able to repay you all"**. Anthony recalls being inspired and encouraged everyday whilst in Critical Care to stay focused and to get moving. He shared that without the high energy, passion, motivational spirit (including a morning singing and dancing ritual), he would not be where he is today.

13. Conclusion and Recommendations

13.1 This year the NHS has possibly faced its greatest challenge in its 73-year history as it responded to the COVID-19 pandemic. National patient experience programmes such as surveys and FFT were paused and the Trust's usual work programme and data collection process was disrupted whilst staff were deployed to provide direct patient care. However, MFT staff demonstrated their commitment to continuous improvement by opted into national work and continuing to deliver improvement activity in new and

creative ways. Additionally, the MFT Experience and Involvement Strategy has been launched, setting out the Trust's commitment to the inclusion of patients and service users in the co-design of services, and hospitals/MCS/LCOs have progressed local implementation plans.

13.2 Whilst all NHS National Surveys were stood down, a New Mothers Experience of Care 2020 Survey was developed to help organisations reach out to new mothers who would have been eligible to complete the NHS Maternity Services Survey. MFT was one of 12 organisations to undertake this survey and although comparisons cannot be made against national data, overall women reported positive experiences of care based on the results of the New Mothers Experience of Care Survey (2020), with improvements across most aspects of maternity care based on survey results for comparable questions with the Maternity Services Survey in (2019).

13.3 The Friends and Family Test (FFT) has been modified to increase the quantity of patient feedback and an Always Events® programme has been initiated to further increase the use of patient and service user feedback to support improvement.

13.4 Many patient services were stood down and in the interest of public safely, hospital and care home visiting restrictions were implemented, which had a significant effect on the emotional wellbeing of many patients and their families. A range of support initiatives such as the virtual visiting service were implemented to support patients and their families. Volunteers played an essential role in the response and the Trust is extremely grateful to them for freely giving their time.

13.5 Despite the significant pressures brought about by the COVID-19 pandemic, examples of **'What Matters to Me'** initiatives across MFT have demonstrated the on-going focus on delivering a personalised approach to care. A framework for continuous improvement, informed by external and internal patient experience feedback, continues to be embedded across the Trust, supported by MFT IQP methodology and monitored through the Trust's clinical accreditation programme.

13.6 Data collection recommenced at the earliest opportunity enabling patient experience satisfaction to be monitored, and a work programme has been set out for 2021/22 to support continuous improvement in patient experience.

13.7 The Board of Directors is asked to note the content of this report, recognise the achievements during 2020/21 and continue to support and prioritise the Trust's WMTM patient experience work programme and achievement of the strategic commitments set out in the MFT Experience and Involvement Strategy.

Appendix 1: SMH Action Plan: New Mothers Experience of Care Survey

Action plan: New mother's experiences of care survey 2020

No.	Finding	Action	Progress	Lead Person	Target date	Close Date
1	85% reported being offered a choice of where to have their baby and 82% reported being given enough information about where to have a baby	Develop a leaflet that describes the choices available	Leaflet in development	Consultant Midwife	30/09/21	
		Update the SM Website to provide accurate information on place of birth	Website being updated and will include update details re options for place of birth and links to GM website	Directorate Manager	31/12/21	
		Ensure that the staff are informed of the new leaflet and website resources to support signposting		Antenatal and Community Matrons	31/12/21	
2	65% reported having access to NHS antenatal education	Review the current provision of education and consider all options including online and reintroduction of face to face sessions	Face to face sessions were suspended due to COVID-19	Parent Education Midwives/ Matron	31/08/21	
3	87% reported staff provided a comfortable atmosphere during labour	Utilise WMTM, FFT and QCR data to identify areas for improvement and use the IQP process to address any themes.	Data reviewed monthly to identify themes and support IQP	Ward Managers	31/12/21	

4	97% reported being treated with dignity and respect	Utilise WMTM, FFT and QCR data to identify areas for improvement and use the IQP process to address any themes.	Data reviewed monthly to identify themes and support IQP	Ward Managers	31/12/21	
5	82% reported that concerns were taken seriously	Utilise intentional rounding and What Matters to Me to provide assurance that women's needs are met and use IQP to address any themes identified	QCR data reviewed monthly	Ward Managers	31/12/21	
6	75% reported discharges were completed without delay	Review the discharge process to highlight areas for improvement, including the delays in test results and obtaining medication for discharge		Inpatient Matrons	31/12/21	
7	51% reported that their partner was able to stay with them as long as they wanted	Consider how women can feel supported outside current visiting hours	Individualised plan of care developed as required.	Inpatient Matrons	31/12/21	
		Ensure that all staff feel supported in making decisions that will enable the individual needs of women to be met, including birth partners staying overnight to support the woman.	Individualised plan of care developed as required.	Inpatient Matrons	31/12/21	
8	65% reported having received help and advice from health professionals about their baby's health and progress	Review postnatal processes and information sharing to ensure that advice re baby's health and progress is provided to meet an individual's needs	Postnatal records capture details of information sharing	Inpatient and Community Matrons	31/12/21	
9	79% were provided with relevant information to support feeding their baby 86% reported receiving help and advice about feeding when at home	Ensure that information is available in suitable formats	Leaflets under review Website in development	Infant Feeding Coordinators	31/12/21	
		Ensure that staff attend for infant feeding sessions and updates	Ongoing programme of education and compliance monitored	Matrons	31/12/21	

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Sue Ward, Group Deputy Chief Nurse Emma Orton, Head of Nursing, Quality, Patient Experience and Professional Practice
Date of paper:	September 2021
Subject:	Annual Accreditation/Assurance Report
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Patient and Staff Experience Patient Safety
Recommendations:	The Board of Directors is asked to note the content of the Annual Accreditation/Assurance Report 2020/21 and continue to support delivery of the accreditation programme.
Contact:	Name: Emma Orton, Head of Nursing Tel: 0161 276 4738

Manchester University NHS Foundation Trust (MFT) Accreditation Assurance Report

01st April 2020 to 31st March 2021

1. Executive Summary

1.1 Members of the Group Board of Directors are asked to note the Accreditation/Assurance Report (2020/21) for Manchester University NHS Foundation Trust (MFT).

1.2 The accreditation process is part of the Trust's assurance mechanisms for ensuring the provision of high-quality care and the best patient experience. However, it was necessary to stand down the usual process in 2020/21 due to the need to focus on the Covid-19 pandemic response. Accreditation teams are made up of senior nurses from operational and corporate roles. It was vital that this workforce was focused on care delivery during the pandemic response. Additionally, movement of staff around the Trust's hospital and community services needed to be limited to essential activities in order to minimise the possibility of transmission of Coronavirus.

1.3 An alternative assurance process was designed and ratified by the Nursing, Midwifery and AHP Professional Board to temporarily replace the 2020/21 accreditation programme in order to provide on-going assurance regarding care standards and the quality of patient experience.

1.4 An agreed template was populated with key data by the Directors of Nursing/Midwifery supported by the Group Quality Improvement Team for all clinical areas. Assurance visits were then undertaken by a single Quality Improvement Manager to undertake an assessment of the environment and aspects of practice, such as infection control processes and medications management. The Deputy Chief Nurse then undertook assurance meetings with each Director of Nursing/Midwifery to review the findings for every clinical area to gain assurance and where necessary identify areas for improvement. Areas were not given an outcome score this year, so maintained the score of bronze, silver or gold from their 2019/20 accreditation.

1.5 Findings from the assurance meetings identified that despite the far-reaching impact of the pandemic, where possible clinical areas had continued to implement quality improvement projects and had used the opportunity to review practice and introduce new ways of working. Any areas for attention and improvement that were highlighted in the assurance meetings were already known by the relevant Director of Nursing/Midwifery who were able to offer confirmation that plans were in place to provide the necessary support.

1.6 The usual accreditation process was reviewed and refreshed during 2020/21 and accreditations recommenced in May 2021, with over 200 accreditations to be completed in 2021/22. It should be noted that following considerable changes in environment and personnel, the addition of North Manchester General Hospital, the on-going response to the Covid-19 pandemic and the extensive recovery programme, the 2021/22 accreditation assessments will provide a baseline outcome for many areas of the Trust.

1.7 The Group Board of Directors is asked to note the content of the report.

2. Introduction and background

2.1 The Clinical Accreditation Programme is a process that assesses the quality of care and aims to raise the overall standard of care provided to patients. The accreditation process is part of the Trust's assurance mechanisms for ensuring the provision of high-quality care and the best patient experience. The process is underpinned by the Improving Quality Programme and supported by, the Trust Values, the 'What Matters to Me' (WMTM) patient experience programme and the Nursing, Midwifery and AHP Strategy.

2.2 Data is used extensively to inform the accreditation process; including Quality of Care Round (QCR), WMTM patient survey data and Friends and Family (FFT) data along with local incident and complaints/PALS data, research activity and staff and learner feedback in order to provide a 360 degree assessment of the area.

2.3 Areas that undergo accreditation include inpatient wards, day-case and treatment areas, critical care areas, theatres, emergency departments, dialysis units, community services and outpatient departments. The accreditation assessment process includes the review of a series of defined standards and metrics within wards and departments across hospitals, Managed Clinical Services and community services. During an accreditation the following domains are assessed: Leadership and culture of continuous improvement, communication about and with patients and staff, record keeping, environment along with a range of nursing and administrative processes depending upon the area being assessed. Each area is required to undertake continuous improvement activities, driven by local data, and to display details of their performance and their improvement programme on their local Improving Quality Programme board in order to ensure visibility to patients, families and staff.

2.4 The process for each of the accreditations has been designed to provide consistency of assessment whilst allowing adequate flexibility to adjust the process based on the differences between the clinical areas.

2.5 The accreditation usually involves assessment against agreed standards within each domain, which are scored as Gold, Silver or Bronze. The collated result across all domains provides an overall result for the area. All areas accredited in 2019/20 were awarded an overall result of Bronze, Silver or Gold. The criteria for each of the scores are as follows:

- Gold: Excellent, achieving highest standards with evidence in the data that success sustained for at least six months
- Silver: Very good, achieving minimum standards or above with evidence of improvement in relevant data
- Bronze: Good, achieving minimum standards or below but with evidence of active improvement work
- White: Not achieving minimum standards and no evidence of active improvement.

2.6 Within the accreditation domains, standards are mapped to the appropriate CQC Key Line of Enquiry (KLOE), to support teams to identify if areas are:

- Safe
- Effective
- Caring
- Responsive to people's needs
- Well-Led

2.7 The accreditation process is described in detail in an Accreditation Standard Operating Procedure (SOP). The SOP is reviewed and updated annually to ensure the assessment standards and processes remain current, relevant and evidence-based.

2.8 156 clinical areas were scheduled to undergo accreditation in 2020/21, however, in order to release clinical and managerial capacity to support the Trust's pandemic response and recovery, and to minimise footfall and the risk of transmission of Coronavirus within clinical areas, the usual accreditation programme was paused during 2020/21. In order to maintain assurance regarding the quality of care and patient experience during this time, an alternative process was developed.

2.9 In the temporary assurance process, assurance meetings were undertaken, led by the Deputy Chief Nurse, with each Director of Nursing/Midwifery/Healthcare Professionals to review key indicators across each of their wards and clinical areas. This process was supported by the Quality Improvement Team who populated an agreed template with relevant quality data prior to the assurance meeting. Directors of Nursing/Midwifery/Healthcare Professionals were then required to provide specific information relating to the performance of their wards/clinical areas.

2.10 Strong leadership has previously been demonstrated to correlate with a gold accreditation outcome and was therefore a core part of the assurance assessment. Leadership analysis focused on evidence of progress against a local IQP recovery plan and evidence that actions implemented as part of the Trust's CQC action plan have been sustained.

2.11 The process was underpinned by a walk round by one Quality Improvement Manager of wards/clinical areas where there were gaps in assurance in order to assess the environment of care, including safe and secure storage of medicines, and to observe an agreed nursing process defined through analysis of local data. The findings of the walk rounds were captured on the assurance template in advance of the assurance meeting.

2.12 All clinical areas maintained their 2019/20 accreditation status during 2020/21 and the outcome of the assurance process informed local improvement activity. 2019/20 accreditation outcomes are provided for information at **Appendix 1**.

3. The Improving Quality Programme (IQP)

3.1 IQP is well established as the Trust's methodology for continuous improvement. The process supports staff to review their data, identify areas of concern, identify best practice based on current evidence, implement changes, follow a structured approach using a Model for Improvement and Plan-Do-Study-Act (PDSA) cycles and to ensure that changes are evidence based, measurable, embedded and sustained in practice. IQP enables teams to improve their ward environment and processes, which is intended to 'release time', that can be reinvested in improving quality, safety and the patient experience.

3.2 As a part of the MFT accreditation process, teams are usually assessed on their continuous improvement journey to ensure the best patient and staff experience. Mandated IQP activity was stepped down during 2020 to enable staff to focus on the pandemic response.

3.3 The IQP training programme was reviewed and refreshed during 2020/21 and, in readiness for the transaction in April 2021, the MFT IQP was rolled out across NMGH during 2020/21 through the delivery of an extensive training programme. This enabled the NMGH clinical areas and teams to be well prepared for inclusion in the 2021/22 accreditation programme.

4. Assurance outcomes 2020/21

4.1 This year it has not been possible to undertake the usual triangulation of accreditation outcomes with workforce and quality indicators due to the necessary change in process, the extensive movement of clinical areas and the unusual impact of Covid-19 on workforce indicators.

4.2 In order to offer assurance to the Board of Directors regarding the on-going focus on quality improvement and care standards, this section of the report provides a summary of the assurance findings for each hospital/MCS across the Group.

Manchester Royal Infirmary (MRI)

4.3 Many wards within MRI were reconfigured and relocated during the pandemic response, resulting in changes to the staff and patient cohort, which significantly impacted the reliability of the quality data associated with each ward. In order to strengthen the MRI corporate structure and to enable assurance to be sought through alternative routes, the frequency of meetings to support communication from Ward Managers to the Director of Nursing was increased and a number of additional posts were established; these included: Workforce and Well-being Matron, Patient Experience and Complex Care Matron, Harm Free Care Matron and Quality Improvement and Assurance Nurse.

4.4 The response to the pandemic required considerable changes to the clinical environments. As a result extensive Well Organised Area (WOA) work was undertaken in outpatient departments to support effective infection prevention and control practice.

4.5 In Q2, The MRI 'Back to Better' programme was launched following learning from the pandemic, and many wards participated in a 12 week Improving Quality Programme to undertake a piece of improvement work in their area. Focused improvement continued in relation to patient experience, documentation, communication, and medication safety. A Director of Nursing fellows programme was also introduced to support staff development and enable focused work on fundamental aspects of care. Additionally, letters between loved ones were established along with virtual visiting supported by the Family Liaison team to mitigate the impact of the necessary restrictions in visiting.

4.6 Pressure ulcer management was identified as an area for improvement, particularly with regard to effective documentation and continued education of staff in relation to incident reporting. The documentation of falls and completion of risk assessments within a 6-hour timeframe from admission were also areas of focus. Additionally, improvements were made in processes to support patients with complex care needs, for example those who require the input of multiple specialities or patients living with a learning disability and/or autism. Nutrition continues to be a particular focus of this work.

4.7 Continued work on the safe storage of medications remained evident, with a targeted approach centred around safe use of medications on discharge. This emphasis demonstrated significant improvements for patient safety.

St Mary's Hospital/MCS

4.8 Saint Mary's Hospital (SMH) experienced a number of ward moves, altered patient pathways and staff redeployment, but continued their quality improvement initiatives. Whilst some clinical areas stepped down their focus on WMTM, good examples of improvement work were presented on the quality information boards.

4.9 IQP projects across the outpatient departments were focused around waiting times for patients in response to analysis of complaints data. All inpatient areas focused on medication administration in order to improve medication standards and reduce incidents. During the accreditation assurance meeting it was noted that there was also good evidence of collaborative working across departments. Across the hospital/MCS the clinical areas focused on positive communication and staff wellbeing, with many initiatives in place to support staff wellbeing. Areas introduced initiatives such as a 'Buddy Bench' to support staff as well as mindfulness sessions that were offered to all members of staff.

Manchester Royal Eye Hospital (MREH)

4.10 Despite the changes to patient pathways, stepping down of some services and the deployment of staff to support other areas, MREH continued with many quality improvement initiatives including developing a children and young person's area in response to patient feedback in the MREH emergency department. As part of Emergency Eye Department's response to the pandemic the department established a pre-triage area to filter patients based on their Covid-19 symptoms and their ophthalmic emergency. This process has remained in place throughout the pandemic. The hospital also introduced patient welfare calls to reduce the need for patients to attend follow up appointments in the hospital when appropriate.

4.11 The hospital teams worked with community optometrists to instigate a Covid-19 Urgent Eye Service (CUES), which allows community optometrists to access MREH staff for information to manage patients in the community. Nurse practitioners implemented a telephone triage system to address and responded to the increase in patient calls for information, advice and support during the pandemic. MREH Theatres undertook improvement work in partnership with other departments to improve turnaround time to reduce pre-operative waiting times.

4.12 Other improvement developments included introduction a learning Disability and Autism Specialist nurse to support both adult and paediatric services and introduction of a Nurse-led Corneal Ectasia Virtual Clinic. Notably, the Macular Treatment Centre received a Macular Society Clinical Service of the Year 2020.

4.13 Themes noted through the assurance process as areas for further improvement included implementation of Well Organised Area standards and ongoing work to ensure that standards for medicines storage are consistently met.

University Dental Hospital Manchester (UDHM)

4.14 UDHM was impacted significantly by the Covid-19 pandemic, with a number of dental services being stood down. Dental staff were deployed extensively to support the Trust's pandemic response. This included establishing a Trust-wide Family Liaison Service to support communication and patient well-being whilst visiting was restricted, and deployment to the Nightingale Hospital, North West to undertake new roles.

4.15 Despite the disruption of the pandemic on the hospital, evidence was identified of improvement activity relating to medicines management and staff well-being.

Royal Manchester Children's Hospital

4.16 Many areas within RMCH reconfigured to during the first wave of the pandemic to accommodate the required increased in adult capacity. RMCH staff were redeployed across both RMCH and adult areas, such as critical care. During this time the hospital teams continued to implement improvements. New ward managers completed the IQP training programme enabling them to use data to drive improvement work. A review of Medication Management was undertaken in response to a theme of medication safety incidents across the hospital/MCS. An online education site was developed by the RMCH Emergency Department for staff to keep up to date the latest evidence-based practice. The ManChEWS early warning too was piloted in the Starlight Unit. Infection prevention and control improvement work included the introduction of Klebsiella bundles and action plans across RMCH. Always Events* improvement work continued on Ward 84 in relation to improving communication at discharge for parents and young people.

4.17 Many areas undertook documentation improvement work, including the development of short stay documentation and a trauma training booklet. Nutrition improvement work has continued and included the introduction of snack rounds and nurse involvement in the meals process in line with the Trust's Mealtime standards. Work was also undertaken to introduce a 'Call Order

Kitchen' for oncology patients in response to patient and family feedback. Many staff well-being initiatives have been implemented across the hospital/MCS including 'Feedback Friday', Employee of the Month and access to psychological support.

Wythenshawe, Trafford, Withington and Altrincham Hospitals

4.18 During the Covid-19 pandemic many areas were reconfigured, footprints changed and staff were redeployed. Never-the-less, many staff took the opportunity to attend the IQP training programme where feasible and implement IQP projects to support care standards. These projects included improvement work on documentation standards, which had been identified by ward teams following review of their QCR data. Following the roll out of the IQP programme, areas have seen an overall improvement within documentation standards, which is reflected in QCR data.

4.19 Medication safety projects were implemented by a number of wards who had identified a need for further education. A programme of education and training relating to policies and protocols was implemented to ensure that staff had the knowledge needed to correctly and safely administer medications. Overall, this project led to a reduction in clinical incidents as well as a marked improvement in compliance audit findings. Work is on-going throughout WTWA to support the embedding of IQP as well as work to continue to embed WMTM into the culture of every clinical area.

Clinical and Scientific Services (CSS)

4.20 CSS provides critical care services across the Trust and was significantly impacted by the pandemic response, which required the rapid introduction of new care models, revised patient pathways, training in new treatments and the introduction of environmental changes along with the implementation of research evidence into practice at pace. IQP methodology supported staff to implement the required changes to enable safe care of patients with Covid-19 alongside other patients who required critical care.

4.21 Quality improvement work included examples of extensive work around communication; introducing technology to support communication between patients, staff and families. Work was also undertaken on pressure ulcer prevention, recognising the specific needs of patients with Covid-19. Accreditation assurance visits, underpinned by QCR and WMTM data, noted high levels of cleanliness throughout the clinical areas.

Research and Innovation (R&I)

4.22 During the Covid-19 pandemic response, the Children's Clinical Research Facility was temporarily relocated to the Adult Clinical Research Facility and considerable numbers of nursing staff were redeployed to areas such as critical care and vaccination clinics. Staff continued to provide care to all participants in research trials, introducing telephone contacts to maintain engagement. The teams also supported the delivery of new Covid-19 studies, whilst maintaining a wider portfolio of research.

4.23 Planned improvement work continued, including installation of electronic Patient Status at a Glance boards (PSAG) to improve communication. Well Organised Area (WOA) improvement work was undertaken to support consistency of environmental standards across the two research facilities. The Children's Adventure room was redecorated to suit the needs of young people and zoned areas were implemented to address patient safety and patient flow.

4.24 A Band 6 and 7 development training programme was introduced, which includes opportunities to shadow managers to develop skills in setting up studies. Opportunities are also provided for staff to attend site selection meetings to support the introduction of new studies. Work has also been undertaken to significantly increase the number of student placements within R&I, which has been received positively by staff and students.

5. Accreditation 2021/22

5.1 As noted earlier in this report, following a review and refresh of the Standing Operating Procedure, and a revision of domains that are assessed, the MFT clinical accreditation process recommenced in May 2021. Over 200 clinical areas, including North Manchester General Hospital, will undergo assessment and be allocated an outcome score. 2020/21 will therefore provide an opportunity to re-establish a Trust-wide baseline, recognising that many Ward Managers will not have undergone the process previously.

5.2 In 2021/22, the accreditation process has been further aligned to CQC Key Lines of Enquiry: Safe, Caring, Effective, Responsive and Well-led. Within these domains core aspects of care are assessed, including food and nutrition, privacy and dignity, communication, medications management and safety and environment. Additionally, lines of enquiry have been introduced relating to health promotion. This will support clinical areas to increase their focus on opportunistic health education and promotion and enable signposting in line with the Trust's priority to support improvements in population health.

5.3 It should be noted that the accreditation programme in 2021/22 will be delivered in an altered landscape to the pre-pandemic position, in that it will be managed in the context of the challenges presented by the continuation of significant levels of Covid-19 activity, urgent and non-elective care pressures and an intensive recovery programme alongside considerable reconfiguration of clinical areas. For many areas the 2021/22 outcome will provide a new baseline position.

6. Conclusion and recommendation

6.1 As a result of the impact of the Covid-19 pandemic, it was necessary to implement a revised, less staff intensive, assurance process in 2020/21. The temporary process provided a vehicle to maintain a focus on care standards and ensure that essential improvement activity continued. Assurance meetings involving the Trust's Directors of Nursing/Midwifery/Healthcare Professionals and the Deputy Chief Nurse identified that several clinical areas continued to implement some IQP projects in response to their feedback data despite the challenges of the pandemic.

6.2 Clinical areas were also seen to have implemented new evidence regarding Covid-19 into practice at pace, including the development of new skills, introduction of new patient pathways, introduction of new approaches to communication and significant changes to the clinical environments.

6.3 Where areas for improvement were identified during the assurance process, Directors of Nursing/Midwifery/Healthcare Professionals demonstrated that they were sighted on the issue and were acting to provide the necessary support.

6.4 A plan to undertake over 200 accreditation assessments in 2021/22 through the Trust's usual process commenced in May 2021. Delivery of the accreditation programme this year will be in the context of considerable on-going pressure across all services as the Covid-19 response continues alongside elective recovery and increased non-elective activity. As a result of Trust-wide changes and reconfigurations in ward and department environments and personnel, and growth of the organisation's footprint it should be noted that 2021/22 accreditation outcomes will provide a baseline position for a considerable proportion of clinical areas.

6.5 The Group Board of Directors is asked to note the content of the Annual Accreditation/Assurance Report 2020/21 and continue to support delivery of the accreditation programme.

Appendix 1: Validated Results 2019/20

Manchester Royal Infirmary (MRI):

Manchester Royal Infirmary	
Emergency Assessment & Access	
Name	**2019/20 Validated Result**
Ward 1 & 2 (Previously ESTU)	08.10.19
Ambulatory Care Unit (ACU)	01.10.19
Acute Medical Unit (AMU)	25.06.19
MRI Emergency Department	27.08.19
Surgical Admission Unit SAU (Ward 15)	10.12.19

Cardio- Vascular Specialties	
Name	**2019/20 Validated Result**
Acute Cardiac Centre (ACC - Ward 35)	02.07.19
Manchester Heart Centre OPD	30.07.19
Ward 3	23.07.19
Manchester Vascular Ward (MVC)	09.07.19
Ward 5 MRI	07.01.2020
Ward 4	16.07.19

GI Medicine & Surgical Specialities	
Name	**2019/20 Validated Result**
AM3	02.07.19
AM4	11.06.19
Ward 8	25.06.19
Endoscopy MRI	24.12.19

Ward 11 & 12	25.06.19

In Patients Medical Specialities	
Name	2019/20 Validated Result
AM1	04.06.19
AM2	01.11.19
Ward 6	01.10.19
Ward 30	24.09.19
Ward 31	06.08.19
Ward 32	27.08.19
Ward 44	11.06.19
Ward 45	23.07.19
Ward 46	14.01.2020
Manchester Ward	15.11.19
Haematology Day case	01.10.19
Urology, Renal & Transplant Specialities	
Name	2019/20 Validated Result
Acute Kidney Unit (Ward 37a)	01.10.19
Altrincham Renal Dialysis Unit	07.01.2020
Tameside Renal Dialysis Unit	19.11.19
ETC: Urology	23.07.19
Ward 9 & 10	09.07.19
Ward 36	02.07.19
Ward 37	04.02.2020
NMGH Renal Dialysis Unit (Hexagon)	25.02.2020
MRI Renal Dialysis Unit	27.08.19

Head & Neck Specialities	
Name	**2019/20 Validated Result**
Head and Neck Surgical Unit	**25.02.2020**
Peter Mount OPD	**12.11.19**
Outpatients Clinical Services	
Name	**2019/20 Validated Result**
Diabetes OPD	**12.12.19**
Rheumatology OPD	**01.10.19**
Main OPD including Fracture Clinic	**15.10.19**
Theatres & Elective In-Reach	
Name	**2019/20 Validated Result**
ETC Day case + Surgical Admissions Lounge (SAL)	**30.07.19**
MRI Theatres	**12.12.19**

Clinical and Scientific Services (CSS):

Clinical & Scientific Services Managed Clinical Service	
Name	**2019/20 Validated Result**
Acute Intensive Care Unit (AICU, based Wythenshawe Hospital)	**03.12.19**
Cardiac Intensive Care Unit (CICU previously CSITU, based MRI)	**15.10.19**
Cardiothoracic Critical Care Unit (CTCCU, based Wythenshawe Hospital)	**04.06.19**
CSS OPD (Physiotherapy 1)	**18.02.2020**
Intensive Care Unit (ICU MRI)	**28.05.19**
High Dependency Unit (HDU MRI)	**18.06.19**
High Care Unit (HCU TGH)	**13.08.19**
Radiology Intervention Unit (RADU)	**12.12.19**

Research and Innovation (R&I):

Research & Innovation	
Name	2019/20 Validated Result
Adults Clinical Research	25.09.19
Children's Clinical Research	09.07.19

Manchester Royal Eye Hospital (MREH) and University Dental Hospital Manchester (UDHM):

Manchester Royal Eye Hospital	
Name	2019/20 Validated Result
Ward 55	02.07.19
Day Case Unit (Eye J)	23.07.19
MREH Theatres and Dental Sedation Unit	18.06.19
Emergency Eye Department	11.06.19
MREH OPD	05.11.19
Macular Treatment Centre's	15.11.19
University Dental Hospital of Manchester	
Name	2019/20 Validated Result
Dental OPD	11.02.2020

St Mary's Hospital (SMH):

Saint Mary's Hospital	
Name	2019/20 Validated Result
Ward 47a (MLU)	CLOSED
Ward 47b (MLU)	02.07.19
Ward 62	10.09.19
Ward 63 EGU	02.07.19
Ward 64 (CDU and Triage)	10.12.19
Ward 65	04.06.19
Ward 66	31.12.19

Ward 68 - Neonatal Intensive Care Unit (NICU) (Based at St Marys Hospital)	09.07.19
Antenatal OPD	25.06.19
Enhanced Recovery Programme (ERP)	26.11.19
SMH Gynaecology OPD	14.01.2020
Reproductive Treatment Centre (Ward 90)	26.11.19
SMH Theatres	17.12.19
Birth Centre (Based at Wythenshawe Hospital)	22.10.19
Ward C2	23.07.19
Ward C3	23.07.19
Delivery Suite (Based at Wythenshawe)	19.11.19
Ward F16	01.10.19
Neonates (NNU) (Based at Wythenshawe Hospital)	01.10.19

Royal Manchester Children's Hospital:

Royal Manchester Children's Hospital	
Name	2019/20 Validated Result
Starlight Inpatients (based at Wythenshawe Hospital)	18.02.2020
Starlight Day Case & OPD (Based at Wythenshawe Hospital)	18.02.2020
BMTU and Stem Cell Unit (Ward 84a & 84c)	01.11.19
Children's Resource Centre (based at TGH)	03.12.19
Galaxy House	28.01.2020
Oncology/Haematology Day case (Ward 84b)	26.11.019
RMCH ED	18.02.2020
RMCH OPD	15.10.19
RMCH Theatres	17.12.19
Ward 75	29.10.19

Ward 76 (Short Stay/Day Case)	13.08.19
Ward 77	26.11.19
Ward 78	03.06.19
Ward 80 (Paediatric Intensive Care Unit)	12.11.19
Ward 81 (Burns Unit)	12.11.19
Ward 82 (Paediatric High Dependency Unit)	03.09.19
Ward 83 (TCU)	03.12.19
Ward 84 (Inpatients)	11.06.19
Ward 85	17.09.19

Wythenshawe, Trafford, Withington and Altrincham Hospitals (WTWA):

WTWA	
Wythenshawe Hospital	
Medicine	
Name	2019/20 Validated Result
Acute Medical Unit (AMU)	05.11.19
Clinical Decision Unit (CDU)	07.02.2020
F4	26.11.19
F7	01.10.19
Ward A9	23.07.19
Ward F12	22.10.19
Ward F14	28.05.19
Ward F15	19.11.19
OPAL House	28.01.2020
Wythenshawe ED	18.02.2020

Heart and Lung	
Name	**2019/20 Validated Result**
Acute Coronary Care unit (ACCU)	19.11.19
Doyle Ward	15.11.19
Jim Quick Ward	06.08.19
North West Ventilation Unit (NWVU)	30.07.19
Pearce Ward	04.02.2020
Ward A7	25.06.19
Ward F11: Planned Investigation and Treatment Unit (PITU)	09.07.19
Ward F2 Lung Surgery	29.10.19
Pulmonary Oncology Unit (POU)	24.09.19
Ward F5 + F2 Day Case	25.09.19
Ward F6	30.07.19
Wilson Ward	13.08.19
Surgery	
Name	**2019/20 Validated Result**
Acute Theatres (A Block)	03.09.19
Burns Unit	17.12.19
Theatres (F Block)	14.01.2020
Treatment and Diagnostic Centre Theatre (TDC)	14.01.2020
Ward A1 - Vascular	02.07.19
Ward A2	10.12.19
Ward A3 - Orthopaedics	29.10.19
Ward A4	06.08.19
Ward A5	31.12.19

Ward A6	11.02.2020
Ward F1	03.12.19
Ward F3 - Urology	26.11.19
Ward F9	28.05.19
Trafford General Hospital	
Name	2019/20 Validated Result
Ward 2	09.07.19
Ward 3 INRU	22.10.19
Ward 4	25.06.19
Ward 6	25.02.2020
Ward 11 (Previously Ward 1 Stroke)	10.09.19
Ward 12 MOC and DC	10.09.19
Altrincham Minor Injuries Unit	15.11.19
Altrincham OPD & MREH OPD	05.11.19
Acute Medical Unit (AMU TGH)	08.09.19
Medical Day Unit TGH	12.11.19
Trafford OPD	03.09.19
Trafford Theatres	04.02.2020
Trafford Urgent Care	22.10.19

Manchester Local Care Organisation (MLCO):

Manchester Local Care Organisation	
Name	2019/20 Validated Result
District Nursing Service - Patch 1	22.10.19
District Nursing Service - Patch 2	21.01.2020
District Nursing Service - Patch 3	29.10.19
District Nursing Service - Patch 4	07.01.2020

Gorton & Levenshulme District Nursing Team	**30.07.19**
Stancliffe Road, Northenden & Chorlton Park	**26.11.19**
Forum & Baguley Health Visiting Team	**11.02.2020**
Chorlton, Fallowfield and Whalley Range Community Services	**19.07.19**
School Nursing Team North	**18.02.2020**
Dermot Murphy House	**04.02.2020**
Buccleugh Lodge	**04.06.19**

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Joint Group Medical Director
Paper prepared by:	Sarah Corcoran- Director of Clinical Governance Dr Nicola Anders – Group Associate Medical Director Helen Rogers – Assistant Chief Nurse, Patient Safety and Clinical Governance
Date of paper:	September 2021
Subject:	1. Update on Group Mortality **2.** Update on Harm and Mortality potentially associated with COVID Infections (Hospital Acquired)
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:	Indicate which by ✓ • Clinical Outcomes ✓ • Safety ✓ • Patient Experience✓ • Staff Engagement • Operational Efficiency Measures
Recommendations:	The Board of Directors is asked to note the content of this report
Contact:	Name: Mrs Sarah Corcoran, Director of Clinical Governance Tel: 0161 276 8764

1. Background

1.1. A paper was presented to MFT's Quality and Safety Committee in February 2021, describing the national background and context of hospital onset Covid-19. This paper provides an overview of mortality for the full year 20/21 and Q1 21/22 and a specific focus on mortality associated with COVID-19, Hospital Onset Covid Infection (HOCI).

1.2. Ascertaining the role the acquisition played in the death of the patients has been recognised nationally as challenging and the guidance underpinning the mortality reviews was to identify themes to ensure learning is optimised. The medical teams undertaking mortality reviews at Manchester Royal Infirmary (MRI), Wythenshawe and North Manchester General Hospital (NMGH) confirmed the difficulty in dissecting out the acquisition and avoidable harm from the diagnosis and actual cause of death. It was therefore agreed that the mortality reviews associated with a Covid-19 acquisition would not be determining avoidability, but rather would focus on what learning could be identified. This is aligned with the agreed National approach. This learning is noted in section 6.

1.3. It was acknowledged that more detailed work needed to be undertaken to:

- Bring together a '**single source of information**' from data held by the informatics team, the Medical Examiner's office and the infection prevention team (IPC), which would inform the ongoing work for reporting, undertaking mortality reviews, and written duty of candour
- Agree the **mortality review process** within each Hospital/MCS, to ensure Structured Judgement Reviews (SJRs)[1] included questions on nosocomial infections

Each of these issues are detailed in the paper that follows.

Key Points to Note

- SHMI March 20 – February 21 **91.88** **(<100)**
- There has been a 10.55% increase in overall deaths in 20/21 from usual position
- The Hospital onset Covid infections (HOCI) reporting and review process is agreed and operational
- **Definite** HOCI deaths account for **129** deaths within MFT (including North Manchester General Hospital) between 01/03/20-26/06/21 (**10.2%** of all HOCIs)

<u>Key Messages/Learning from Analysis of Mortality reviews</u>

- Outcomes in line with national performance
- Staff stepped up and managed care well, sometimes outside of their area of expertise
- End of life care was managed well
- Ward changes and patient moves were necessary but complicated and may have contributed to HOCI
- Timeliness of discharge – delays increased the risk of HOCI
- Staffing pressures were recognised
- National guidance for swabbing has changed over the pandemic
- Quality of record keeping needs to improve
- Prolonged stay increases risk of poor outcome

[1] The structured judgement review (SJR) review methodology has been validated and used in practice within a large NHS region. It is based upon the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible.

- SHMI for most specialties in line with requirements – Cardiology and HPB require further scrutiny which is underway
- Infection prevention and control (IPC) reviews linked to the structured judgement review (SJR)/mortality review for those patients who have died with a definite HOCI have been completed for 121/129 patients.

2. Update on Process

2.1. A 'Rapid Decision Group' meeting has been established, with senior members of Informatics, IPC, Patient Safety/Clinical Governance team and the Medical Examiner's office, and a final data set has been agreed. This group has met regularly and driven the development of the data set, the mortality review and the duty of candour processes.

2.2. A process for the reporting, investigation and undertaking of duty of candour on HOCI has been agreed and is underway. All HOCI have now been reported as individual incidents within the Ulysses[2] system with one StEIS[3] report submitted to cover all individual cases.

2.3. The duty of candour process is supported with template letters for personalisation and completion within Hospitals/MCS.

2.4. The Mortality Review Portal and Ulysses System have been updated with required key lines of enquiry in line with National guidance.

2.5. Mortality data is now being sourced differently, detailed later in the paper, to ensure a more contemporaneous approach to understanding outcomes across the Group.

2.6. The Hospital sites have undertaken their reviews and their reports are summarised at section 6.

2.7. Both the Learning from Deaths Committee and the Infection Prevention and Control Committee will receive this report for information and action.

3. MFT Mortality 20/21 – Q1 21/22

3.1. The crude in-hospital death rate for England is 2-2.3% (excluding the London Hospitals which at 1.6% is lower, this is likely to be due to the high volume of specialist services.) The Northwest crude in-hospital death rate is 2.1%, the lowest in England outside of London.

3.2. MFT has the lowest crude non-elective mortality rate in the Northwest, this is largely due to the low death rates in some of our specialist hospitals (Royal Manchester Children's Hospital, Manchester Royal Eye Hospital, Saint Mary's Hospital MCS and University Dental Hospital Manchester). The SHMI[4] is a much more reliable indicator with which to triangulate other information and assess the overall outcome data.

3.3. The rolling SHMI for MFT (March 20 – Feb 21) was **91.88.** Table 1 below presents that data against 4 Shelford Trusts[5] for comparison. These data are based on Hospital Episode Statistics (HES).

[2] Ulysses is the MFT electronic reporting system for the management of incidents.

[3] Strategic Executive Information System – an electronic portal for the reporting of serious incidents to National bodies

[4] The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at trust level across the NHS in England using a standard and transparent methodology. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

[5] The Shelford Group is a collaboration between ten of the largest teaching and research NHS hospital trusts in England of which MFT is one.

Table 1. ***Part Shelford Comparison March 20-Feb 21***

Organisation (provider)	SHMI	Expected number of deaths	Number of patients discharged who died in hospital or	Number of mortalities occurring in the hospital	Number of provider spells	Average comorbidity score per spell	Crude mortality rate	SHMI (in hospital)	Expected number of deaths (in-hospital SHMI)	SHMI (out-of-hospital SHMI)	Expected number of deaths (out-of-hospital SHMI)	Obs.- Exp.
R0A - MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	91.88	2568.5	2360	1642	127911	3.63	1.85%	96.8	1696.2	81.92	876.5	-208
RHQ - SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	101.18	2674.4	2706	1840	88434	4.45	3.06%	106.39	1729.46	90.77	954.02	32
RJ1 - GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	72.99	1448.11	1057	655	64792	4.56	1.63%	72.54	903	72.78	552.31	-391
RJZ - KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	98.75	2339.27	2310	1662	78974	4.48	2.93%	105.69	1572.58	84.02	771.25	-29
RTH - OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	93.08	2884.51	2685	1875	93812	4.33	2.86%	100.56	1864.58	78.58	1030.83	-200

Figure 1b below shows the MFT position against a wider group of Acute NHS Trusts for comparison.

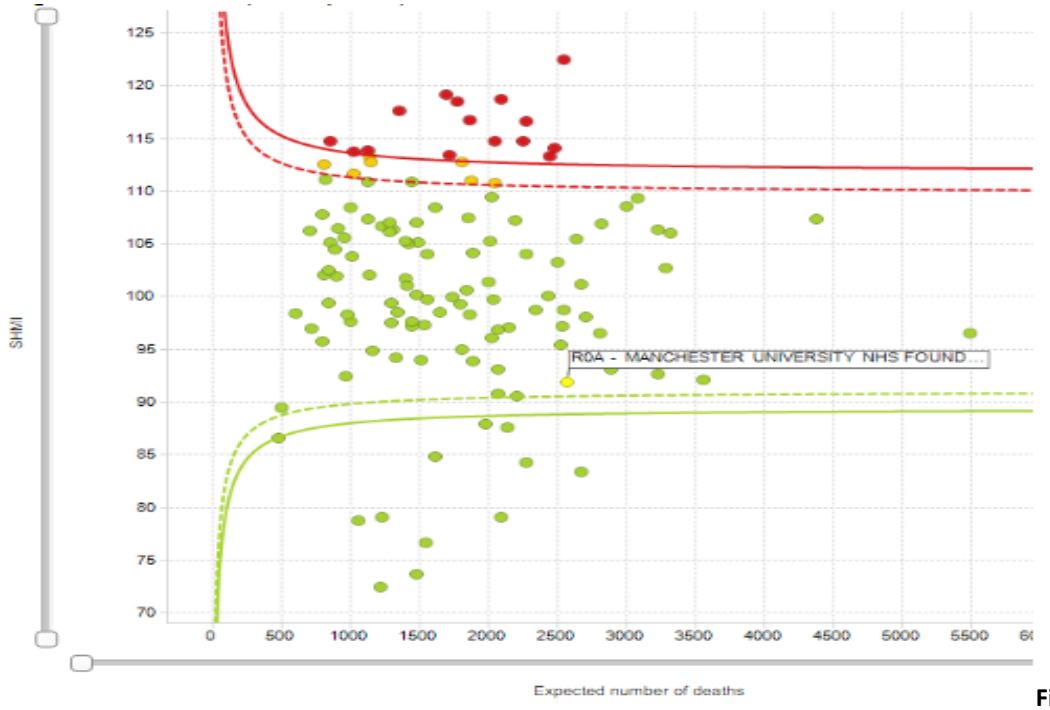


Figure 1b

3.4. **91.88** is below the average 100 and demonstrates that there were less deaths than expected based on risk adjusted analysis of the patients treated.

3.5. To note, the Hospital Standardised Mortality Ratio (HSMR) for the same period is **78.29,** again well within the acceptable threshold. Given the broader scope of SHMI this report will focus on that indicator.

3.6. MFT is now able to review SHMI and HSMR reporting in a much more contemporaneous way, and can look at analysis by site, specialty, ethnicity and other factors. This is being undertaken and will be reported through the Learning from Deaths Committee.

3.7. Table 2 shows the SHMI comparison by site for MFT (please note the site data for Saint Mary's Hospital and the Royal Manchester Children's Hospital have been removed from these data as SHMI is not an appropriate measure for those specialties). These data cover the period March 2020 – February 2021[6] and are taken from NHS Digital Data published March 2021.

Table 2 – ***Site Comparison March 20-Feb 21***

Hospital Site	**SHMI**
Manchester Royal Infirmary	94.02
Wythenshawe Hospital	88.46
Trafford General Hospital	66.25
North Manchester General Hospital	115.1

3.8. The most recent data presented by NHS Digital indicates that the following specialties require further scrutiny, and this is underway.

- Cardiology (Coronary atherosclerosis, heart valve disorders, acute myocardial infarction)
- HPB (Cancer of the pancreas, nephritis, chronic renal failure, liver disease)

3.9. It is worth noting here that it is likely these data will be impacted upon significantly (positively) by the implementation of HIVE in September 2023 and this is currently under review. The impact of documentation of co-morbidities and symptom codes on both the SHMI and HSMR is well documented and in both cases the accuracy of this information is likely to improve. This will significantly aid understanding of mortality and clinical outcomes going forward.

4. Mortality Associated with COVID-19

4.1. Table 3 sets out the actual number of deaths across MFT (including NMGH) the total number of patients who were admitted with a Covid-19 infection, and in the last column the total number of patients who died as a result of the Covid infection

Table 3 – ***Actual deaths and COVID-19 Diagnoses*** (*all Covid-19 infections, hospital and community acquired).

Year	**Total Inpatient Deaths**	**Pts with COVID**	**Pt COVID Deaths***
19/20	3496	134	43
20/21	3865	7247	1571
1st April 21 to 26th Jun 21	624	423	35
Total	**7985**	**7804**	**1649**

4.2. For the entire period reported there were **7804** COVID-19 diagnoses made on admitted patients and **1649** deaths. This indicates a **21.13%** mortality rate for COVID-19 in-patients across all sites.

4.3. For context in the period April 2019 – March 2020 there were **3496** deaths; this increased to 3846 in 20/21, thus an increase of **369** deaths (10.55%) across MFT sites in 20/21.

4.4. COVID-19 deaths in 20/21 accounted for **40%** of all deaths in 20/21 across all sites.

[6] To note, for the period reported NMGH was part of the Pennine Acute NHS Trust and reported accordingly

4.5. Figure 2 shows a comparison of COVID-19 and non-COVID-19 deaths across the period, with the associated peaks in waves 1, 2 and 3 being visible in purple.

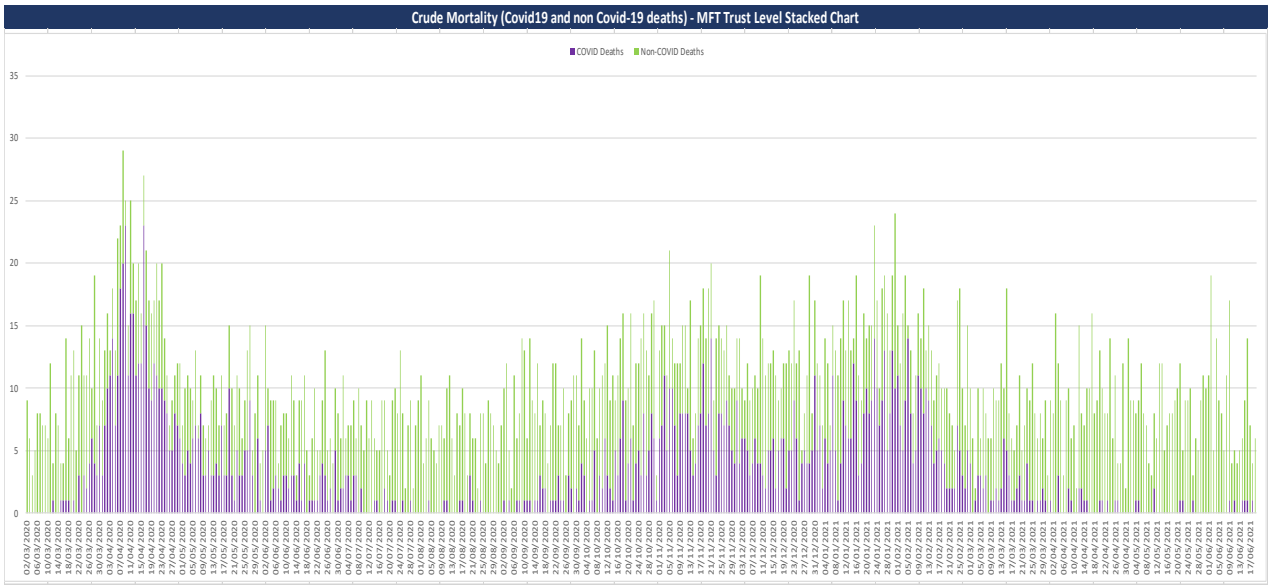


Figure 2 – *COVID-19 deaths and Non-COVID-19 Deaths*

5. Hospital Onset COVID-19 Infection (HOCI)

5.1 A hospital Onset Covid-19 Infection is defined as the first positive Covid-19 swab confirmed 8-14 days after admission (probable HOCI) or greater than 15 days after admission (definite HOCI)[7] . A review of the data for the period 1st March 20 to June 26th, 2021 shows that there were 1,266 patients with a confirmed HOCI from across MFT, including NMGH. There may be additional patients to report who had an interhospital transfer.

5.2 The table below shows the split of the 1266 patients with a confirmed HOCI by site, and with the associated mortality by site. **19.9%** (n=253) of patients with a confirmed HOCI died within 30 days of their diagnosis (All causes of death).

Table 5

Site	HOCI cases by Site	HOCI Deaths by site
Oxford Rd Campus	484	87
Wythenshawe /Trafford	591	111
NMGH	191*	55*
Total	**1266**	**253**

* To 31st May 2021

5.3 Table 6 depicts of those 253 patients who died from a HOCI, the split into a definite or a probable HOCI, according to the previous definition. There were 129 patients across MFT who died from a definitely acquired HOCI, which represents **10.2%** patients from all identified HOCI.

[7] https://www.england.nhs.uk/coronavirus/

Table 6

Site	Definite HOCI deaths by site	Probable HOCI deaths by site
Oxford Rd Campus	53	34
Wythenshawe /Trafford	59	52
NMGH	17*	38*
Total	**129**	**124**

* To 31st May 2021

5.4 It was agreed that Hospitals would undertake local review of each of the 129 definite cases, extract learning and undertake duty of candour Out of the 129 cases, 121 mortality reviews have been undertaken. There are 8 still to complete. Section 6 details the learning from these 121 mortality reviews

6. Learning Report Summary

As part of the Manchester University NHS Foundation Trust (MFT) Group wide approach every definite and probable HOCI case has been reported within Ulysses, where the appropriate scrutiny via the Infection Prevention and Control (IPC) and Structured Judgement Review (SJR) process is being recorded.

For those patients who have died as a result of HOCI, learning has been extracted from the SJR and IPC reviews and areas of good practice have also been identified and detailed below.
Individually drafted Duty of Candour letters will be sent to identified next of kin from each Hospital Medical Director and Director of Nursing. The findings of the SJR and IPC review will inform the content of the letter, whilst also providing a formal apology that the patient contracted HOCI, which sadly led to their death, whilst under our care.

The template letter advises that if the family have further questions, they can get in touch with a given a point of contact detailed within the letter. This will enable monitoring of further contact and direction to the most appropriate clinical team to contact the next of kin and arrange a further meeting to discuss concerns if wished.

6.1 Specific learning related to the pandemic

Asymptomatic carriage and transmission may have been contributed to by:

- Ambulant patients leaving the ward to wander round the hospital or go outside for a smoke
- Dialysis patients requiring transfer to dialysis stations for therapy several times a week. This vulnerable group of patients had increased contact with more members of staff and exposure to other patients.
- Movement of staff between complex patients, particularly if multiple members of staff involved in their care (e.g. clinicians, nursing staff, physiotherapists, occupational therapists)

Inconsistencies in frequency of swabbing advice (which reflected changes in the National policy) were identified and may have contributed to transmission:

- Inconsistencies with swabbing frequency delaying time to isolation
- Moving patients to different wards on multiple occasions increasing the risks of potential exposure. Nightingale wards became a particular issue.

- Site management – inadequate documentation of decisions being made over site management – e.g. concerns raised around Critical Care step down, a patient being taken to a Ward, one of whom, it transpired became a Ward index case

6.2 Other clinical lessons learnt from the reviews

- Nursing of patients with long term conditions such as dementia who cannot understand the need for isolation, may exacerbate their condition and behaviours
- Age was a factor with a number of the ward-based patients who died being considerably older than the critical care patients
- Most patients died as a result of respiratory failure, the commonest causes being pneumonia, pulmonary embolism, and COPD
- Cardiac causes of death were also prevalent, especially coronary artery disease and heart failure
- A temperature over 38 degrees should trigger a sepsis screen including a COVID-19 PCR test
- CURB65[8] (pneumonia scoring does not help in COVID-19 pneumonitis), and an elevated CRP on admission may indicate a poorer prognosis in COVID-19 illness
- Immunocompromised patients formed the bulk of surgical patient mortalities
- There was an early cessation of the majority of surgery, according to Government policy, most of which has now resumed, but is not at previous levels

6.3 Other significant learning from the reviews

- Clinical teams raised concerns around teams covering larger admission areas without an increase in medical or nursing staff. At the time staffing levels were assessed daily to ensure they met requirements.
- Quality of the written record in some cases – these issues are part of an ongoing workstream under 'Fundamentals of Care' work.

Some of the above issues will be resolved with the introduction of the Electronic Patient Record (EPR) via HIVE.

6.4 Learning from good practice

- Decisions on ReSPECT[9] and DNACPR[10] were generally made (appropriately) early during admission
- Staff members stepping up to alter working patterns and cope with huge increase in demand in work and emotional resilience
- Ability to increase critical care bed capacity to cope with surge in demand across the Organisation (including adult patients to RMCH)

[8] CURB-65, also known as the CURB criteria, is a clinical prediction rule that has been validated for predicting mortality in community-acquired pneumonia and infection of any site.
[9] The ReSPECT process creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices.
[10] DNACPR stands for 'Do not attempt cardiopulmonary resuscitation (CPR)'. It means that if a person has a cardiac arrest or dies suddenly, there will be guidance on what action should or shouldn't be taken by a healthcare professional, including not performing CPR on the person.

- Proactive recruitment of patients into clinical trials for different treatment options – brought MFT into forefront of COVID-19 treatment
- Outstanding support from palliative care teams was given to many patients, staff and families

7. Summary Learning and Conclusion

7.1. The review noted the following:

- Advanced age, frailty, significant comorbidity, alcohol related liver disease, obesity, diabetes, smoking, renal failure and raised CRP all impact on mortality
- Delayed discharge and the patients most susceptible to that (those often termed as 'complex discharges') are at increased risk of nosocomial infection
- National evidence suggests patients with a recognised learning disability have poorer outcomes
- Patient moves, patient outliers, patient placement and tertiary referral processes contribute to nosocomial infection rates
- Environment and bed space are contributory factors
- Some patients are admitted with COVID-19 symptoms but have a negative swab, they have a positive swab at a later date, this may cause some wrongly attributed nosocomial infections
- Consistent compliance with PPE requirements has been identified, particularly for staff in clinical areas not providing direct patient care
- Sustained rise in community transmission was accompanied by an increase in HOCI
- Asymptomatic cases remain a significant challenge
- Availability of PCR testing for staff in early phases of the pandemic challenged the diagnosis of asymptomatic carriage

The depth of knowledge gleaned from the reviews has enabled the Trust to address the duty of candour owed to each of the families and loved ones of the patients affected by Hospital onset COVID-19 and established a process going forward to ensure learning is shared and acted upon and real time analysis and reporting of each case can be undertaken until such time as this is no longer needed.

7.2. The process of review will now continue with the process agreed and in place for ongoing review of all patients who die and are identified as having acquired COVID-19 as an inpatient. The acquisition data suggests these numbers are decreasing and the aim is to eradicate HOCI.

7.3. The next significant piece of work will be the agreement and completion of the process for *probable* HOCI and duty of candour. This will be built upon the work already completed for definite HOCI and it is anticipated that this will be complete by Q3 despite the greater numbers involved.

8. Recommendation

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

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Joint Group Medical Director
Paper prepared by:	Cameron Chandler, Professional Standards Manager
Date of paper:	September 2021
Subject:	Annual Report to the Board of Directors: Management of Medical Appraisal and Revalidation
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	The issues contained in this report have an impact on medical staff engagement, quality improvement and organisational reputation
Recommendations:	The Board of Directors is asked to note the contents of this paper, progress made to date and the challenges to be faced in the coming year. The Board of Directors is asked to approve submission of the Annual Statement of Compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013), signed on behalf of the designated body by the Group Chief Executive Officer (Appendix 2).
Contact:	Name: Miss Toli Onon, Joint Group Medical Director Tel: 0161 701 0205

1. Executive summary

This report describes the progress of the Trust over the last financial year in the management of medical appraisal and revalidation.

Summary of key points:

- at the end of the last appraisal year (31 March 2021), MFT had 1,920 doctors with a prescribed connection plus an additional 86 dentists
- 93.4% of connected doctors had an appraisal within the year
- the Quality Assurance of the process is subject to ongoing review and appraisers are being trained or refreshed to ensure they all meet the required standards
- appraisers were rated as Very Good or Good by 98% of appraisees who submitted feedback
- medical appraisal and revalidation were amended to streamline the system due to the COVID-19 pandemic
- the Trust has been requested to submit a signed Statement of Compliance to NHS England for 2020/21

2. Purpose of the paper

The purpose of this report is to:

- summarise the Trust's performance in relation to medical appraisal and revalidation for the period April 2020 to March 2021
- provide assurance to the Board that the Trust is compliant as a designated body for medical revalidation, continues its pursuit of quality improvement, and that the Responsible Officer (RO) is discharging their statutory responsibilities

3. Background

Revalidation was formally launched in the UK in January 2013 and is the process by which all licensed doctors are required to demonstrate, on a regular basis, that they are up to date and fit to practise in their chosen field and able to provide an appropriate standard of care. The process of revalidation seeks to give extra confidence to patients, the public and the profession that the doctor is being regularly checked by both their employer and the General Medical Council (GMC). Licensed doctors must revalidate usually every five years, part of which is the requirement to have an annual appraisal based on the GMC's Good Medical Practice framework[1]. The Trust's appraisal and revalidation process is managed operationally by the team of the Responsible Officer (RO); a role established in statutory legislation[2] and currently undertaken by Miss Onon. The RO's role is supported by Professor Daniel Keenan and Dr Emma Hurley, Group Associate Medical Directors for Appraisal and Revalidation, in addition to the Chief of Staff, Professional Standards Manager and the Revalidation Admin team.

The revalidation process is based on a recommendation from the RO to the GMC, the regulator making the final decision about the revalidating of a doctor. In order to make this recommendation, the RO must be assured that:

- the doctor has a track record of engagement with annual appraisals consistent with the guidance on strengthened medical appraisal and has been appraised on the full scope of their practice (including the independent sector) at a single appraisal meeting

[1] http://www.gmc-uk.org/static/documents/content/GMP_pdf
[2] The Medical Profession (Responsible Officers) Regulations 2010, amended 2013

- any concerns about the doctor raised through the appraisal have been brought to the attention of the relevant medical line manager and successfully addressed
- the doctor has undertaken a multisource feedback evaluation of their work and professional behaviour, including feedback from both colleagues and patients, and that this has been discussed with their appraiser (one formal multisource feedback per five-year revalidation cycle)
- there are no outstanding concerns about the doctors' performance or professional conduct known to the Trust

Options available to the RO are to recommend revalidation, defer the recommendation for a period of up to 12 months (either due to insufficient information for a positive recommendation or because the doctor is subject to an ongoing process), or to notify the GMC of the doctor's non-engagement with the process.

4. Designated body

Manchester University NHS Foundation Trust is a designated body, as established in the Responsible Officer Regulations; this also determines which doctors should be connected to the Trust for appraisal and revalidation. At 31 March 2021 (the end of the last appraisal year), 1,920 doctors were connected; 1,280 Consultants, 94 SAS grade doctors, 537 temporary and short-term contract holders (including Clinical Fellows) and 9 other doctors (such as Clinical Trial Physicians). There was an increase on the previous year of 84, primarily comprising new Consultants.

Doctors who work jointly within the Trust and the University of Manchester in an academic position are required to undergo a joint appraisal under the Follett Principles. These doctors connect to the Trust for revalidation. Additional doctors who work for the Trust, who are not connected for appraisal and revalidation, include GPs (who connect to one of the NHS England local teams), and doctors who undertake work at MFT but also with another NHS organisation, who is their main employer and designated body. Despite not connecting directly with these doctors, the Trust still has an obligation to monitor their fitness to practise and report any concerns to the doctor's RO. Doctors in a training grade are appraised and revalidated separately by Health Education England.

Although North Manchester General Hospital (NMGH) entered a management agreement under MFT on 01 April 2020, NMGH remained as part of the Pennine Acute designated body for the purpose of medical appraisal and revalidation throughout the year ending 31 March 2021.

5. COVID-19

Medical appraisal was halted from 19 March 2020 due to the COVID-19 pandemic; this was in response to guidance issued by Professor Stephen Powis, National Medical Director for NHSE/I. The medical appraisal process at MFT recommenced in July 2020 with support from NHSE in line with the national expectation that the process recommenced by October 2020. All MFT connected doctors were written to by the Group Associate Medical Directors outlining the steps to be taken and when appraisal should be scheduled, the expectation was that everyone undergoes an appraisal by 31 March 2021 unless an approved deferral, for instance due to maternity leave or similar, applies. The appraisal process was amended to have a 'lighter touch', with less supporting evidence required to be presented and more of a focus on reflection and development. A new portfolio section was also included to reflect on work and any changes to this due to COVID-19, to include any positive and negative experiences, achievements and any learning that resulted.

6. Revalidation

For the appraisal year 01 April 2020 – 31 March 2021, only 12 doctors were due to be revalidated, due to an initial pause in revalidation by the GMC and subsequent deferral of all revalidations due up to 31 March 2021 by one year, because of the pandemic. Of these, all 12 doctors were recommended for revalidation with zero deferrals; all recommendations regarding revalidation have been approved by the GMC.

Due to the pause of revalidation, a greater number of doctors are due to be revalidated this year (01 April 2021 – 31 March 2022) with 628 due in total.

7. Appraisal

All doctors must ensure that they undergo appraisal within each financial year and are responsible for the continuous collection of their portfolio of evidence covering their full scope of practice. For medical staff who are registered with the GMC as well as the General Dental Council, continued engagement with appraisal is necessary over the course of the five-year revalidation cycle.

At 31 March 2021, 1,920 connected doctors were due to have an appraisal within year (01 April – 31 March). The appraisal rate for the 2020-21 appraisal year is as follows (Table 1):

Table 1. Number of medical appraisals at MFT during 2020-21

Group	Connected	(1) Completed appraisal	(2) Approved incomplete or missed appraisal	(3) Unapproved incomplete or missed appraisal
Consultants	1,280	1,229 (96%)	50 (4%)	1 (0.1%)
SAS	94	87 (93%)	5 (5%)	2 (2%)
Temporary or short-term contract holders	537	469 (87%)	67 (13%)	1 (0.2%)
Other	9	9 (100%)	0 (0%)	0 (0%)
Total	**1,920**	**1,794 (93.4%)**	**122 (6.4%)**	**4 (0.2%)**

Category definitions (as established by NHS England)[3]
1: Appraisal held within year
2: Appraisal not held or completed within year with approval from the RO (e.g. maternity leave)
3: Appraisal not held or completed within year without approval from the RO

8. Revalidation management system

The SARD appraisal software was launched in April 2019 with all medical appraisals held via this system. The single software across all sites has enabled the Managed Clinical Services working across multiple sites to have all their staff within one single system, and Hospitals and MCS are able to report directly from this. This has also removed the need to use two separate systems for multisource feedback as this can also be done via the SARD system. Medical Directors and other clinical managerial staff can view and report on the staff within their hierarchy level and monitor appraisal progress directly. The system can be developed individually for each sub-group of users within the organisation allowing MFT to tailor the system for specific requirements; providing a bespoke appraisal portfolio for each clinician according to their role and specialty, so that only the relevant information is requested to be submitted.

[3] england.nhs.uk/revalidation/qa/

9. Appraisers

The Trust has a responsibility to support appraisers in the maintenance and development of their skills, to assure the quality of medical appraisals, and to ensure that appropriate resources are available to support this. Those who undertake medical appraisals for the Trust mut be adequately trained in this role. Refresher training should be undertaken every one – three years, since September 2020 these have been held virtually facilitated by the Group Associate Medical Directors. Work has also started with OD&T to produce an online appraiser training module which will be supported by a shorter facilitated session. During the 2020/21 appraisal year, 368 of the 570 appraisers attended an appraiser training session; 518 of the appraisers are currently in date with training. Of the 52 not currently compliant, 23 are booked onto an upcoming training session. The remaining 29 are being written to, to confirm if they wish to book on to a training session or come off the appraiser list if not.

10. Appraisee feedback

Following each completed appraisal, appraisees are asked to submit feedback regarding their appraisal, appraiser, and the overall process. For the last appraisal year, a total of 1,276 feedback responses were received. Individual reports for each appraiser are collated and added to their appraisal portfolios for discussion at their own appraisal. Of the responses received:

- 90% rated their appraiser overall as Very Good and a further 8% as Good
- 72% Strongly Agreed that their appraisal discussion was important in their professional development and 22% Agreed
- 69% Strongly Agreed that the overall administration of their appraisal had been satisfactory and 27% Agreed

11. Quality assurance

The need for a robust Quality Assurance (QA) process for appraisal as part of the Medical Revalidation process is self-evident, but also explicitly expected by both NHS England, as the Senior Responsible Owner of the revalidation process, and the GMC. A need for oversight of both appraisers and appraisal outputs is necessary to ensure a consistent, effective, and constructive appraisal system, benefiting both the doctor's development and the Trust assurance processes.

Appraisers are responsible for ensuring the quality of the appraisal outputs for the appraisals they undertake. They must ensure that both the appraisal summary and the Personal Development Plan (PDP) adhere to the required standards. Feedback is requested from doctors following an appraisal; this information is collated and used to assist appraisers with their development and gives an indication of how the process is progressing.

An appraisal quality tool ASPAT (Appraisal Summary and PDP Audit Tool) developed by NHS England has been incorporated within SARD so that a random sample of appraisals can be audited online to assess the quality of the appraisal process. The process for this is currently being developed with an aim to audit a representative sample of all outputs.

Appraisal and revalidation are covered by the Trust's Revalidation and Appraisal Policy for Medical and Dental Staff (November 2018). Compliance and quality assurance are also monitored via the Appraisal and Revalidation Group which meets quarterly with clinical and managerial representatives from each Hospital / MCS, Medical Education, and Workforce in addition to the Group Revalidation team.

An internal audit of all appraisal processes (medical and non-medical) was undertaken by KPMG which had an outcome of significant assurance with one improvement opportunity concerning the recording of supporting information. Specifically, this referred to a lack of continuing professional development (CPD) information in a small sample of reviewed appraisals and a failure to record mandatory training compliance.

- CPD: This may be due to reduction of this area of activity by the GMC in their response to the pandemic (see Section 5). To ensure compliance however, this is being emphasised in subsequent training for appraisers to ensure that they do look for adequate CPD in appraisal portfolios
- Mandatory Training: During the year, this has been clarified and streamlined for medical colleagues, and is tracked through the Learning Hub. Core training needs to be recorded in annual appraisal and we will be emphasising that in our appraiser training. Additionally, automated transfer of training records into SARD is being explored to reduce the burden associated with the collection of such data

12. Summary and future challenges

Despite the challenges of COVID-19, appraisal for consultants and other permanently employed clinicians are still being completed at a sufficient rate. Although the appraisal compliance for clinical fellows and doctors transferring from abroad in particular is gradually increasing, work is still required to ensure that this group is not overlooked and is fully supported and engaged with the appraisal process. This is complicated by the fact that many of these doctors have fixed term contracts of relatively short duration. The roll out of appraiser allocation by Hospital sites as aided this increase in compliance, and further work is being taken in conjunction with Medical Education to closer align the work of Educational Supervisors and the Revalidation team.

Work is also continuing to ensure that the processes for all doctors in MFT are aligned and consistently applied, following the acquisition of NMGH, and to support the doctors who have transferred. A successful migration of all appraisal data from their previous system to SARD has taken place.

13. Recommendations

The Board of Directors is asked to note the contents of this paper, progress made to date and the challenges to be faced in the coming year. The Board of Directors is asked to approve submission of the Annual Statement of Compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013), signed on behalf of the designated body by the Group Chief Executive Officer (Appendix 2).

Appendix 1 – MFT Appraisee Feedback 2020-21
Total responses: 1,276

1: The Appraisal Process		Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Don't know	Not Reported
1a	The Appraisal Policy is clear and comprehensive	20	13	78	589	564	5	7
1b	I knew what to expect from the appraisal process	20	11	48	555	625	1	16

2: The Appraiser		Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Don't know	Not Reported
2a	My Appraiser listened to and reflected what I said to him/her	14	0	2	171	1083	0	6
2b	My Appraiser was supportive	14	0	3	124	1127	0	8
2c	My Appraiser gave me constructive advice and helpful feedback	14	0	6	160	1081	0	15
2d	My Appraiser helped me to think about new areas for development	14	1	19	245	976	1	20
		Very poor	Poor	Average	Good	Very good	Don't know	Not Reported
2e	My Appraiser's preparation for the appraisal was	1	0	11	194	1060	4	6
2f	My Appraiser's skills in appraising me were	1	0	4	152	1107	1	11
2g	Overall I rate my Appraiser as	2	0	8	103	1144	1	18

3: The Appraisal Discussion		Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Don't know	Not Reported
3a	My Appraiser regularly referred to my portfolio of supporting information	6	1	6	310	946	0	7
3b	My Appraiser reviewed progress against my last PDP (where available)	5	0	17	258	973	13	10
3c	My Appraiser challenged me to make me think about my practice and development	6	0	32	298	930	1	9
3d	My new PDP is an accurate reflection of the priorities for my development	5	0	13	256	990	2	10
3e	My Appraisal discussion was important in my professional development	7	5	43	279	914	4	24

4: The Administration of Appraisal		Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Don't know	Not Reported
4a	The allocation of my Appraiser was straightforward	9	16	35	339	867	6	4
4b	I was given the required notice of the date of my appraisal	8	11	25	320	904	1	7
4c	The arrangements (room, length, interruptions etc) for my appraisal were satisfactory	7	1	24	298	935	5	6
4d	I had access to the supporting information which I required for my portfolio	7	7	19	346	889	3	5
4e	I understand how this appraisal contributes to the process of my Revalidation by the GMC	7	2	21	340	890	3	13
4f	Overall the administration of my appraisal has been satisfactory	6	1	16	349	886	0	18

Appendix 2

Classification: Official

Publications approval reference: B0614

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

Annual Organisational Audit (AOA):

At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their annual Board report and Statement of Compliance.

Board Report template:

Following the revision of the Board Report template in June 2019 to include the qualitative questions previously contained in the AOA, the template has been further updated this year to provide organisations with an opportunity to report on their appraisal data as described in the letter from Professor Stephen Powis.

A link to the letter is below:

https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/

The changes made to this year's template are as follows:

Section 2a – Effective Appraisal

Organisations can use this section to provide their appraisal information, including the challenges faced through either pausing or continuing appraisals throughout and the experience of using the Appraisal 2020 model if adopted as the default model.

Section 2b – Appraisal Data

Organisations can provide high level appraisal data for the period 1 April 2020 – 31 March 2021 in the table provided. Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested is enough information to demonstrate compliance.

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.[1] This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

Statement of Compliance:

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board of Manchester University NHS Foundation Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: None Comments: Miss Toli Onon (3442971) Action for next year:

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: None Comments: Action for next year: None

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: None Comments: Action for next year: None

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: None Comments: Action for next year: None

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: Liaise with comparably large, multi-site organisation to arrange peer reviews. Comments: Prevented from undertaking due to the pandemic. An internal of all appraisal processes (medical and non-medical) was undertaken by KPMG which had an outcome of significant assurance with minor improvement opportunities. Action for next year: Liaise with comparably large, multi-site organisation to arrange peer reviews.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: None Comments: Action for next year: None

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

Action from last year: None

Comments: The appraisal process was amended to have a 'lighter touch', with less supporting evidence required to be presented and more of a focus

on reflection and development. A new portfolio section was also included to reflect on work and any changes to this due to COVID-19, to include any positive and negative experiences, achievements and any learning that resulted.

Action for next year: None

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: None

Comments: Appraisal postponement forms are requested prior to any approved deferment or missed appraisal, excluding maternity leave and long-term sickness as these are reported from HR. An escalation process for non-approved appraisals

Action for next year: None

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: None

Comments: Policy last ratified November 2018; due for renewal by November 2021

Action for next year: Ensure medical appraisal policy is reviewed and ratified within the appropriate timescale

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: None

Comments: Current ratio is approximately 1 appraiser for every 4 doctors

Action for next year: None

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

Action from last year: None Comments: Action for next year: None

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: Ensure ASPAT has been launched in SARD and a significant sample of appraisals audited. Comments: ASPAT functionality has been developed within SARD and recently gone live. A process for this is currently being developed with an aim to audit a representative sample of all appraisals Action for next year: Ensure a representative sample of all appraisals are audited.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2021	**1,920**
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	**1,794**
Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021	**126**
Total number of agreed exceptions	**122**

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: Ensure all recommendations are made on time

Comments: For the appraisal year 01 April 2020 – 31 March 2021, only 12 doctors were due to be revalidated, due to an initial pause in revalidation by the GMC and subsequent deferral of all revalidations due up to 31st March 2021 by one year, because of the pandemic. All recommendations were made on time.

Action for next year: None

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: None

Comments: Confirmation letters are sent to all doctors who have a positive revalidation recommendation submitted. Those whose recommendation is deferred are contacted prior to this, to check for any the outstanding information (if applicable), and doctors are notified of the intention to defer. Those who might have a non-engagement recommendation submitted will have had multiple communications from a Group Associate Medical Director explaining the consequences of non-engagement and the actions they need to complete to avoid this

Action for next year: None

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: None

Comments: MFT has good governance systems in place, confirmed by CQC full inspection report March 2019

Action for next year: None

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Continue discussions with Ulysses to link systems

Comments: SARD are happy to link to Ulysses but need to obtain agreement from Ulysses. There is a strong reporting culture with feedback to staff. Sharing of relevant information with doctors can be improved. Work on this was prevented from being undertaken due to the pandemic.

Action for next year: Work with SARD to develop links with Ulysses.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: None

Comments: Policy for managing concerns about doctors ratified December 2018, due for renewal December 2021.

Action for next year: Ensure policy for managing concerns is reviewed and ratified within the appropriate timescale

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: Embed Empactis case management system

Comments: Roll out of Empactis for case management has been delayed due to COVID; work has recommenced and should be completed this year.

Action for next year: Embed Empactis case management system

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: None Comments: Transfer of information process within NHS is managed by Appraisal Administrator and Professional Standards Manager. Sharing of information with 2 main private providers in locality is managed by RO and Group AMDs for professional matters. Action for next year: None

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Monitor and report on management of doctors of concern, including protected characteristics Comments: Work on this has been prevented by the pandemic. Work is currently being undertaken to assess the medical workforce in line with the WRES and monitor the protected characteristics of doctors involved in an ongoing process and GMC referrals, and those who have deferral recommendations made to the GMC. This will be further enabled by the roll out of the Empactis case management module. Action for next year: Monitor and report on management of doctors of concern, including protected characteristics

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: None Comments: Action for next year: None

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 6 – Summary of comments, and overall conclusion

- General review of last year's actions

- Actions still outstanding:
  - Liaise with comparably large, multi-site organisation to arrange peer reviews
  - Liaise with IT system supplier for SARD to develop e-link to Ulysses (incident reporting system) to facilitate transfer of information for doctors' appraisals
  - Embed Empactis case management system
  - Monitor and report on management of doctors of concern, including protected characteristics

- Current issues

- New actions:
  - Ensure medical appraisal policy is reviewed and ratified within the appropriate timescale
  - Ensure a representative sample of all appraisals are audited.
  - Work with SARD to develop links with Ulysses
  - Ensure policy for managing concerns is reviewed and ratified within the appropriate timescale.

Overall conclusion:

Despite the challenges of COVID-19, appraisal for consultants and other permanently employed clinicians are still being completed at a sufficient rate; Although the appraisal compliance for clinical fellows and doctors transferring from abroad in particular is gradually increasing, work is still required to ensure that this group are not overlooked and are fully supported and engaged with the appraisal process. This is complicated by the fact that many of these have fixed term contracts, The roll out of appraiser allocation by Hospital sites has aided this increase in compliance, and further work is being taken in conjunction with Medical Education to closer align the work of Educational Supervisors and the revalidation team.

Work is also continuing to ensure that the processes for all doctors in MFT are aligned and consistently applied, following the acquisition of NMGH, and to support the doctors who have transferred. A successful migration of all appraisal data from their previous system to SARD has taken place.

Section 7 – Statement of Compliance:

The Board of Manchester University NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Manchester University NHS Foundation Trust

Name: Sir Mike Deegan Signed: 

Role: Group Chief Executive

Date: 13th September 2021

NHS England and NHS Improvement
Skipton House
80 London Road
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This publication can be made available in a number of other formats on request.

Publication approval reference: PAR614

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Joint Group Medical Director
Paper prepared by:	Vanessa King, Solicitor, MFT Legal Services
Date of paper:	September 2021
Subject:	Manchester Arena Public Inquiry
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/patient experience
Recommendations:	The Board of Directors is asked to note the content of this report.
Contact:	Name: Michelle Lindup, Head of Legal Services Tel: 0161 276 4023

Trust Position Statement

Background

The Board will be familiar with the tragic circumstances giving rise to the Manchester Arena Inquiry in which on 22 May 2017, 22 victims (plus one attacker) died, and more than 800 were wounded.

Of the 22 victims who died during this attack, three victims died at Hospitals under the management of the Trust, Royal Manchester Children's Hospital (RMCH) and Manchester Royal Infirmary (MRI).

Of the above three victims, the circumstances around the care of SRR, who died at RMCH is the most complex and sensitive, and has received significant media coverage.

The Manchester Arena Public Inquiry was established, under the Chair of Sir John Saunders, to investigate the deaths of the victims of the attack. This was commenced on 0709 20 and is ongoing.

Current Position

- The Trust have instructed **James Down**, Partner at Hempsons Solicitors, and **Craig Hassall QC** to act on behalf of the Trust and to provide support to Trust witnesses at the Inquiry.
- The relevant Inquiry chapters involving the Trust are Chapter 11 (expert overview on blast injuries), which we understand will be heard over 3 days **commencing the week of 20 September 2021**, followed by Chapter 12 which is likely to last 4-6 weeks. Chapter 12 will explore the stories of each victim, including an analysis of their injuries and any questions as to survivability.
- We have been notified of **14 potential Trust witnesses** to attend and provide evidence during Chapter 12 of the Inquiry. A final witness list and schedule should be provided in early September.
- The Trust have not yet been granted core participant status to the Inquiry. This limits our access to information and documents. An application will be made to the Chair by 3 September 2021 and is expected to be granted.

Staff support

All 14 potential witnesses have been contacted and advised that they may be called to give evidence at the Inquiry. Contact was made via a senior member of staff in the MRI and RMCH divisions and their educational supervisors advised. Staff were also signposted to employee health and wellbeing, psychological wellbeing support and the Greater Manchester resilience hub for additional support if required.

Staff will also be supported through the Inquiry process by the ORC Legal Services Department, our Trust Solicitors and QC.
Witness meetings with the legal team are being arranged throughout the **week commencing 13 September 2021** to ensure that staff have the opportunity to discuss fully their involvement with the 3 victims, ask any questions they wish and to ensure they have the necessary support they require.