NHS
Manchester University
NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS' MEETING

Meeting Date: 10th May 2021

DUE TO THE IMPACT OF THE ONGOING COVID-19 NATIONAL & LOCAL EMERGENCY RESTRICTIONS, THE 'VIRTUAL' MEETING WAS RECORDED IN FULL AND POSTED FOR OPEN VIEWING ON THE TRUST'S PUBLIC WEBSITE FOR SEVEN DAYS.

68/21 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 whilst today's meeting (10/05/2021) was not held in a public setting, all deliberations would be recorded in full (via MS Teams) and posted on the MFT Public Website for seven days. In addition, it was explained that the agenda and supporting documents had 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 shared recording and content of the reports presented/discussed to the following e-mail address: Trust.Secretary@mft.nhs.uk.

69/21 Apologies for Absence

Apologies were received from Miss Toli Onon (Joint Group Medical Director).

70/21 Declarations of Interest

There were no declarations of interest received for this meeting.

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

71/21 Minutes of the 'virtual' Board of Directors' Meeting held on 8th March 2021

It was noted that the Minutes of the 'virtual' Board of Directors' meeting held on 8th March 2021 were approved at the Board meeting (not held in a Public setting due to the ongoing COVID-19 National Emergency Restrictions).

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

72/21 Matters Arising

There were no matters arising.

73/21 Group Chairman Report

i) The Board noted that organisations across Manchester were coming together to explore what support could be practically offered to the COVID-19 pandemic in India and meetings were currently being held at senior levels to explore how aid to Indian could be coordinated in a city wide partnership and as part of the UK wide offer. MFT continued to support colleagues across MFT during this extremely difficult and worrying time, many of whom have family and friends in India.

ii) It was reported that MFT's Helipad, located on the roof of the Grafton Street Carpark, had become operational on 10th May 2021. The Helipad was recognised as the first elevated Helipad of its kind in the Northwest to enable critically injured, ill or injured babies, Children and Adults to be airlifted to the Major Trauma Centres of the MRI and the Royal Manchester Children's Hospital.

iii) The Board was reminded that *Equality, Diversity and Human Rights* celebrated its 10th anniversary week commencing 10th May 2021 which was the national platform for organisations to highlight work done to create a fairer and more inclusive NHS. The official theme was based on pledges from the NHS People promise, compassion and inclusivity, safe and health of voice that counts, recognised and rewarded and being a team and the Trust had summarised the pledge into the theme *'27,230 Individuals, One Trust.'*

iv) MFT celebrated the *International Day of the Midwife* on 5th May 2021. The annual day enabled the Trust to pause and consider all the incredible work of our Midwives across the Saint Mary's Managed Clinical Services and especially during the COVID-19 pandemic year. In addition, on 12th May 2021, it was reported that MFT would be celebrating the *International Day of the Nurse* with the Group recognising our diverse workforce and the importance of celebrating that Nursing is a global family.

v) The Group Chairman was very proud to announce that a total of 13 MFT staff members were shortlisted for an award at this year's National Black, Asian and Minority Ethnic Health and Care Awards in April 2021. Congratulations to winners, *Nour Moterek* and *Hafsa Atique-Ur-Rehman* from the Pharmacy Team (CSS), who were named winners in the Workforce Innovator of the Year category. Another special well done to *Bindu Kurien,* from the Manchester Royal Infirmary (MRI), who was Highly Commended in the Workforce Innovator of the Year category. *Gayathri Subramanian,* from the Children's Hospital, also received a commendation, as she was Highly Commended in the Health and Wellbeing Advocate of the Year category.

Group Chief Executive's Report

vi) On behalf of the Board, a huge thank you to all Staff at MFT for the work that colleagues had put in tirelessly over the last 15 months: *"As a Board of Directors, we are so proud of all the achievements of our staff and as we start to move forward into the recovery phase this is going to be really demanding on our Staff and Teams and we need to take all the lessons that we have learned over the last 15 months and apply them in terms of how we move forward."*

i) It was noted that the Greater Manchester Health & Care System was now working through how all available assets throughout the conurbation are used in the most agile way in order to start treating prospective patients on elective waiting lists rapidly and to the safest and highest quality possible. There are some important pieces of work underway that will ensure how the system priorities the right patients and utilise all available capacity.

ii) It was reported that MFT had delivered over 100,000 vaccinations with 40,000 Health and Care Staff being vaccinated. Great work from everyone who had been (and continue to be) involved at MFT and the big challenge now was how to move forward on a sustainable basis into the autumn and beyond. An incredibly strong start from the team over the past number of months.

iii) The Board was extremely pleased to note that the Trust had formally welcomed North Manchester General Hospital (NMGH) into the MFT family on 1st April 2021. This was a wonderful landmark which had achieved the vision of creating a *Single Hospital Service* for the whole of the city of Manchester.

iv) It was noted that the MFT Research Team had recruited the final participant for the COVID-19 antibodies study. Over the last 12 months, 268 members of staff had been involved in the study investigating how COVID-19 antibodies could protect against the virus.

v) Finally, it was reported that MFT had successfully reached the end of the financial year (2021/22) and demonstrated a strong level of performance and discipline. The 2020/21 accounts had been submitted to NHSI with the Group delivering a modest surplus and securing a good platform moving forward into 2021/22.

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

74/21 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 an overview of MFT's continued response to the COVID-19 National Emergency, including ongoing operational planning and performance against national NHS constitutional standards, the impact of COVID-19 on patient wait times, further development of Recovery planning and modelling, and, an update on staff testing.

The Board was reminded in the report presented that a 3rd wave of COVID-19 in January 2021 necessitated a further period of national lock-down, with restrictions partially lifted at the end of March 2021. The Board recalled that the Trust had experienced two peaks of COVID-19 attendances during January, namely, the first peak which occurred in the second week of January and saw 423 COVID attendances, and, a second rise in COVID attendances at the end of January which had resulted in a peak of 453 COVID patients occupying in-patient beds (with 64 patients in Critical Care beds - level 2/3).

The Board recalled that in response to the increase in COVID incidence in the 3rd and 4th Quarter of the year (2020/21), the MFT Strategic Group had prepared and delivered plans to address this COVID wave, which aligned with national and regional guidance.

The COO confirmed that the decision-making process to support Group escalation and its associated consequences, continued to be led by the Chief Operating Officer (and AEO); Medical Directors; Group Chief Nurse and the Group Executive Directors. The Board also noted that individual Hospital / MCS / LCO escalation plans approved via the MFT Strategic Group in October 2020, continued during Q4 (2020/21) with a tiered approach to the escalation processes to balance the impact on all activity programmes. It was further recalled that the MFT Strategic Group had taken the decision to reduce routine elective activity from the start of November 2020, in order to release bed and staff capacity to support critical care, and this also continued through January, February and into March 2021. It was noted that as a result, the ongoing response to the COVID-19 National Emergency meant continued impact on the Trust's recovery workstreams and performance against national standards during this period.

The COO went on to describe the consideration which had been given during Q4 and into April 2021 by the Strategic Group to the potential of partially relaxing some of the reductions in the Trust's elective and outpatient activities, and, restrictions in operating practices. The cautious approach adopted by the Strategic Group were duly noted in the report presented.

The COO explained that the continued incidence of COVID-19 and the need to stand down elective activity for significant periods since March 2020 had a profound impact on the shape and size of the waiting list at the Trust. It was noted that activity cessation and changes in patient behaviour, meant the NHS was now facing a large backlog of non-COVID care. It was also confirmed that MFT and NMGH had seen a significant rise in the overall waiting list size and the volume of >52-week waiters across the year. At the end of March 2021, it was reported there was a total of 17,433 patients who had waited longer than 52 weeks for treatment and of this, 13,820 related to MFT (11.99% of total wait list) and 3,613 related to NMGH (20.5% of total wait list). The Board especially noted the growth in long waiters across these organisations between April 2020 and March 2021 in the data presented in the report.

The COO provided assurance that the Trust, including NMGH, continued with ongoing performance management of Hospital / MCS delivery and clinical validation and priority work across Hospital / MCS sites to ensure that the number of long waiters was minimised where possible.

The Board received an overview of the work undertaken by the Group's Recovery and Resilience Board (RRB) which had been driving the ongoing Recovery programme with a much greater focus on operational delivery. It was especially noted that Transformation activities associated with the elective, cancer, outpatient, urgent care and long-term conditions programmes reported to the RRB alongside updates of EPRR activities and key enablers such workforce, estates and informatics.

The Board noted the details around the permanent shifts in operating models across MFT and the wider GM system which was now required to respond and recover from the COVID-19 pandemic and this would entail significant demands in terms of staff engagement and leadership capacity. The key principles which had been developed to underpin the Trust's Recovery Programme whilst maintaining patient safety, minimising potential harm associated with long waits whilst continuing to acknowledge the role that staff had played through the pandemic (to date) and support them through Recovery were duly noted.

In response to questions and observations from Dr Ivan Benett, the Board particularly noted that the Trust had successfully developed a robust process to meet the objective of prioritising treatment of clinically urgent patients based on the Federation of Surgical Specialist Association guidelines. It was confirmed that enhanced site-based MESH (Manchester Emergency & Elective Surgical Hub) groups had meet regularly since the start of the calendar year (2021), one for Wythenshawe/Trafford/Withington/Altrincham (WTWA), one for North Manchester General Hospital (NMGH) and one for the Oxford Road Campus (ORC). It was also noted that these groups were clinically led and continued to oversee the validation and prioritisation of single pooled specialty Patient Treatment Lists.

It was recognised that the Group MESH had been mobilised to ensure oversight and effective use of resources across MFT sites, including Independent Sector capacity already agreed for use of MFT. Outputs from the site-based meetings would come forward for Group MESH prioritisation of access to theatre capacity, to ensure patients with highest clinical priority were operated on first and that there was equity of access across specialties and sites. The Board was also reminded that The Group was chaired by one of the joint Group Medical Directors, and it had wide clinical and operational representation from Group and also had oversight of the process for referral of cancer patients to GM Cancer Hub, if required. Details of the Trust's Recovery Modelling was also noted as presented by the COO in detail within the update report along with progress on key Recovery Workstreams with a focus on *Urgent Care & Flow*, *Discharge Planning*, and, *Outpatients.*

The COO also confirmed that the programme of asymptomatic staff testing remained ongoing and had run alongside focused outbreak testing of symptomatic staff. It was noted that MFT staff and affiliates continued to self-test twice a week, with the aim of helping to reduce the level nosocomial infection rates within MFT and community transmission in the region. It was confirmed that as at 22nd April 2021, a cumulative total of 229,971 tests had been undertaken and reported by staff with the number of staff who had reported a positive lateral flow test being 665 (0.29% of tests reported). It was confirmed that MFT had put in place several actions to encourage participation and recording, including the development of a distribution portal, and an app to submit to streamline the process for staff to regularly record their test results. However, it was recognised that the programme was voluntary and the extremely successful roll out of the MFT COVID vaccination programme in Quarter 4, had contributed to a decrease in the number of tests being recorded regularly by staff in March and April compared to January and February 2021.

The Board noted the latest Trust performance under each of the following headlines: 'Urgent Care' (inc NMGH); 'Planned Care' (RTT & 52 Weeks); 'Diagnostics'; and, 'Cancer' (inc. >104 day and >62 day cancer waits).

Professor Dame Sue Bailey (in her capacity as the Chair of the Board's Quality & Performance Scrutiny Committee) welcomed the update report presented by the COO with support from Group Executive Director colleagues which demonstrated a clear way forward with the Trust's Recovery Programme and provided assurance on the continued focus on maintaining the highest levels of patient safety and quality care.

In response to questions and observations from Mr Barry Clare, the COO agreed to provide further data to Group NEDs on the impact of the COVID-19 pandemic on the Group's Transplant Programmes. It was also agreed that Dr Veronica Devlin (Group Transformation Officer) would be invited to a *Weekly NED Briefing Session* to provide a further details of the Group's dynamic Transformation Programme going forward.

In conclusion, the Board of Directors noted the content of the update report as presented.

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

Update on the COVID-19 Vaccination Programme

The Group Chief Nurse confirmed that the COVID-19 vaccination leadership team were running an effective vaccination programme in a rapidly changing environment. It was confirmed that there had been good uptake of the COVID-19 vaccination across MFT staff with 91.0% of staff having received their 1st vaccine, and 90.07% of staff having either had or booked their 2nd t dose. It was further reported that 80.3% of BAME staff had received their vaccination.

The Board was advised that Walk-in and evening clinics had been established and work was continuing to develop longer-term plans regarding the programme's transition to *'business as usual'* and MFT continue to work with Manchester Health and Care Commissioning and Trafford Care Commissioning Group to support the wider vaccination programme.

The Group Chief Nurse explained that the current focus was to administer as many vaccines as possible, in line with JCVI guidance, by continuing to provide first and second dose vaccinations to staff groups, whilst offering the vaccine to new patient cohorts and eligible family members of MFT staff. It was also confirmed that the focus would also consider vaccine availability, clinic capacity, workforce requirements, and any national directives that may be released going forward.

In response to observations and question from Mr Nic Gower, discussion also centred on the timescales and logistics of introducing *potential booster vaccinations* later in the year.

In conclusion, the Board of Directors noted the content of the report.

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

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

The Group Chief Nurse provided an update on Nosocomial Transmissions of COVID-19, progress on the Infection Prevention and Control Development Pathway, and, the healthcare associated objectives.

In summary, the Board noted that the prevention and management of COVID-19 Nosocomial Infections was multifaceted, and practice had evolved throughout the pandemic as the organisation and the NHS learnt more about the COVID-19 virus and how it was transmitted. It was explained that prevention of all transmissible infections, both viruses and bacteria were paramount to patient safety and started with adherence to good IPC practice by all staff.

The Group Chief Nurse also explained that whilst there was evidence that the number of new cases of COVID-19 amongst in-patients was declining, there had nevertheless been an increase in the overall number of HCAI (non Covid related). She also confirmed that the Trust was adopting the NW SJR guidance in reviewing deaths relating to COVID-19 Nosocomial Infections.

The Board acknowledged that whilst the overall reduction in Covid-19 infections was welcomed, practice could not yet return to pre-pandemic practices and all staff must continue to be vigilant.

In response to questions and observations from Mr Trevor Rees, the Group Chief Nurse and Joint-Group Medical Director described the lessons learnt and application of 'best practice' in the management of HCAI across the Group during the previous 12-15 months coupled with the robustness of the available data and more scientific approach to the 'lessons learnt' which were also shared across GM and the North West.

In response to a question and observation from Mr Barry Clare regarding the potential impact of COVID-19 restrictions being incrementally lifted and the cautious relaxing of travelling outside the UK, the Group Chief Nurse confirmed that 'triaging protocols' within settings such the Emergency Departments throughout the Trust would not be relaxed or diluted. It was also confirmed that a managed approach to 'visiting arrangements' was in place across many different areas (e.g. one visitor per bed at any one time with a focus on IPC). It was also confirmed that the Trust had maintained a flexible approach to visiting throughout the pandemic (e.g. attendance of partners during births, and, relatives for 'end of life').

Professor Dame Sue Bailey (as Chair of the Board's Quality & Performance Scrutiny Committee) commended the Group Chief Nurse and her teams for the diligence and heightened levels of focus on IPC and HCAI throughout the pandemic coupled with rapid application and embedding of 'learning' throughout the organisation.

In conclusion, the Board of Directors noted the actions and progress to reduce the risk of transmission of COVID-19 and other HCAI across all MFT services.

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

75/21 Group Chief Finance Officer's Report

The Group Chief Finance Officer presented the key highlights from the Month 1 (2021/22) Report.

The Board noted that the financial regime for 2021/22 had 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-19 reduced but the implications of reduced activity over the previous period manifested themselves across almost all areas of clinical activity. It was noted this was also in the context of a range of workforce implications and ongoing health and wellbeing concerns.

The Board also noted that the added dimension of increased system working at a Greater Manchester level was also a factor in determining the financial plan for 2021/22 in terms of both revenue and capital together with the clinical/operational planning at a GM level including performance reporting. It was confirmed that the funding for H1 of 2021/22 was heavily linked to 2019/20 levels together with system level funding as a "top up" element to address aspects of cost pressures and activity recovery.

It was explained that overall, there was a national premise that Providers had sufficient funding to deliver the 85% of 2019/20 activity while operating in a changed Infection Prevention and Control environment. It was also stated that whilst separate financial planning documents had been shared and approved by the Board of Directors, it was key to recall that a significant assumption of receipt of £43m of system monies had been included in the plan for H2 and this remained the key risk in the plan.

The Group Chief Finance Officer emphasised that strong financial governance and control remained essential, particularly in the face of an extraordinary and challenging operating environment and a revised framework for 2021/22. It was also confirmed that Hospitals/MCS/LCO would be expected to develop year-end and 'month by month' forecasts on a monthly basis and would be held to account on their forecast variance to their Control Total.

The Group Chief Finance Officer re-stated that the change in future funding arrangements and the weakening of the links between activity and income was a key factor, however, this also presented some opportunities regarding service / pathway redesign. It was noted that robust monitoring and management of underlying run rates would be required for the foreseeable future together with a drive to achieve recurrent *Waste Reduction Programme (WRP)* savings in support of sustainable clinical service models would be crucial for the Trust as a whole.

The Board was advised that the Trust had delivered a small surplus in April 2021, representing a stable financial position. It was reported that at 31st March 2021, the Trust had a cash balance of £271.2m and this had increased to £280.2m at the 30th April 2021. It was also explained that the capital plan reflected the result of negotiations across Greater Manchester to bring the total planned spend across Greater Manchester into line with the new capital envelope. It was confirmed that spend in April 2021 was below that planned as a result of the late notification of the HIP Southern Sector enabling works.

In conclusion, the Board of Directors noted the content and key messages within the Month 1 (2021/22) report.

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

76/21 Update on Strategic Developments

The Group Executive Director of Strategy updated the Board of Directors in relation to strategic issues of relevance to MFT.

Attention was drawn to the *2021/22 Priorities and Operational Planning Guidance* which had been published by NHE England on 25th March 2021. The Board was advised that the guidance describe the key challenges for 2021/22 which included restoring services, meeting new care demand and addressing backlogs, supporting staff recovery and addressing inequalities. It was explained that six priorities were highlighted as follows with a number of specific areas for action under each (also noted in the accompanying appendices):

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

It was noted that the financial settlement that accompanied the guidance had been set for the first half of the year only; the funding for the second half of the year would be agreed once there was greater certainty around the circumstances facing the NHS later in the year.

The Group Executive Director of Strategy emphasised that effective partnership working across systems was at the heart of the plans and this was reflected in the process. He explained that plans were to be submitted at the ICS level and would increasingly be monitored and assessed at the ICS level reflecting the shift in emphasis with performance at system level was becoming more important than at the level of the individual organisation.

The Group Executive Director of Strategy went on to describe the recently published White Paper - *Integration and Innovation: working together to improve health and social care for all.* It was reported that the Priorities and Operational Planning Guidance required systems to prepare to establish statutory arrangements for formalising partnership working set out in the White Paper 'Integration and Innovation: working together to improve health and social care for all', subject to the legislation progressing through parliament. It was noted that for Greater Manchester, this was dovetailing with the work to review the Health and Social Care Partnership.

The Group Executive Director of Strategy explained that during 2021/22, the following would be published to support providers to work in collaboration:

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

The Board also noted in the report presented that NHS England had published guidance on the establishment of diagnostic networks that would be responsible for asset management, financing, quality, staffing and location of all elective and non-elective imaging. It was explained that these networks would be essential to help capacity keep pace with growing demand and would be critical to support elective recovery post-pandemic. It was noted that under the Provider Federation Board, colleagues from across Greater Manchester were working on plans to establish Imaging and Pathology networks for GM.

The Group Executive Director of Strategy reported that colleagues across MFT, Manchester and Trafford Local Care Organisations, Manchester Health and Care Commissioning and Trafford CCG had been developing plans to establish Community Diagnostic Hubs (CDH) to cover Manchester and Trafford. National capital and revenue funding as being made available in 2021/22 and the plan would see a CDH established at Withington Community Hospital in the first instance, with a CDH at NMGH to follow in-line with the wider site redevelopment. It was confirmed that the plans would also see the establishment of Digital Ophthalmology Diagnostic Hubs at Altrincham Hospital and Manchester Royal Eye Hospital; initial bids were being submitted to the regional team in early May with a decision expected in June (2021).

The Board was advised that the MFT Annual Plan was being developed as part of a single process that brought together the production of the MFT Annual Plan, Hospital / MCS Annual Plans and MFT's input to the Greater Manchester submission (as described in the accompanying sections of the report). It was confirmed that a first draft of the MFT Annual Plan was in development and a session to seek the views and input of the Council of Governors had been planned for 25th May 2021. It was expected that the final version of the plan would be presented to the Board of Directors in July 2021.

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

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

63/21 Update on the Acquisition of NMGH on 1st April 2021

The Group Executive Director of Workforce & Corporate Business confirmed that there were three primary areas of focus in relation to the acquisition of NMGH since April 2021, namely, the ongoing 'complex' review of previously reported *Due Diligence* workstreams; the review of £30m of *Service Line Agreements* (SLAs); and, completion of the *'Statutory Acquisition'* (following the successful completion of the prime *'Commercial Transaction')* and the Post-Transaction Governance Programme.

The Board particularly noted the conclusion of the paper which stated that despite the deferral of the SRFT transaction, NMGH successfully transferred to MFT on 1st April 2021, and this completed the five year programme to bring the hospitals in Manchester together into a single service.

It was also noted that the Statutory Transaction was expected to take place at 1st October 2021, and this would deliver the dissolution of PAHT and the transfer of all its assets and liabilities.

It was particularly confirmed that work was now needed to progress the next stage of disaggregation and to consider how/when NMGH might extricate itself from these arrangements and integrate more fully into MFT. The Group Executive Director of Workforce & Corporate Business explained that the first stage of this process, to determine the anticipated duration of SLAs across all service areas, had already started and Hospital Leadership Teams had provided their initial thoughts on how long their respective SLAs should remain in place. He also explained that planning processes for those services that wished to cease their SLAs within 12 months would now begin and further work, to agree high level plans for services that might take longer to disaggregate, would also commence.

The Board was advised that the next, and final version of the Post Transaction Integration Plan (PTIPv3) would be developed over the coming months and would be submitted to the North Manchester Programme Board in August 2021. The Group Executive Director of Workforce & Corporate Business confirmed that the document would: set out the post transaction governance arrangements; review the work already undertaken to achieve the transaction; review the first three months of operation; set out progress against Day 100 plans, set out plans for future disaggregation; and contain details of how transaction activities would be closed down and transitioned to *'business as usual'* arrangements. It was also confirmed that the review process for the Outline Business Case was continuing, and the Enabling Works would proceed.

In conclusion the Board of Directors noted the work undertaken and proceeding to complete the statutory transaction as the basis for the dissolution of PAHT and the efforts being made to ensure a timely re-build of NMGH.

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

77/21 Delegated Authority to Sign-Off the MFT Annual Report and Accounts for 2020.21 to the Audit Committee

The Group Chief Finance Officer requested that the Board delegated authority, as in previous years, to the Audit Committee for the formal sign-off of the MFT Annual Report & Accounts 2020/21 (which included the Annual Governance Statement) to the MFT Audit Committee.

Decision:	The Board 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.	**Action by:** The Group Chief Finance Officer. and, Chair of the Audit Committee	**Date:** 8th June 2021

78/21 Report on the NHSI FT Self-Certification Requirements (2021)

The Group Executive Director of Workforce & Corporate Business reminded the Board of Monitor's healthcare licensing regime and that all NHS Foundation Trusts were required to self-certify whether or not they had complied with the conditions of the NHS provider licence, had the required resources available if providing commissioner requested services, and, had complied with governance requirements.

The Board was also reminded that MFT had an NHS Provider Licence (No. 130164) and the guidance issued by NHSI in April 2017 required NHS Providers to self-certify only three Licence Conditions after each financial year-end, namely, Condition G6(3); Condition G6(4); Condition FT4(8); and, Condition CoS7(3).

The Group Executive Director of Workforce & Corporate Business provided an overview of the evidence presented for each condition and following a short discussion it was agreed that based on the evidence highlighted in the supporting documentation, Condition G6(3) & Condition G6(4) Self-Certification would be formally signed-off as 'Confirmed'. Similarly, and based on the evidence highlighted, the Board agreed that declaration 'B' within the Condition CoS7(3) Self-Certification would be formally signed-off as 'Confirmed'.

With regards to Condition FT4(8), it was noted that the Board had already received an electronic copy of the *draft* summary set of evidence to support this Condition with the aim of identifying any risks with compliance and any action taken, or, being taken to maintain future compliance.

It was agreed that the Board would review and comment (via the Board Secretary) on the draft governance statements during May and early June 2021 and that the Group Chairman & Chief Executive would be given delegated authority to 'sign-off' the Self-Certification ('Condition FT4(8)') in order to meet the self-certification deadline of 30th June 2021; which was prior to the next Board of Directors meeting on 12th July 2021.

The Board approved Self Certification Conditions G6(3), Condition G6(4) and CoS7(3) as 'Confirmed' and agreed that the Group Chairman & Chief Executive would be given delegated authority to 'sign-off' the Self-Certification ('Condition FT4(8)') in order to meet the self-certification deadline of 30th June 2021.

Decision:	Self Certification Conditions G6(3), Condition G6(4) and CoS7(3) approved as 'Confirmed'	**Action by:** Trust Board Secretary	31st May 2021
	Delegated authority agreed for the Group Chairman & CEO to sign-off Condition FT4(8) before 30.06.21	Trust Board Secretary	30th June 2021

79/21 Report on the MFT Staff Survey 2020/21

The Group Executive Director of Workforce & Corporate Business provided an overview of the MFT Staff Survey for 2020/21 with the following summary of the key highlights duly noted:

- The Group staff engagement score was 7.0 (7.1 in 2019);
- MFT was within 0.1 of the average sector score for 9 of the 10 Key Themes (highlighted in the accompanying appendices);
- Two themes showed a statistically significant improvement on 2019: 'Health and Wellbeing' and 'Safe Environment – violence';
- Five themes had recorded a statistically significant decline on 2019: 'Equality, Diversity and Inclusion', 'Immediate Managers', 'Morale', 'Staff Engagement' and Teamworking';
- There had been statistically significant improvements in the scores for 8 of the 78 core questions, with a statistically significant decline for 32;

- Analysis suggested that for those staff working remotely during the Pandemic, including from home, scores were higher across all Key Themes, except for 'Quality of Care' and 'Safety Culture' where they were similar. Scores were generally lower for those staff who were working on a COVID ward and / or redeployed, especially for 'Health and Wellbeing' and 'Bullying and Harassment';
- For questions contributing to the Workforce Race Equality Standard (WRES), all staff groups reported a decline in experience of harassment, bullying or abuse from patients, relatives, or the public in the past 12 months, with the decline greater for BAME staff. There was a general increase in staff experiencing discrimination and bullying and harassment from manager / colleagues and this was greatest for BAME staff;
- For questions contributing to the Workforce Disability Equality Standard (WDES), staff with and without a long-term condition or illness reported a decline in experience of harassment, bullying or abuse from patients, relatives, or the public in the past 12 months. There was also general increase in staff experiencing bullying and harassment from manager / colleagues. Across most of the contributory questions for the WDES, the experience of staff with a long-term condition of illness was more negative, although there was an improvement in staff believing that the organisation provides equal opportunities for career progression or promotion; and,
- Initial data indicated that staff at NMGH were much more likely to experience violence, bullying and harassment and discrimination from patients or members of the public, and to be less likely to be advocates of their organisation as a place to work or receive treatment.

The Group Executive Director of Workforce & Corporate Business explained that staff experience of working the COVID-19 Pandemic and the related pressures had created a significant impact on their responses to the 2020 Staff Survey.

The Board noted that MFT's results indicated that the experience of those staff who were redeployed during the Pandemic or working on a dedicated COVID-19 wards, generally led to lower scores in the staff survey across the key themes. It was acknowledged therefore, that the Group's priorities for 2021-22 would be focused on supporting staff recovery from the Pandemic, providing them with the opportunity to pause, rest, reflect and restart.

It was also confirmed that the 2020 results had been discussed at the Group Management Board in March 2020 and the results had been disseminated to Hospitals / MCSs / LCOs and Corporate Leadership Teams to consider, reflect and develop action plans.

It was explained that in order to support a consistent approach to action planning and goal setting, the Group's Organisational Development Team had created a *'Staff Survey Action Plan Playbook'* which supported leaders and managers to work through a four-stage process in developing their plans. It was further confirmed that work was underway to extract local Equality, Diversity and Inclusion data for each Hospital / MCS / LCO / Corporate to understand the lived experience of staff with protected characteristics during the Pandemic.

The Group Executive Director of Workforce & Corporate Business also confirmed that the 2020 results were also informing several work streams that were being combined including *Putting People First, Civility Saves Lives,* Bullying and Harassment and Just Culture.

In conclusion, the Board of Directors considered the strengths, improvements and areas for development following the 2020 Staff Survey Results and endorsed the actions being taken in response to the survey results.

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

80/21 Putting People First

The Group Executive Director of Workforce & Corporate Business provided a summary overview of the work being undertaken to improve Trust people practices in relation to employee relation matters. Particular attention was drawn to the programme of work which had commenced titled 'Putting People First at MFT' which incorporated several initiatives, namely, 'Putting People First' (Learning lessons to improve our people practices following the tragic death of Amin Abdullah); 'A Fair experience for all'; 'Personal Responsibility Framework'; and, 'Just Culture in Patient Safety Incidents'.

The Group Executive Director of Workforce & Corporate Business explained that following the release of the National 2020 Staff Survey results, work was also underway to bring together workstreams such as bullying and harassment work being led by Equality, Diversity and Inclusion and the Civility Saves Lives Programme, previously on hold due to the COVID-19 Pandemic. It was noted that this work would allow a level of consistency across the different workstreams, maintaining joint working, collaborative approach to ensure employee experience in MFT was fair and equitable.

It was noted that an Employee Relations Oversight Group had been established with Executive oversight and HRD, Associate Medical Director membership. This group had developed monitoring and reporting practices which provided operational oversight and escalation to Executive level members whilst also ensuring that current policy and processes were fit for purpose and supportive of all staff who may be involved in any investigatory and / or disciplinary procedures. Mr Blythin confirmed that it had been reported to date in 2020/2021 that there were no reported 'never events' relating to any staff member who was involved in an investigatory or disciplinary procedure.

In conclusion, the Board of Directors noted the developments to date and endorsed actions planned for 2021/22.

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

68/21 Quarter 4 (2020/21) Complaints Report

The Board of Directors received the Quarter 4 (2020/21) Complaints Report and PALS activity across the Group.

Attention was particularly drawn to the brief summary of activity (Complaints and Patient Advice & Liaison Service (PALS); Q4 in context (increase in outpatient related complaints, recommencement of local resolution meetings and The Parliamentary and Health Service Ombudsman (PHSO) position); overview of Complaints and PALS contacts including a brief analysis of themes; Care Opinion and NHS Website feedback; improvements made and planned to ensure learning from complaints was embedded in practice; results of the Complaint Handling internal audit; and, the supporting information presented in accompanying tables and graphs.

In response to observations and questions from Dr Ivan Benett and Mr Barry Clare, discussion also centred on the review and oversight of 'Compliments' received within the Group (especially during the pandemic), and, the anticipated response by Members of the Public to the heightened Wating List challenges previously referenced under Agenda Item No. 74/21 (above).

In conclusion, the Board noted the Quarter 4 (2020/21) Complaints Report as presented.

Decision:	Report Noted	**Action by:**	**Date:**

81/21 Annual Nursing and Midwifery Revalidation Report 2020/21

The Group Chief Nurse presented the annual overview of Nursing and Midwifery Revalidation at MFT, describing the current practice and assurance systems in place to support Nurses, Midwives and Nursing Associate to meet the Nursing and midwifery Council's (NMC) revalidation requirements. It was noted that the report covered the Group's activity from 1st April 2020 to 31st March 2021.

The Board noted the background of the requirements to undergo a three-yearly process of revalidation to demonstrate that practice is in line with the Nursing and Midwifery Council (NMC) professional standards of practice for nurses, midwives and nursing associates.

Attention was drawn to the current position and especially the Revalidation Changes due to the COVID-19 National Emergency; with the NMC acknowledging that the pandemic could make it more difficult for registrants to meet revalidation requirements. It was noted that to support registrants during this period, the NMC had applied temporary changes to the revalidation process and these changes came into effect from March 2020. It was explained that nurses, midwives and nursing associates due to revalidate between this timeframe were automatically given a twelve-week extension and these changes had remained in effect until March 2021.

The report confirmed that for staff due to revalidate from April 2021 onwards, if they required an extension, they had to individually apply to the NMC. It was also noted that the Trust had put in place temporary assurance measures to monitor where extensions had been granted to ensure that revalidation compliance was maintained; the monitoring and escalation process remained unaffected.

The Board noted that the total number of the Trust's nursing and midwifery workforce who had revalidated with the NMC between the 1st of April 2020 - 31st of March 2021 was 2128 out of a total number of 2136 staff. It was also confirmed that in order to support revalidation across MFT, a number of priorities had been identified for 2021/2022 and were duly noted as presented in the report.

In conclusion, the Board of Directors acknowledged the content of the report and the identified actions for 2021/22 to support revalidation for nurses, midwives and nursing associates across MFT.

Decision:	Report and Actions for 2021/22 Noted	**Action by:** n/a	**Date:** n/a

82/21 Summary Report on the NHS Resolution Maternity Incentive Scheme

The Group Chief Nurse provided an update to the Board of Directors in relation the compliance with the third year of the Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme for Maternity Safety Actions. She explained that the scheme offered a financial rebate of up to 10% of the maternity premium for Trusts that were able to demonstrate progress against a list of ten safety actions.

The Group Chief Nurse explained that the report presented provided assurance that NHS Resolution (NHSR) Maternity Incentive Scheme (MIS) year 3 standards had been met within the Group, and, that it had been agreed by NHSR that separate CNST submissions would be made for Saint Mary's Managed Clinical Service (SMH MCS) and North Manchester General Hospital (NMGH) to reflect the separation of the two organisations for much of the MIS year three reporting period. She also explained that two separate reports for Saint Mary's MCS and for NMGH had now been provided to the Board of Directors to provide assurance for each submission to NHSR.

The Board noted the background detailed within the report and that the scheme for 2020/21 had built on previous years to evidence both sustainability and ongoing quality improvements. It was explained that the safety actions described were considered to be a contributory factor to achieving the national ambition of reducing stillbirths, neonatal deaths, perinatal morbidity and maternal deaths by 50 % by 2025.

It was recognised that as in previous years, Trusts that could demonstrate they had achieved all of the ten safety actions would recover the element of their contribution relating to the CNST maternity incentive fund (which was 10% of their premium) and would also receive a share of any unallocated funds. The Board was reminded that there were 10 safety actions to be achieved with a total of 128 standards which needed to be evidenced in order to be fully compliant. It was also anticipated that a number of the actions would be subjected to external validation as they involved electronic submission to national databases such as PMRT, MBRRACE, NHS Resolution and the Maternity Services Dataset.

The Board noted in the report presented that ten safety actions for year three of the scheme were first published by NHSR on 23rd December 2019 but were subject to change as a direct result of the COVID-19 pandemic. It was also noted that whilst 'Safety' remained paramount, after a pause on the scheme during the first wave of the pandemic, NHSR had relaunched the Scheme on the 1st October 2020. It was explained that there were updates to the scheme with the final version in March 2021 and a submission deadline of 15th July 2021. The Board was advised that the relaunched Scheme included the addition of elements aiming to ensure key learning from important emerging COVID-19 themes were considered and implemented.

The Group Chief Nurse reminded the Board that following the publication of Donna Ockenden's first report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust on 11th December 2020, NHS England and Improvement (NHSE & I) mandated that all Trusts providing maternity services should proceed to implement the full set of the Ockenden Immediate and Essential Actions (IEAs).

The Group Chief Nurse also reminded the Board of Directors assurance reports had been received by the Board from Saint Mary's MCS in January 2021 and March 2021 in response to the Ockenden IEAs. It was also confirmed that Saint Mary's had cross referenced the MIS year 3 safety actions which informed and supported the Trust response to the seven Ockenden IEAs. The Board was also reminded that an update report on the Trust's response to the Ockenden IEAs would be presented at the next meeting in July 2021.

In conclusion, the Board of Directors confirmed that it was satisfied that the evidence provided demonstrated compliance with the ten MIS safety actions. It was also acknowledged that the Saint Mary's MCS had provided two full assurance reports to the Board of Directors with the evidence and compliance against the ten safety actions for Saint Mary's MCS and for NMGH.

Decision:	Confirmation that the Board of Directors confirmed was satisfied that the evidence provided demonstrated compliance with the ten MIS safety actions.	**Action by:** n/a	**Date:** n/a

83/21 Board of Directors Declarations of Interest

The Board received and noted the MFT Board of Directors' Register of Interests (April 2021).

Decision:	MFT Board of Directors' Register of Interests (April 2021) noted.	**Action by:** n/a	**Date:** n/a

84/21 CQC Regulatory Regulation Update

The Group Chief Nurse reminded the Board that MFT was required to register all new locations and de-register any decommissioned locations with the Care Quality Commission (CQC) as per the CQC regulations. It was noted that the purpose of the report now presented was to inform the Board of Directors of the de-registration of the Nightingale North West Hospital and removal from MFT's CQC registration, as nationally, the NHS Nightingale Hospitals have been decommissioned.

It was explained that the Trust was required to update its statement of purpose document to reflect that whilst there was no change to function or purpose, the Nightingale North West Hospital had been removed from the statement of purpose.

In conclusion, the Board of Directors noted the de-registration of Nightingale North West Hospital from MFT's CQC registration.

Decision:	De-registration of Nightingale North West Hospital from MFT's CQC registration noted.	**Action by:** n/a	**Date:** n/a

85/21 Committee Meetings

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

- Group Risk Oversight Committee held on 22nd March 2021
- Charitable Funds Committee held on 30th March 2021
- Audit Committee held on 31st March 2021
- Finance Scrutiny Committee held on 31st March 2021
- Quality & Performance Scrutiny Committee held on 6th April 2021
- HR Scrutiny Committee held on 13th April 2021

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

- LCO Scrutiny Committee held on 3rd March 2021

Decision:	Board Sub-Committee 'virtual' meetings held in March & April 2021 received and noted	**Action by:** n/a	**Date:** n/a

86/21 Date and Time of Next Meeting

The next meeting of the Board of Directors will be held on **Monday, 12th July 2021** at **2pm**.

87/21 Any Other Business

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

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

(v) Attendance via 'Electronic Co

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

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS' 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	*Actioned*

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Directors
Paper prepared by:	Alex Livesey, Head of Information, Information Management, MFT
Date of paper:	July 2021
Subject:	Board Assurance Report – May 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: Alex Livesey, Head of Information, Information Management Tel: 0161 276 4768

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS

BOARD ASSURANCE REPORT

(May 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.

3. Key Priority Areas

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

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

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

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

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

> Board Assurance Narrative Report – Guidance Notes

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

Summary Bar (Example –Safety Domain)

Safety
R.Pearson\T.Onon

Core Priorities	✓	◇	×	No Threshold
	3	1	1	0

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

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

Headline Narrative

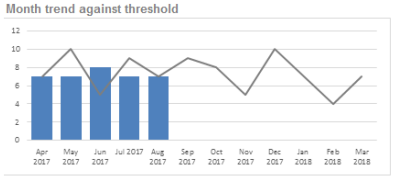
Headline narratives give context to the domain, stating current issues, good news stories, future challenges and risks, and commenting on the latest developments around performance of the indicators. Narrative is provided by the person(s) accountable for the individual domain

Section - Core Priorities

Hospital Incidents level 4-5
MFT

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

Month trend against threshold



12 month trend (Sep 2016 to Aug 2017)

Hospital level compliance

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

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

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

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

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

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

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

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

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

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

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

NHS Manchester University NHS Foundation Trust

> Board Assurance

May 2021

Safety

J.Eddleston\T.Onon

Core Priorities	✓	◇	✕	No Threshold
	4	0	2	0

Headline Narrative

There are two core priorities which are not currently being met.
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 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 3 Never Events (YTD April 21 to May 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	2	R12m (Jun 20 to May 21)	**Accountability**	J.Eddleston\T.Onon
Threshold	0	(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
✓	✓	✕	✓	✓	✓	✕	✓
0	0	1	0	0	0	1	0

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

Key Issues

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

The role of the Group Learning from Deaths Committee in supporting dissemination of good practice, lessons and action plans is being developed. Mortality review processes are generally robust, but will be altered by the introduction of a Medical Examiner system. The Chief Medical Examiner and a supporting team have now been appointed. The Medical Examiner referral and review process commenced formally in July 2020.

Significant work has been undertaken during the COVID pandemic across all hospitals to ensure learning from deaths in patients with COVID is acquired and embedded in clinical practice. This has included alignment of IPC reviews with a mortality review. This learning and creation of formalised processes to review outcomes associated with COVID has fed into Regional and National workstreams.

Actions

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

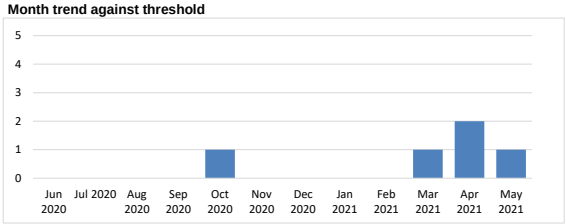
The Trust is working with the GM Mortality cell on learning.

Never Events

✕

Actual	3	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
✕	✓	✕	✓	✓	✓	✓	✓
2	0	1	0	0	0	0	0

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

Key Issues

Never events are those clinical incidents that should not happen if appropriate policies and procedures are in place and are followed.The list is determined nationally.
YTD (April 2021-May 2021) there have been 3 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 and the availabilty of guidance

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

NHS
Manchester University
NHS Foundation Trust

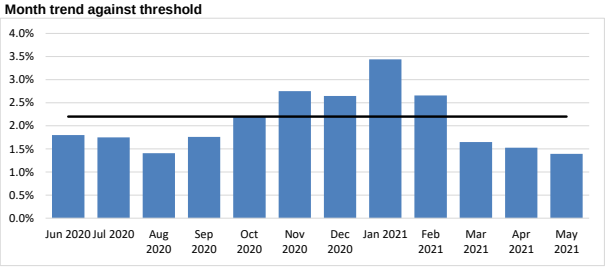
> Board Assurance

May 2021

Crude Mortality

Actual	1.46%	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
✗	✓	✓	✓	✓	✓	✗	✓
13.1%	1.9%	0.1%	0.1%	0.0%	0.0%	2.7%	1.5%

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

Key Issues

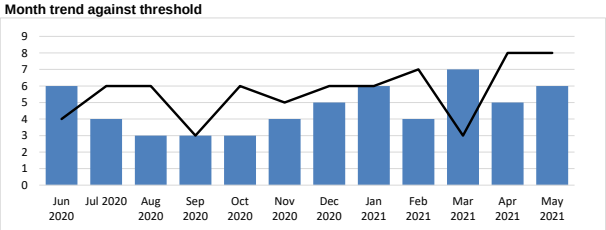
Crude mortality reflects the number of in-hospital patient deaths divided by the total number of patients discharged as a percentage and with no risk adjustment.

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	11	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	7	1	0	0	0	2	1

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 0.2% of incidents were graded as level 4/5 harm between 1/4/20 and 30/5/21. 1.2% of incidents being notifiable (graded 3 and above). Currently work is underway to benchmark this data effectively.
Understanding reporting trajectories in the MRI has been compromised because of delays in the Rapid Learning Review process during Quarters 3 and 4 20/21, resulting in the identification of the level of harm being delayed. The site is now in a better position.
SPC analysis identified special cause variation in relation to pressure ulcer, restraint and sepsis incidents across the incident profile. These have all been analysed and where required further action taken to mitigate risk (restraint) and learn from good practice (Pressure ulcers-related to management of critically unwell patients with COVID, and sepsis-proactive use of the system to monitor compliance with gold standard indicators)

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
- Transfer of patients into tertiary care

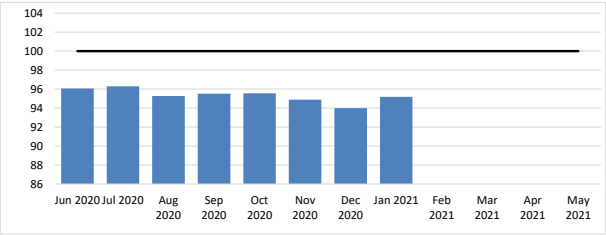
The Hospital Onset COVID infection reporting process was agreed during this period. The reports relate to incidents over the past 12 months and are not reported within this data set, once validated they will be included.

> Board Assurance

May 2021

SHMI (Rolling 12m)

Actual	93.0	R12m (Feb 20 to Jan 21)	**Accountability**	J.Eddleston\T.Onon
Threshold	100	(Lower value represents better performance)	**Committee**	Clinical Effectiveness



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).

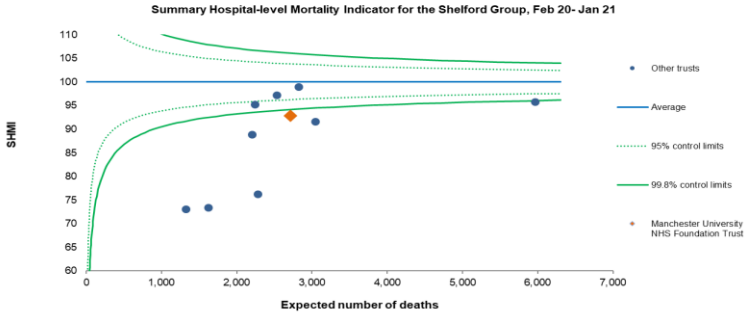
Risk adjusted mortality indices are not applicable to specialist children's hospitals.

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

Performance is well within the expected range.

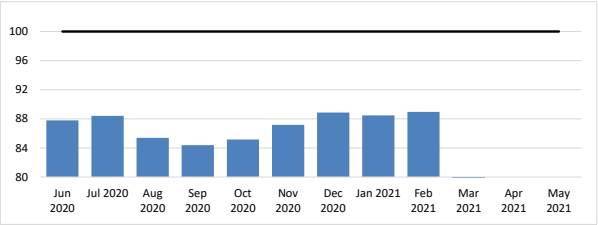
Hospital level compliance

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	95.7	NA	NA	NA	NA	89.7	NA



HSMR (Rolling 12m)

Actual	89.0	R12m (Mar 20 to Feb 21)	**Accountability**	J.Eddleston\T.Onon
Threshold	100	(Lower value represents better performance)	**Committee**	Clinical Effectiveness



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)

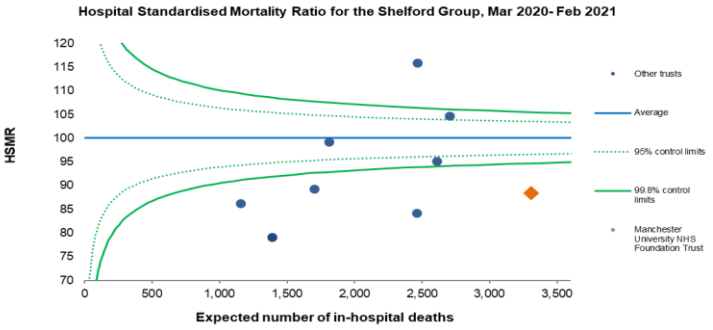
Performance is well within the expected range.

Progress

The Group HSMR is within expected levels.

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	82.7	NA	NA	NA	NA	95.1	NA



Patient Experience

C.Lenney

Core Priorities	✓	◇	×	No Threshold
	4	0	2	2

Headline Narrative

In May 2021 the percentage of formal complaints that were resolved in the agreed timeframe was 94.4% this is an increase of 4.1% from the previous month. MFT have consistently exceeded the set 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 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.

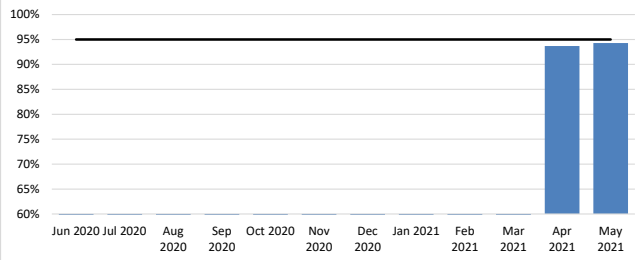
Infection prevention and control remains a priority for the Trust. Trust performance for the previous financial year was above trajectory for MRSA and CDI: when comparing MFT's 2020/2021 position to that of 2019/2020, CDI rates have increased from 19 to 34 per 100,000 overnight beds and MRSA bacteraemia rates have increased from 1 to 3 cases per 100,000 overnight beds. 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 reported so far this year, against a threshold of 26. 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 14 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

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
✓	×	×	✓	✓	✓	✓	×
97.1%	94.8%	90.7%	97.4%	98.1%	99.6%	96.4%	87.1%

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 May 2021 is 94.3 % compared to 93.7% in April 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.

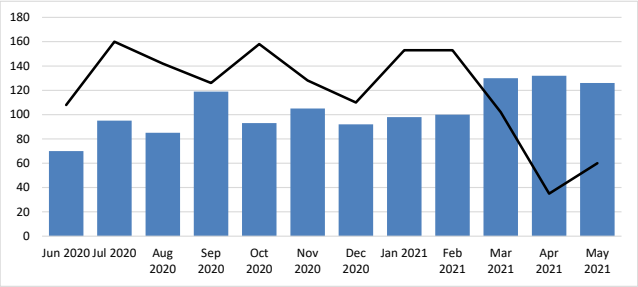
Actions

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.

Complaint Volumes

Actual	258	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
✓	✗	✓	✗	✓	✗	✓	✗
9	72	27	36	6	6	57	24

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 May 2021 was 126. When compared with the 132 complaints received in April 2021 this is a decrease of 6 complaints.

MRI received 30 complaints in May 2021 which is the highest number of complaints in the Trust (23.8% of the Trust total). When compared to the previous month however this is a decrease of 12 complaints.

Of the 30 MRI complaints received the specific themes were 'Treatment/Procedure', 'Communication' and 'Appointment Delay / Cancellation (OP)'. There were no specific areas identified in the complaints relating to these themes.

At the end of May 2021 there was a total of 23 complaints that were over '41 days old'. This represents a decrease of 7 when compared to the previous month when there were 30. The service area with the highest number of cases over 41 days at the end of May 2021 was Manchester Local Care Organisation who had 7 (23.3% 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).

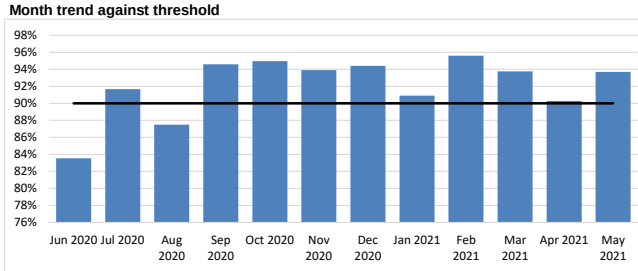
Progress

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	92.2%	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%	98.5%	92.6%	96.8%	100.0%	100.0%	92.6%	66.7%

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 May 2021 data identifies that 93.7% of complaints were resolved within the agreed timescales compared to 90.3% in April 2021: this is an increase of 3.4%.

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).

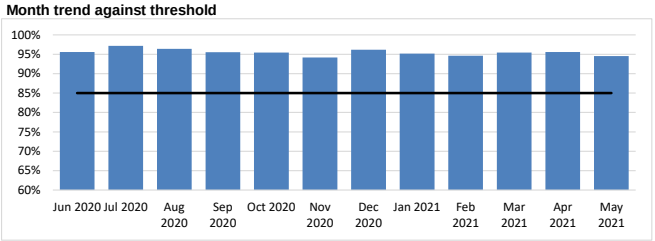
> Board Assurance

May 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
✓	✓	✓	✓	✓	✗	✓	✓
89.4%	95.9%	89.1%	92.3%	98.4%	57.1%	97.6%	94.7%

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.

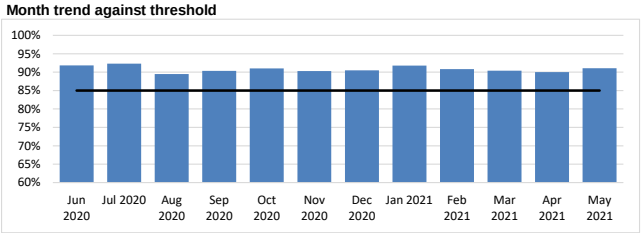
Utilising the Improving Quality programme (IQP) methodology, the MDT workstream engaged with patients and staff on Ward 12, at TGH to identify key areas to focus on improvement. Work commenced on the introduction of a hot breakfast and a 'snack round' from February 2020 with initial feedback reporting 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
✓	✓	✓	✓	✓	✓	✓	✓
91.5%	88.4%	88.5%	91.3%	100.0%	100.0%	94.1%	90.0%

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.

> Board Assurance

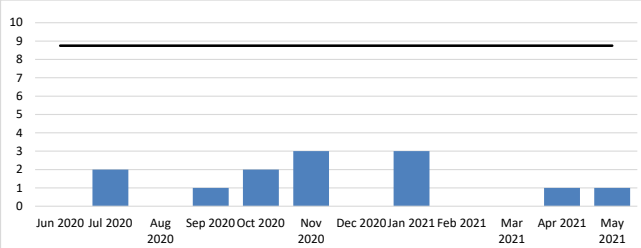
May 2021

Clostridium Difficile – Lapse of Care

✓

Actual	2	YTD (Apr 21 to Mar 22)	**Accountability**	C.Lenney
Threshold	18	(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

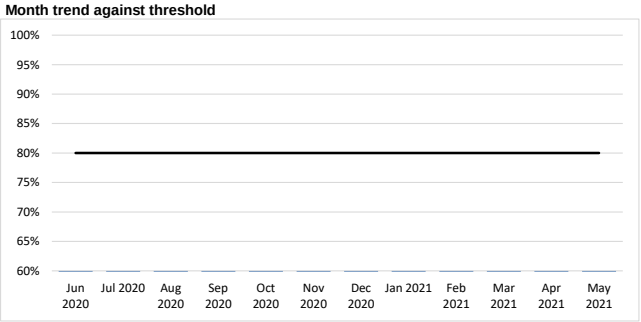
A total of 215 CDI cases were reported during 2020/2021: 179 (83%) of which were trust-attributable against a trajectory of 132. There have been 23 trust-attributable CDI reported so far this year, against a threshold of 26. Of these cases, 2 have been identified as demonstrating a lapse in care. There were 12 trust-attributable CDI cases reported for May 2021, all of which are pending review.

Nursing Workforce – Plan v Actual Compliance for RN

●

Actual		(May 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 was temporarily suspended from March 2020 due to the significant number of changes that took 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. Therefore the data available was not considered accurate with the risk of providing false assurances internally and externally and potentially leading to misguided decision making if used. As wards have been reconfigured as part of the pandemic recovery plan, the Health Roster templates have been adjusted to reflect the changes, ensuring the Trust are able to recommence the NHSI Safe Staffing submission in 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.

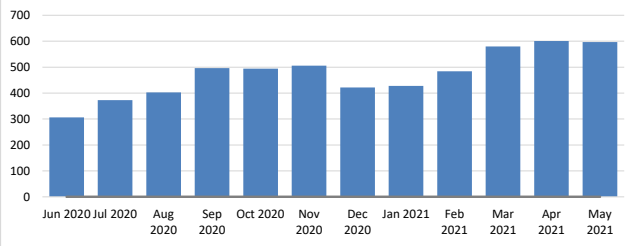
> Board Assurance

May 2021

PALS – Concerns

Actual	1198	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
-	-	-	-	-	-	-	-
72	262	110	159	44	41	299	150

Key Issues

A total of 597 PALS concerns were received by MFT during May 2021 compared to 601 PALS concerns in April 2021: this is a decrease of 3 concerns.

WTWA received the highest number of PALS concerns in May 2021; receiving 144 (24.1% of the total). This is a decrease of 11 for WTWA when compared to the 155 in April 2021. The specific themes for WTWA related to 'Appointment/Delay/Cancellation', 'Communication' and 'Treatment & Procedure'. ENT and Orthopaedics are specific areas identifed in the concerns relating to 'Appointment/Delay/Cancellation (OP)' with General Medicine being noted as a specific area identified in PALS concerns relating to 'Communication'.

Actions

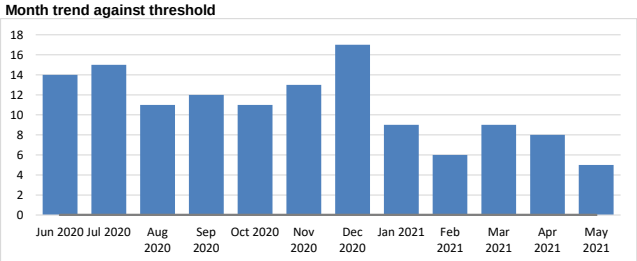
PALS concerns are formally monitored alongside complaints at the weekly meetings within each Hospital/MCS/LCO.

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	13	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
-	-	-	-	-	-	-	-
1	2	3	2	0	0	5	0

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 13 trust-attributable E. coli bacteraemia reported so far in 2021/2022, of which 5 were reported during May 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 (SMH, RMCH and Wyth).

Operational Excellence

J.Bridgewater

Core Priorities	✓	◇	✕	No Threshold
	1	0	9	0

Headline Narrative

The Covid 19 (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 however been a slow decline in Covid inpatient and critical care patient numbers. As a result, a staged approach to reconfiguration and desclation has been agreed through 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 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. For instance:
• Utilisation of available elective capacity is 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 has allowed Outpatient activity to increase; and
• Specific Committee and programme governance meetings are being re-introduced or returned to pre Covid formats.

MFT continues to manage the Trusts recovery programme through a Recovery and Resiilence Board, incorporating operational workstreams such as Outpatients, Elective Care, Urgent Care and Cancer. Each workstream has a designated Group Executive 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 Trust Strategic Group chaired by the Group Chief Operating Officer.

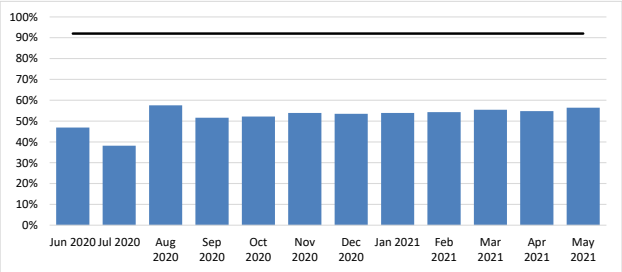
May Summary:
§ Some improvement in diagnostic performance, including NMGH performance post merger.
§ MFT waiting list size has continued to grow throughout 2020 and Q1 of 2021. At the end of May 2021 there were 137,393 patients on the wait list compared to 113,552 (inc NMGH) at April 2020.
§ There were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

Operational Excellence - Core Priorities

RTT - 18 Weeks (Incomplete Pathways)

Actual	56.4%	(May 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.
• Redeployment of staff to support critical care requirements associated with Covid.
• Cautious resumption of the elective programme during Q1 of 2021/22 using a clinically priortised basis through regular Group MESH meetings.

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
✕	✕	✕	✕	✕	✕	✕	✕
79.1%	54.4%	60.6%	48.0%	63.3%	58.6%	59.4%	51.1%

Progress
• The impact of Covid and the suspension of the elective programme has had a detrimental impact on MFT's wait list and RTT position since April 2020, which is also reflected nationally.
• The end of May wait list stands at 137,393. This is an increase of 2,959 (2.20%) on April (including NMGH).
• The number of patients waiting longer than 52 weeks in May was 15,755 (11.47%) of the overall waiting list. This is a 6.9% decrease on the April positon of 16,882.
• The number of patients waiting longer than 104 weeks in May was 266 (0.20%) of the overall waiting list. This is an increase on the April position of 129 (106%). 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 May was 31% of all appointments.

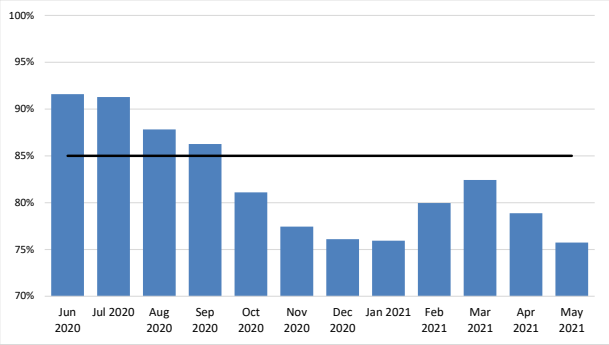
> Board Assurance

May 2021

A&E - 4 Hours Arrival to Departure

Actual	77.2%	Q1 21/22 (Apr to May 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	69.2%	84.3%	91.4%	99.7%	NA	82.9%	65.3%

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.
• The effect of lower attendances is seen in the June and July 2020 performance values, and again in February and March 2020.
• During April and May however performance has significantly deteriorated. This is largely as a result of attendances often higher than cumulative averages and at pre-Covid levels. Part of the pressure has been as a result of increases in walk in and minor illnesses stream.
• As a result of increased demand and the continued need to split estate and flow to meet IPC requirements the number of breaches has been significantly high across MFT EDs

Actions

• Hospital Senior leadership teams at MFT are responding to current performance pressures and have submitted improvement trajectories.
• 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.Further engagement with NHS111 Urgent Care by appointment system;
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).
• GM have also established a programme of work to support urgent care recovery, which is focused on implementation of the requirements set out in the long term plan, which were in progress prior to Covid including: increasing Streaming in ED, maximising Same Day Emergency Care, supporting flow out of hospital. reducing long length of stay.
• MFT Urgent Care Recovery Workstream is aligned to the GM planning.

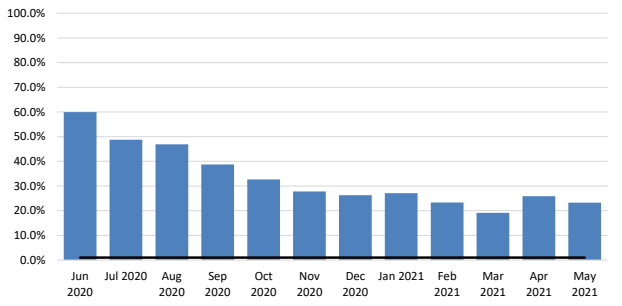
Progress

• ED attendance demand for the majority of 2020/21 was significantly reduced compared to the previous year with 2020/21 levels at 37.82% of 2019.
- May 2021 evidenced 5,200 (12.4%) additional attendances compared to April 2021. Both volume and the higher acuity of patients impacted on delivery increasing the number of breaches by 23.7%.
- Attendances in March, April and May 2021 were 46,9610 (45%) higher than the same period of 2020, however this was 2,217 (2.07%) less than same period of 2019. Breaches were 6,199 (27.5%) in the period of March, April and May 2021 versus the same period in 2019
• MFT reported performance of 79.69 % for Q4 and 82.42% and 78.86% for March and April respectively. At the end of May the Q1 MFT performance delivery was 77.19%.
• Safety remains a keys indicator for the Trust, There were two 12 hour breaches, WTWA and MRI, both were patients with mental health conditions.
• Current performance against Long Length of Stay (LoS):
- The total length of stay 14 days and over, where the patient is now medically optimised has increased in April by 55% compared to March 2021. Subsequently a further 29% increase was seen from April to May. Following the integration of NMGH lengths of stay were included from April onwards. Figures are taken at the first submission for each month.
nb. The Trust will always have a element of LLoS due to clinical complexity.

Diagnostic Performance

Actual	23.3%	(May 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	✗	✗
7.5%	53.1%	78.2%	27.3%	NA	NA	39.1%	37.0%

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 declined in 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 breach numbers was as a result of the merger with NMGH effective 1st April.

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.

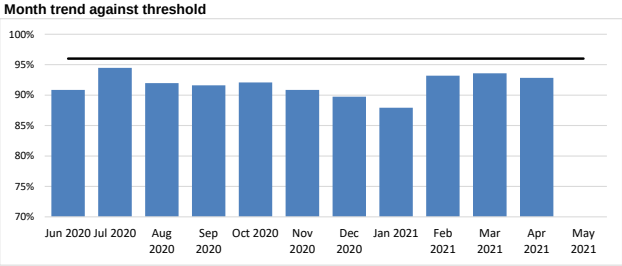
Progress

- 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 (compared to 23,848 in June 2020).
- Post merger, and inclusion of NMGH diagnostic numbers, the wait list has increased to 26,680 in May 2021.
- Performance, including NMGH, has improved, with 23.25% breach rate compared to 48.76% breach rate in June 2020.

Cancer 31 Days First Treatment

Actual	92.8%	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	82.5%	100.0%	78.9%	NA	NA	96.7%	93.5%

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

Key Issues

- Cancer Demand, 3 key challenged pathways: Lung, Urology and Gynaecology, excerbated 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 and GI services (especially HPB where a large number of patients require HDU capacity).
- Gynaecoology and skin also underperformed 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.
- NMGH has the largest number of undated urology patients and capacity is being sought at ORC and WTWA
- Cancer Recovery Workstream in place, details under the 62 day standard.
- WTWA is performing against the standard

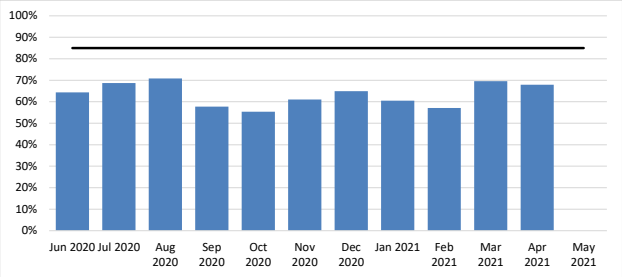
> Board Assurance

May 2021

Cancer 62 Days Referral to Treatment

Actual	67.9%	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	61.8%	NA	38.1%	NA	NA	71.0%	73.9%

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.

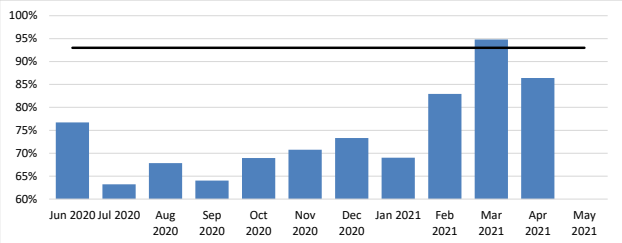
Progress

- Demand – average monthly referrals were 2,921 in 2019 (Jan to June) and this has increased to average 3,170 oper 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.
- Safety remains a key priority and harm reviews continue to be undertaken for the longest wait patients.

Cancer Urgent 2 Week Wait Referrals

Actual	86.4%	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	96.8%	100.0%	97.6%	NA	NA	76.2%	91.4%

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

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.

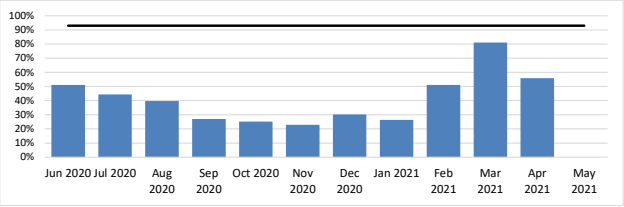
Progress

- 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.
- ORC hospitals performed against the target in April, NMGH narrowly underperformed with main underperformance in Breast and Gynaecology. WTWA main underperformance was breast. Position has improved for May and June, May performance is currently 89% across ORC and WTWA.
- The Skin and Breast cancer sites are affecting the overall Group performance, due to their size, and also capacity challenges as a result of Covid. These services don't lend themselves to virtual appointments and therefore, alternative options have had to be considered.

Cancer 2 Week Wait - Breast

Actual	55.8%	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	NA	NA	✗	✗
NA	NA	NA	NA	NA	NA	52.8%	60.7%

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.

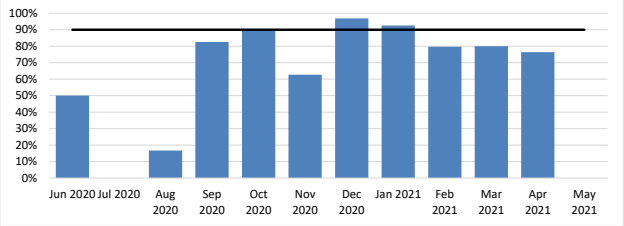
Progress

See the 2ww measure.

Cancer 62 Days Screening

Actual	76.4%	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	11.1%	NA	0.0%	NA	NA	93.0%	100.0%

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.

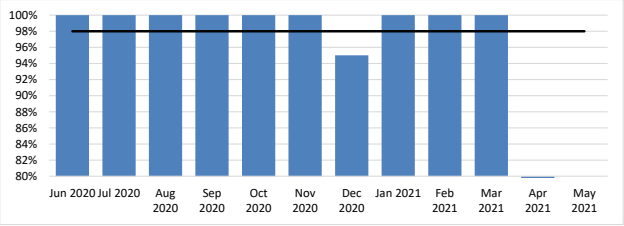
Progress

• 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	52.2%	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 requiring increased local surveillance.

Actions

• Actions are outlined under the cancer 62 day standard.

Progress

•Standard achieved in month.

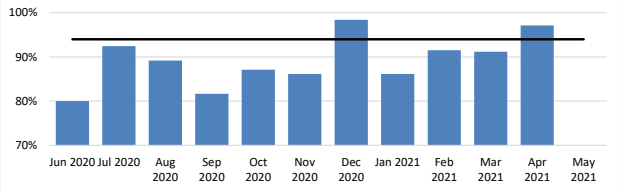
> Board Assurance

May 2021

Cancer 31 Days Sub Surgical Treatment

Actual	97.1%	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	75.0%	NA	100.0%	NA	NA	100.0%	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 62 day standard.
- MRI were the only site to underperform with 2 breaches in Urology.
- WTWA treat the most patients on the subsequent pathway with breast and skin surgery.

Workforce and Leadership

P. Blythin

Core Priorities	✓	◇	×	No Threshold
	4	0	6	3

Headline Narrative

Following the successful acquisition of North Manchester General Hospital, work continues to fully embed the MFT Workforce & 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 'grip' across NMGH.

Our COVID-19 workforce recovery programme is underway, putting staff health and wellbeing, inclusion, compassion and news ways of working at the forefront of our 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.

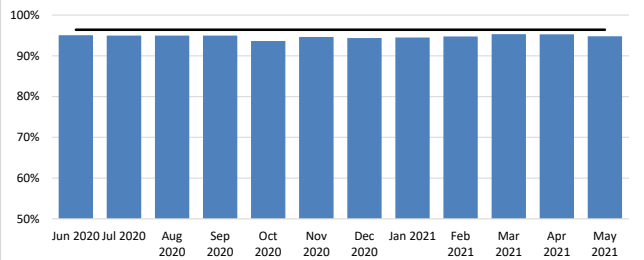
The MFT People Plan has also now been launched. A governance structure and performance monitoring dashboards are currently being embedded to oversee delivery.

Workforce and Leadership - Core Priorities

Attendance

Actual	94.8%	(May 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
×	×	×	×	×	×	×	×
95.5%	93.8%	95.1%	95.2%	92.1%	93.2%	94.8%	94.8%

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 May was 94.8% which is lower than the previous month's figure (95.3%). The attendance rate was the same at this point last year (May 2020) at 94.8%. The latest figures released by NHS Digital show that for January 2021 the monthly NHS staff sickness absence for the whole of the North West HEE region was 6.3% or 93.7% 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.

Due to the COVID-19 pandemic the timetable to launch Absence Manager was expedited across all hospitals/MCS. Throughout the pandemic the Absence Manager system proved invaluable, providing the Trust with real-time intelligence on staff absence to inform workforce reporting, planning and modelling. Work continues to support our managers make best use of the system and support the health and wellbeing of our staff.

Following the acquisition of NMGH in April 2021, this is the only outstanding Hospital which currently does not use the Absence Manager system. Plans are in place for the rollout in NMGH to begin in August 2021.

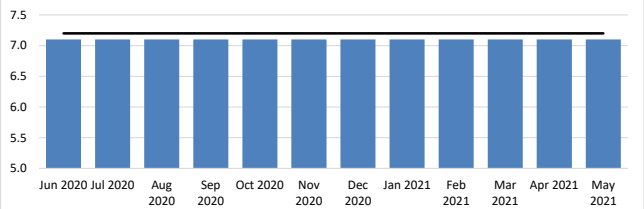
> Board Assurance

May 2021

Engagement Score (quarterly)

Actual	7.10	Q1 21/22	**Accountability**	P. Blythin
Threshold	7.20	(Higher value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



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.

From July 2021, MFT will be required to participate in the QSS on a quarterly basis (except quarter 3), during the months of April, July and January. It will utilise the nine engagement theme questions from the annual National Staff Survey Arrangements for the 2021 NHS Staff Survey will begin in July.

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.

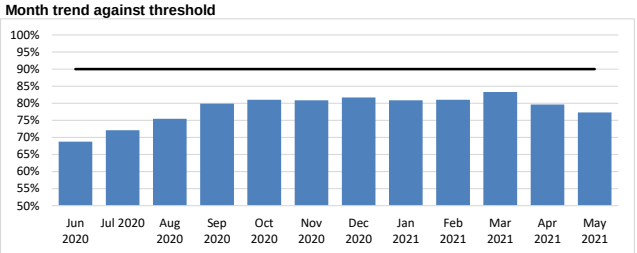
Hospital level compliance

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

Appraisal- non-medical

Actual	77.3%	(May 2021)	**Accountability**	P. Blythin
Threshold	90.0%	(Higher value represents better performance)	**Committee**	HR Scrutiny Committee

Month trend against threshold



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 May 2021. Only the Dental Hospital and Eye Hospital increased their compliance score from April 2021, all other Hospitals and MCS's have a lower compliance rate compared to the previous month. The MRI had the biggest drop in compliance at 7.1% with a score of 82.7% compared to 89.8% in April.

Actions

During the pandemic, appraisal reporting and compliance remained a key focus area with weekly and monthly reporting provided. Virtual sessions on effective appraisals 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.

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
✗	✗	◇	✗	◇	◇	✗	✗
79.8%	82.7%	85.9%	82.6%	85.7%	86.5%	84.3%	45.4%

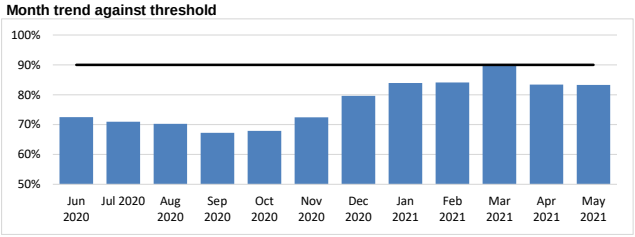
> Board Assurance

May 2021

Appraisal- medical

Actual 83.3% (May 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
✓	◇	◇	✓	✓	◇	◇	✗
90.3%	89.8%	85.2%	91.8%	97.1%	89.9%	89.5%	37.1%

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

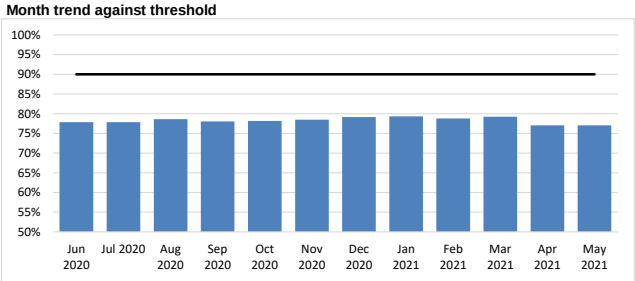
Key Issues
Compliance decreased by 0.1% in May 2021 to 83.3%.

Actions
During the pandemic, appraisal reporting and compliance remained a key focus area with weekly and monthly reporting provided. Virtual sessions on effective appraisals 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 77.1% (May 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
✗	✗	✗	✗	✗	✗	✗	✗
77.4%	80.0%	79.8%	82.4%	78.2%	78.4%	80.1%	60.9%

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.

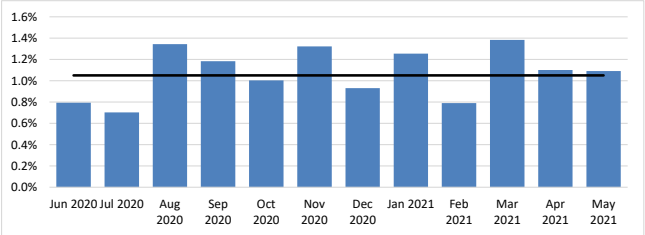
Key Issues
Compliance increased by 0.1% across the Group in May to 77.1% and is now 12.9% below the Trust target. NMGH showed the largest increase in compliance from April 2021 with a 1.5% increase, although they still have the lowest compliance score of all Hospitals/MCS's.

Actions
The Mandatory Training Steering Committee, chaired by the Group Executive Director of Workforce and Corporate Business, is scheduled to reconvene in July. The 5 key Mandatory Training work streams, chaired at CEO / Director level have worked toward the KPMG audit where we received significant reassurance and are now progressing towards integration in business as usual processes. 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 1.1% (May 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	✗	✗
0.67%	1.42%	0.35%	1.34%	0.00%	NA	1.33%	1.17%

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.

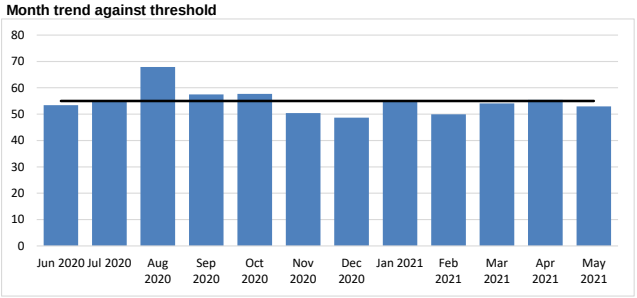
Key Issues
The turnover for May 2021 is 1.1% against a monthly target of 1.05%. This is the same as the previous month where turnover was 1.1% (April 2021). The rolling 12 month average for B5 Nursing and Midwifery turnover was 13.6% in May 2021 which is 1.0% lower than last year (14.6%, May 2020).

Actions
Retention of Nurses and Midwives remains a key focus for the Trust. During the pandemic recovery work will continue to focus on staff engagement, career opportunities and support for new starters through the preceptorship programme.

Time to Fill Vacancy

Actual	52.9	(May 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
✓	✓	✓	✗	✓	✗	✓	✗
48.8	43.4	51.0	59.7	44.4	62.5	48.5	61.6

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 figure without Band 5 Nursing included has reduced from 53.36 in April to 49.32 in May. The time to fill reduced in all of the staff groups. The Trust also saw a reduction in the time to fill for NMGH from 68.14 in April to 61.57 in May which is a reduction of 6.57 days.

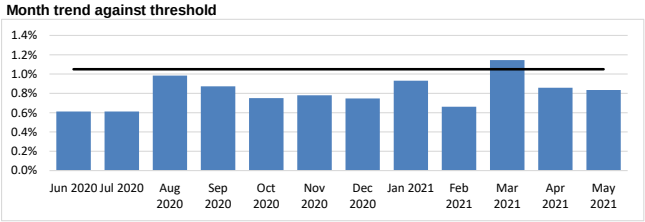
Actions

The time to fill improvement is as a result of work to improve efficiencies within the Recruitment team as well as investment at both coordinator and team leader level which is enabling more scrutiny on the processing of the pre-employment checks in the most timely manner. The team will continue to work to drive this number further down, and work is underway to review time to fill data by hospital and by staff group to identify specific areas for improvement.

Turnover (in month)

Actual	0.83%	(May 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
✓	✓	✓	✗	✓	✓	✓	✓
0.83%	0.74%	0.59%	1.21%	0.55%	0.93%	0.96%	0.81%

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

Key Issues

The single month turnover position for the Group has decreased to 0.8% when compared to the previous month (0.9%).

The turnover rate was slightly lower at the same point last year (May 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.

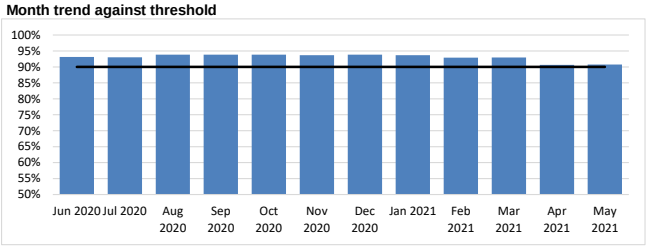
> Board Assurance

May 2021

Level 1 CSTF Mandatory Training

Actual	90.7%	(May 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
✓	✓	✓	✓	✓	✓	✓	✗
91.0%	93.8%	92.8%	93.9%	93.4%	93.3%	92.8%	78.7%

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 May the aggregate compliance increased by 0.1% to 90.7%. Only NMGH has a compliance score below the 90% Trust target.

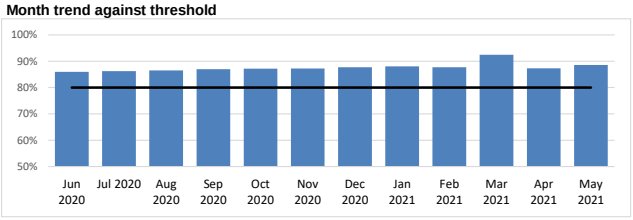
Actions

The Mandatory Training Steering Committee, chaired by the Group Executive Director of Workforce and Corporate Business, is scheduled to reconvene in July. The 5 key Mandatory Training work streams, chaired at CEO / Director level have worked toward the KPMG audit where we received significant reassurance and are now progressing towards integration in business as usual processes. North Manchester have now been successfully integrated into the Learning Hub from 26th April 2021 which enables us to manage compliance levels.

Nurse Retention

Actual	88.6%	(May 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
87.3%	88.7%	90.8%	87.9%	91.4%	94.7%	87.2%	NA

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 May 2021, Nursing and Midwifery retention stands at 88.6% 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.

> Board Assurance

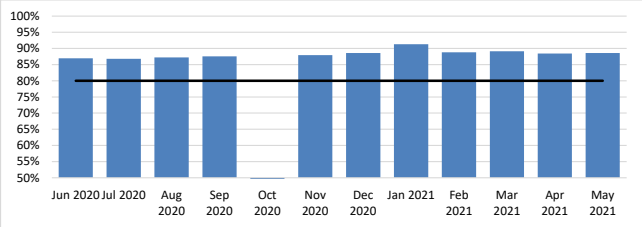
May 2021

BME Staff Retention

✓

Actual	88.6%	(May 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%	87.2%	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 May was 89.2%.

Action

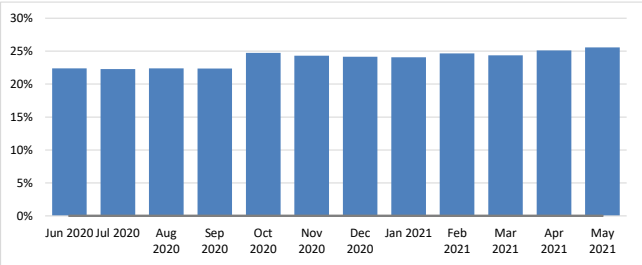
All Hospitals / MCS / LCO are tracking this KPI within their AOF and their retention rates are all above the Trust's threshold of 80% and developing plans to address where negative gaps are being identified.

% BME Appointments of Total Appointments

-

Actual	25.6%	(May 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
-	-	-	-	-	-	-	-
25.5%	28.2%	24.2%	20.5%	34.8%	47.4%	27.2%	20.0%

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

Over one in four appointments is of black and minority ethnic origin (25.6%); which is consistent month on month.

The Trust has increased its % BME appointments of Total Appointments by 2.4% when compared to the same point last year (May 2020, 23.2%). 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 plan 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

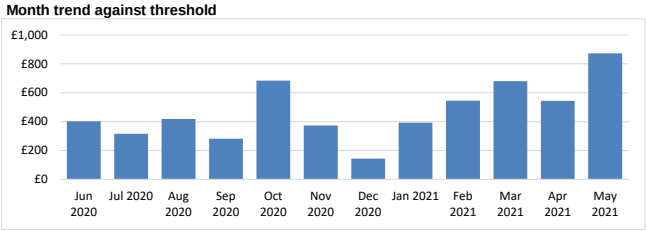
> Board Assurance

May 2021

Medical Agency Spend

Actual	£873	(May 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
-	-	-	-	-	-	-	-
£91.8	£239.7	£97.0	-£1.2	£83.9	£0.0	£276.2	£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 May total value of Medical and Dental agency staffing was £872k compared to £543k in April. This is the highest in the last 12 months and reflects an increase in agency usage to support recovery work.

Actions

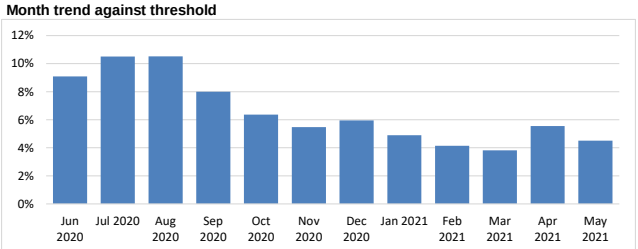
Spend continues to be reviewed for both bank and agency medics across all hospitals and grades. This is including an in-depth monthly review of all of the cost centres using medical agency workers and opportunities identified where possible to reduce this.

A 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.

Qualified Nursing and Midwifery Vacancies B5 Against Establishment

Actual	4.5%	(May 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
-	-	-	-	-	-	-	-
-8.3%	8.0%	-2.3%	2.4%	15.2%	NA	7.2%	

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 May 2021 there were 269.6 (5.7%) 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, and it is anticipated this may lead to an increase in the overall band 5 nursing vacancies.

Actions

A Group Resourcing Plan is being developed to support recruitment plan through virtual events and social media. These events have commenced to build a workforce pipeline to support workforce plans over the next 12 months.

> Board Assurance

May 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

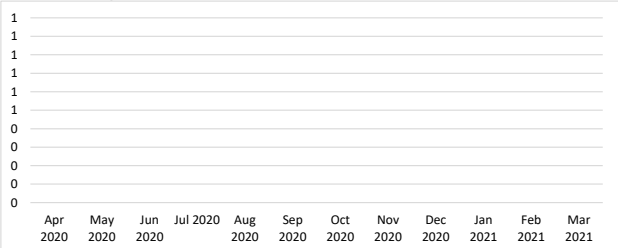
Actual

Threshold

Accountability A.Roberts

Committee TMB and Board Finance Scrutiny Committee

Month trend against threshold



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.

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

Regulatory Finance Rating

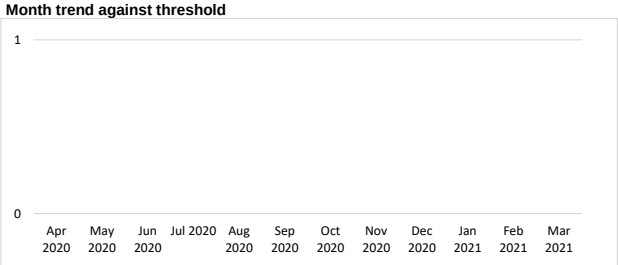
Actual

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 Performance and EPRR
Date of paper:	June 2021
Subject:	Update on MFT ongoing response to Covid
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	To achieve high standards of patient safety and clinical quality across the Trust demonstrated through performance outcome measures
Recommendations:	Board of Directors are asked to note the contents of the report
Contact:	Name: James Allison, Director of Performance and EPRR Tel: 0161 276 6718

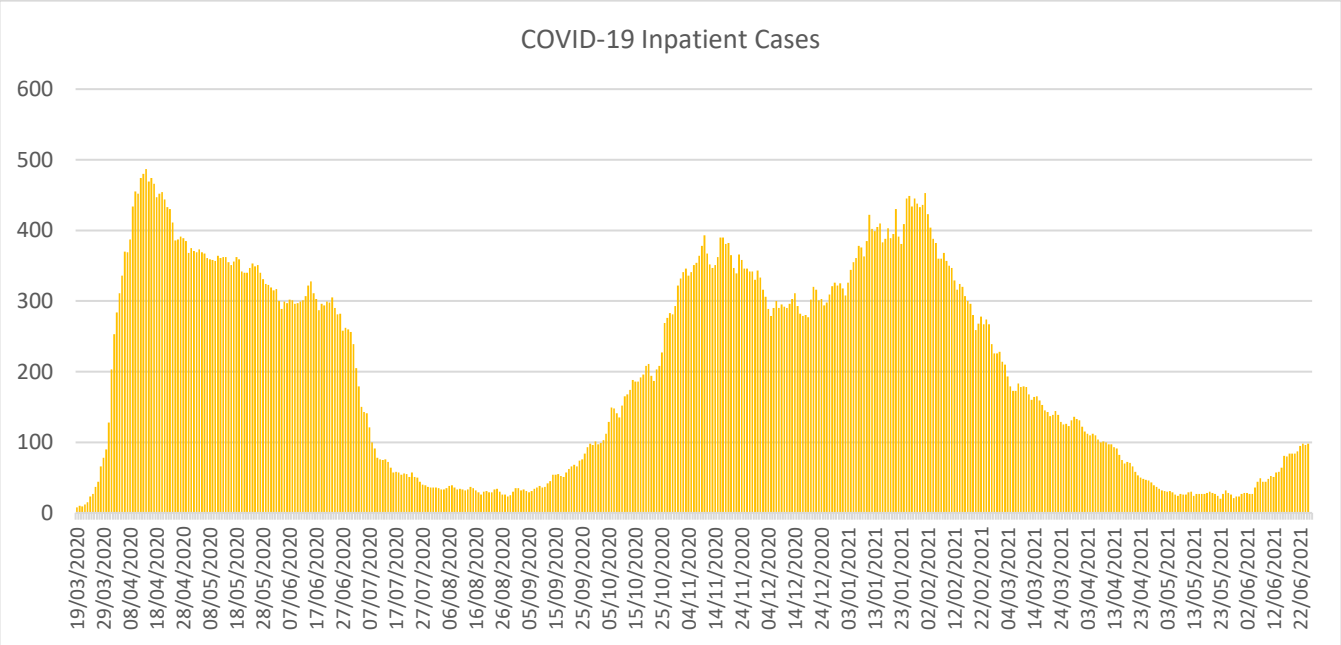
COVID – UPDATE ON THE TRUST ONGOING RESPONSE

1. PURPOSE

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

2. COVID POSITION

- MFT had two peaks of Covid attendances during Quarter 1 (Q1) of 2021.
    - The first peak occurred in the second week of January and saw 423 Covid attendances.
    - A second rise in Covid attendances at the end of January resulted in a peak of 453 Covid patients occupying in-patient beds, with 64 patients in Critical care beds (level 2/3).
- Inpatient Covid numbers of 453 in January represented 93% of the wave 1 Covid peak (487 inpatients, 14th April 2020).
- Between February and May there was a slow decline in Covid inpatient and critical care patient numbers. However, from the start of June there has been an increasing incidence of the Delta variant of Covid in the community.
- This has resulted in a sharp increase in Covid inpatient numbers at MFT. At 29th June MFT had 111 Covid inpatients and 24 patients in Critical Care.
- Table 1. MFT Covid inpatient cases (March 2020 to June 2021)



3. CONTINUED COVID PLANNING

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

The standing down of Group Tactical meetings, and the retention of a shadow rota was agreed by MFT Strategic Group in Q1 of 2021/22. Arrangements can however be quickly stood up again should there be a need to manage any further increase in numbers of Covid inpatients and Critical Care patients as a result of Delta or other variants. This ensures coordination of the overall day to day incident management and response to external partners.

Individual Hospital / MCS escalation plans approved via the MFT Strategic Group in the second half of 2020/21 have continued into Q1 of 2021/22. The ongoing response to Covid has resulted in continued impact on the Trust's recovery workstreams and performance against national standards in this period.

In order to continue to address the needs of Covid demand, these plans had a tiered approach to the escalation processes to balance the impact on all activity programmes. Following the slow decline in Covid inpatient and critical care patient numbers during Q1 2021/22 MFT Strategic Group took the decision to cautiously increase routine elective activity, focusing on priority patients including Cancers in line with national guidance.

The recent marked increase in Covid patients requiring inpatient and critical care support has required a need to re-implement appropriate estate escalation plans across relevant sites. The tiered escalation plan approach allows MFT to quickly flex ward configurations to balance the provision of care to Covid and Non-Covid patients.

Notwithstanding this increase in Covid demand across sites, operational efforts continue with the resumption and retention of services. e.g.

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

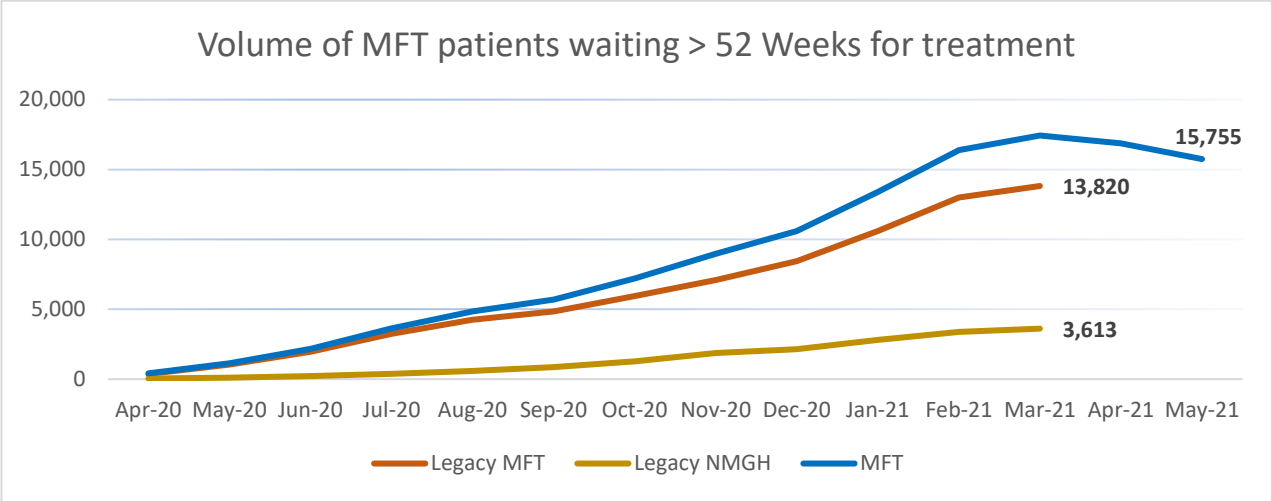
At the end of March, NHSE/I planning guidance was published that sets out the planning and delivery priorities for 2021/22, including restoration of services, meeting new care demands and reducing wait time back logs arising as a direct consequence of Covid. MFT continues to take actions to improve performance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

4. IMPACT OF COVID 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 May 2021 was 137,393 of which the volume of >52-week waiters at the end of May 2021, was 15,755 (11.5%).

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

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



The Trust continues to performance manage hospital / MCS delivery and clinical validation. The priority of this work is to ensure the number of long waiters is minimised where possible.

5. RECOVERY PROGRAMME

5.1 RECOVERY PLANNING

A permanent shift in operating models across MFT and the wider Greater Manchester system (GM) is now required to respond and recover from Covid. This will entail significant demands in terms of staff engagement and leadership capacity. Working collaboratively with other GM Health provider organisations, MFT supported the development and submission of elective recovery plans for the first half of 2021/22. Plans set out the GM ambition for elective recovery; including details of how collectively GM would start to address the overall waiting list and take the opportunity to transform service delivery in the process.

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. Development of these green sites is framed within a number of GM objectives to:

- Utilise a clinically led approach to restarting elective activity as soon as possible;
- Take a system approach to ensure equity of access across GM for those on waiting lists;
- Protect Covid free pathways – ensuring ability to maintain adequate segregation of Covid positive and negative patients;
- Ensure available capacity to deliver elective activity is sufficient to provide to cope with short term capacity issues and / or staff shortages or peaks in Covid activity; and
- Guard against increased IPC risk through regular changes to wards between Covid and Non-Covid.

To progress restoration of elective care a GM Task and Finish Group has been established, reporting into the GM Elective Recovery and Reform Programme Board. The Recovery Task and Finish Group, chaired by Professor Jane Eddleston, has oversight of seven clinical priority workstreams, agreed by GM Medical Directors:

- Trauma & Orthopaedics;
- Ophthalmology;
- Gynaecology;
- General Surgery;
- ENT;
- Oral Surgery; and
- Paediatric surgery including dental.

A Clinical Reference Group (CRG) has been established for each specialty, chaired by a GM Medical Director and including clinical representation from across the care pathway as well as commissioning representation. The focus of each CRG is to maximise restoration of activity and identify and implement opportunities to transform delivery including supported self-care, optimising referrals, and exploring changes in care settings. As part of the Trauma and Orthopaedic workstream, MFT is planning use of Trafford General Hospital as a standalone elective hub facility.

Internally, MFT continues to develop its approach to general Recovery. Hospitals / MCS have developed implementation plans that have been consolidated into an overarching Recovery Plan at Group level. Work continues on the detailed implementation plan and key priorities for the immediate period remain:

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

5.2 ELECTIVE CARE - CLINICAL PRIORITIATION / MESH

As a result of the challenging operational environment caused by Covid, effective management of elective waiting lists at hospital / MCS level is required to ensure MFT treats its most clinically urgent patients first given infection prevention and control and staffing constraints. This 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. These groups are clinically led and continue to oversee the validation and prioritisation of single pooled specialty Patient Treatment Lists, ensuring that sites utilise their resources to treat the most clinically urgent patients.

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

5.3 RECOVERY MODELLING

At the end of March, NHSE/I published a series of documents outlining national, system and organisational priorities for April to September 2021/22 (H1 Period). These included operational and financial planning guidance for recovery and transformation, comparing planned restoration activity to 2019 activity baselines. The documentation set out expectations of planning at Integrated Care System levels ("ICS") with the support of local NHS organisations to develop agreed operational and financial plans. Six key priorities were identified within the planning guidance for consideration and planning:

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

Given uncertainty around the continued pattern of Covid transmission across the H1 Period, a lack of clarity on potential levels of non Covid demand and the ability to service that demand remained. As a result, the March national planning guidance set out a limited number of planning assumptions:

- Overall non-elective demand from both Covid and non-Covid returns to pre-pandemic (2019/20) levels from the beginning of 2021/22, subject to the impact of any planned service developments.
- Covid general and acute bed occupancy remains at less than 5% during the H1 Period.
- Infection Protection Control: continued, reliable application of the UK IPC guidance (and therefore implications for productivity and capacity).

MFT worked with GM health partners to shape the format, and trajectory / timing of system wide elective recovery planning. A draft Integrated Care System plan was submitted to NHSEI on the 6th May with a final submission on the 3rd June. Similar to the process for the first phase of modelling in early March, a working group was set up that met twice a week. The group brought representatives together from operations (Group and hospital / MCS), clinical and nursing, informatics, finance and workforce colleagues in order to develop the required planning information.

It was previously agreed that the draft activity plan would be based on an overall MFT model and the final activity plan would be based on hospital-level models. Working with their principal analysts, hospitals developed local plans. These were developed at the site, specialty and point of delivery ("POD") level, including opportunities from different ways of working. These local plans were then aggregated to a final MFT activity plan.

The detailed hospital level plans demonstrated a higher level of recovery (based on financial value) than the initial MFT top down plan. The hospital level plans also represented a much more granular view of activity, taking into account the productivity achieved across the hospitals. This was demonstrated through the actual value of the elective level of activity in April 2021 being 10% higher than predicted in the initial model. As a result, an 'improved' MFT trajectory was included in the final submission.

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

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.

6.1 URGENT CARE AND FLOW

Since Mid-February, MFT EDs have encountered significant pressures with attendances often higher than cumulative averages and at pre-Covid levels. Part of the pressure has been as a result of increased walk in attendance, and other key drivers have been noted across all sites within:

- Paediatrics: all acuity levels;
- Adult Minor injury / illness (Self presenters); and
- Mental Health presentations: all ages with an increase in 'new to service' referrals requiring more in-depth assessment and higher levels of acuity, either with or without a degree of self-harm.

As a result of increased demand and the continued need to split estate and flow to meet IPC requirements the number of breaches has been significantly high across MFT EDs. Hospital Senior leadership teams at MFT are responding to current performance pressures and have submitted improvement trajectories that 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:

- Working with system partners to promote redirection at streaming stage through initiatives such as helicopter nurse;
- Continued development of Same Day Emergency Care capacity across sites;
- Further engagement with NHS111 Urgent Care by appointment system;
- 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).

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 and improvement trajectories is being impacted by an ongoing need to manage increasing Covid and Non-Covid attends. Given the extreme pressures on ED and inpatient &critical care bed base the Trust has continued to work closely with system partners across the final to provide additional focus on effective and timely discharge. Support to further improve processes across the Trust has been provided by the Trust Transformation team.

6.2 OUTPATIENTS

The prolonged impact of Covid in Q4 of 2020/2021 and Q1 of 2021/22 has had a significant impact on delivery against outpatient activity plans across most of the MFT hospital sites. Whilst occupancy levels of Covid inpatients started to decline in late March and early April, social distancing requirements remained in place and staff continued to be redeployed.

The proportion of activity that has been delivered virtually across MFT during Q1 of 2021/22 sat at c.32% with consistent delivery of over 5.0%. of consultations undertaken via video. MFT has regularly exceeded or met the NHSE / I target of 25% virtual outpatient appointments, either by telephone or video during Q1 and Q2, and the overall level of virtual delivery has remained steady to the end of May.

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

7. STAFF TESTING

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

As at 23rd June 2021, a cumulative total of 285,554 tests had been undertaken and reported by staff. The number of staff who have reported a positive LFT was 689, a 0.24% positive rate, with 83% of LFT positives being confirmed by a subsequent PCR test.

The distribution of LFT kits is ongoing, but there has been a declining uptake following the successful vaccination campaign. The Trust is taking a number of steps to promote testing and recording of results. This includes 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 and simplified distribution and testing procedures based on staff feedback.

8. PERFORMANCE

Urgent Care:

MFT

- Safety remains a key priority for the organisation.
- MFT were ranked 3rd across GM in April, dipping to 6th in May for the 4-hour performance target and are presently ranked 5th for Quarter 1 2021/22.
- Acuity of patients presenting and limitations on bed capacity due to flow restrictions and social distancing at times of attendance have impacted performance in Q1 of 2021/22.
- WTWA and MRI have each reported a twelve-hour breach at their respective sites. On both occasions the patients delayed had Mental Health conditions which required assessment from Mental Health Teams. Work to develop the escalation process into GMMH is underway.

4 Hour Performance	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Q1
MFT %	90.18	93.40	91.60	91.80	88.20	86.30	81.07	77.40	76.10	75.95	79.96	82.41	78.87	75.73	75.79
MFT GM Rank	3	3	2	2	3	3	2	2	3	3	4	3	3	6	5
NMGH %	88.10	87.90	81.00	82.40	79.40	75.80	68.20	69.20	70.00	71.00	72.02	72.30			
GM %	89.80	93.30	90.50	89.50	86.20	82.40	76.30	74.70	74.30	75.30	79.43	79.97	79.43	78.04	77.19
National %	90.35	93.50	92.78	92.13	89.25	87.28	84.42	83.84	80.28	78.51	83.92	86.14	77.32		

Planned Care:

RTT & 52 Weeks:

MFT

- The number of patients waiting >52 weeks has increased since April 2020 primarily due to the response to Covid.
- Within MFT there are now 15,755 patients waiting past 52 weeks at the end of May 2021, including NMGH.
- Between April and May the number of 52 week waiters has decreased by 1,127 (6.9%).
- 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 declined in April to ~32% and remained at that level in May, compared to a high of 36% in March

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	April	May
MFT	Wait List	98,785	102,318	101,203	102,381	104,150	106,272	106,438	106,706	109,452	111,006	113,659	115,222	134,434	137,393
	52 Weeks	369	1,042	1,959	3,245	4,260	4,846	5,946	7,100	8,443	10,602	12,999	13,820	16,882	15,755
	% of W/L >52 weeks	0.4%	1.0%	1.9%	3.2%	4.1%	4.6%	5.6%	6.7%	7.7%	9.6%	11.4%	12.0%	12.60%	11.47%
NMGH	Wait List	14,767	14,790	14,250	14,806	14,745	14,375	14,862	15,443	14,992	15,505	16,295	17,653		
	52 Weeks	46	99	210	391	583	855	1,269	1,877	2,148	2,798	3,382	3,613		
	% of W/L >52 weeks	0.3%	0.7%	1.5%	2.6%	4.0%	6.0%	8.5%	12.2%	14.3%	18.1%	20.8%	20.5%		
National position	Wait list *Million	3.94	3.83	3.86	4.05	4.22	4.35	4.44	4.21	4.28	4.31	4.42	Not available	Not available	Not available
	52 Weeks	11,042	26,029	50,536	83,203	111,026	139,545	162,888	186,310	215,641	288,160	366,194			
	% of W/L >52 weeks	0.3%	0.7%	1.3%	2.1%	2.6%	3.2%	3.7%	4.4%	5.0%	6.70%	8.3%			

Diagnostics:

MFT

- The waiting list size for diagnostic tests at MFT has reduced slightly (256) between April and May to 26,680.
- The breach rate for the 6-week standard increased to 25.81% in April, but has decreased in May by 2.56% to 23.25%.
- The increase in April reflected the inclusion of NMGH. Previously the breach rate had shown a decline month on month for MFT from May 2020 as evidenced in the table below.
- In March the breach rate was 19.14% of the total wait list for MFT, the lowest rate during the 2020/21 year.

DMO1 Breach rate	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
MFT	46.90%	64.90%	59.90%	48.80%	46.90%	38.70%	32.70%	27.80%	26.30%	27.10%	23.35%	19.14%	25.81%	23.25%
NMGH	54.10%	51.30%	45.20%	40.60%	47.10%	43.30%	34.00%	27.80%	31.30%	16.60%	6.30%	9.91%		
National	55.70%	58.50%	47.80%	39.60%	38.00%	33.00%	29.20%	27.50%	29.20%	33.30%	28.50%	Not available	Not available	Not available

Cancer:

MFT and NMGH

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

		Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
MFT	2WW %	93%	83.2	87.7	76.7	63.2	67.9	64.0	68.9	70.8	73.3	69.0	82.9	94.8	86.4
	31 Day %	96%	93.2	88.1	90.9	94.5	92.0	91.6	92.1	90.9	89.7	87.9	93.2	93.5	92.8
	62 Day %	85%	64.2	51.3	64.4	69.3	71.8	57.7	55.4	61.1	65.0	60.5	57.1	69.6	67.9

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

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

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

9. RECOMMENDATION

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

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Alison Lynch, Corporate Director of Nursing
Date of paper:	July 2021
Subject:	COVID-19 Vaccination Programme
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	• Improve patient safety, quality and outcomes • Improve the experience of patients, carers and their families
Recommendations:	The Board of Directors are asked to note: • The information provided in the report in relation to the COVID-19 Vaccination Programme
Contact:	Name: Alison Lynch, Corporate Director of Nursing Tel: 0161 276 5655

1. Background

1.1. The national vaccination programme commenced in December 2020. So far, more than 43 million people have had a first vaccine dose - about 80% of the adult population - and over 31 million have had a second.

1.2. Nationally, uptake and vaccine confidence remain very high. The latest PHE study shows that over 14,000 lives have already been saved and over 42,000 people have not needed to attend hospital because of the protection offered by the vaccination[1]

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[2].

2.2. Through the MFT staff vaccination programme[3]:

92.2% have received their first vaccine[4]
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.

3. Context of vaccine delivery in Manchester

3.1. As a result of increasing COVID-19 cases especially linked to the Delta variant, Greater Manchester, including Manchester, was designated an Enhanced Response Area (ERA) on Tuesday 8th June 2021.

3.2. MFT are supporting the Manchester Vaccination programme, specifically working with Manchester Health Care Commissioning Group to increase vaccine coverage in Manchester where 58%[5] of adults over the age of 18 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.
- 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.
- Offer of vaccination to pregnant women of all ages, including staff who are booked for care at St Mary's.
- Care home staff vaccination programme support, Christie staff, National Blood and Transplant staff, and Greater Manchester Mental Health NHS Foundation Trust (GMMH) new starter support in line with clinic availability.

[1] COVID-19 vaccine surveillance report: 10 June 2021 (week 23)
[2] Trafford deliver AZ vaccine only
[3] Data accurate at 22rdJune 2021
[4] Excluding those exempt or declined as at 22nd June 2021
[5] Data accurate at 22nd June 2021

- Opportunistic in-patient vaccination, including paediatric in-patients[6] and particularly vulnerable groups, for example patients with cystic fibrosis and parents/guardians of babies in neonatal units.

4.2. As part of the response to increase vaccination uptake, MRI, Wythenshawe and NMGH clinics have received national approval to operate as Hospital Hub Plus sites until the end of Phase 2.

4.3. A period of 'on-boarding' as Hospital Hub Plus sites has commenced. Benefits of this status include:

- increased clinic availability/choice to the public thus offering wider opportunities for vaccination across Manchester
- reduction in the administration burden to offering vaccination beyond MFT staff groups through the National Booking System (NBS).
- opportunity for earlier allocation of vaccines other than Pfizer or AZ as they become available.

4.4. Further focussed and targeted clinics at MFT have been offered and agreed by the MHCC vaccination team.

4.5. MFT has actively promoted the vaccine take up for pregnant women with all women attending our clinics being offered the vaccine. In addition we have developed a strong social media campaign and supported GMHSCP.

5. Vaccine Programme, Delivery and Supply

5.1. The MFT vaccination programme has delivered over 129,000 vaccines through the four clinics. The pharmacy team work closely with the vaccine clinic teams to ensure sufficient supply is available to match demand.

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

6. Responding to National Guidance

6.1. On 14th May 2021, the JCVI recommended that the second dose interval be brought forward from 12 to 8 weeks for people in priority cohorts 1-9 who were yet to receive their second dose. This was implemented in all MFT clinics.

6.2. Recent responses to updates to PHE's Green Book[7] and the National Protocol used to deliver the vaccine have been incorporated into MFT policies and procedures.

7. Policies, procedures and guidelines

7.1. 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.

8. Data and reporting

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

- Frontline Healthcare staff

[6] 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.

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

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

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

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

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

9. Communications and Engagement

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

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

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

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

10. Governance

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

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

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

11. Summary

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

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

- 92.2% of staff having received their 1st vaccine
- 93.8% of staff having either had or booked their 1st dose.
- 87% of BAME staff have received their vaccination

11.3. Walk-in and evening clinics have been established to support increase in vaccination across Manchester.

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

11.5. 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 and eligible family members of MFT staff. The focus will consider vaccine availability, clinics capacity, workforce requirements, and any national directives that may be released.

12. Recommendations

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

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Julie Cawthorne, Assistant Chief Nurse Infection Prevention and Control/Clinical DIPC Alison Lynch, Corporate Director of Nursing
Date of paper:	June 2021
Subject:	To provide assurance to the Board of Directors on the Management of Nosocomial Infections
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Staff and Patient safety Patient experience
Recommendations:	The Board of Directors are asked to note the actions and progress to reduced the risk of transmission of COVID-19 across all our services.
Contact:	Name: Julie Cawthorne, assistant Chief Nurse Infection Prevention and Control / Clinical DIPC Tel: 0161 276 4042

1. Introduction

1.1 The Trust is committed to the prevention and management of Nosocomial Infections as demonstrated in the continuing actions and improvement programmes set out in the Infection Prevention and Control (IPC) Board Assurance framework (BAF) updated June 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 and staff testing.

1.3 This paper provides an update on the IPC BAF, Nosocomial transmissions of COVID-19 and updated guidance on FFP3 Resilience in the Acute Setting.

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.

2.2 It also serves as an improvement tool to optimise actions and interventions. NHSE/I updated the IPC BAF in February 2021 to include additional indicators in 5 of the 10 IPC standards. This paper provides information relating to the most recent assessment of the IPC BAF.

3. The IPC Board Assurance Framework

The IPC Board Assurance Framework has been reviewed at the following Board of Directors meetings or 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 Group, a Sub-Committee of the Board of Directors
- 9th November 2020. Board of Directors Meeting (amalgamated into the Trust Board Assurance Framework).
- 11th December 2020. Extraordinary Board of Directors Meeting
- 11th January 2021. Group Infection Prevention and Control Group.
- 8th March 2021. Board of Directors Meeting (as part of a report relating to Nosocomial Infections)
- 20th April 2021. Group Infection Prevention and 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 use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users (updates included on pages 8, 9, 14, & 15)

- Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections (updates included on pages 24 & 25)

- 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 29)

- 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 34)

- 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 (no change)

- Provide or secure adequate isolation facilities (no change)

- Secure adequate access to laboratory support as appropriate (updates included on page 46)

- 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 (no change)

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

- Patients and visitors are fully aware of the measures staff are required to take to prevent COVID-19 infections, and the measures they are themselves required to take to prevent COVID-19 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
- 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

4.1 The most recent figures from the Scientific Advisory Group for Emergencies (SAGE) accessed 24th June 2021 indicate the latest reproduction number (R) rate of Coronavirus (COVID-19) in the North West is 1.3 to 1.5.

4.2 As the COVID-19 pandemic has progressed, multiple lineages of the SARS-CoV-2 virus have emerged in various countries as the virus continues to evolve. Some of these lineages have been identified as variants of concern (VOC) based on evidence that they are associated with factors that impact public health management (for example vaccine efficacy and transmissibility).

4.3 Public Health England and NHS England have implemented assays that identify COVID-19 variants of concern. There are two main types of test: VOC polymerase chain reaction (PCR) tests and Whole Genome Sequencing (WGS).

4.4 From 14th June 2021, the Public Health Laboratory at MFT began to test all COVID-19 positive samples using the VOC PCR assay locally for the first time. The Delta (Indian) VOC is now the predominant COVID-19 strain in the North West as reflected by the majority of laboratory PCR results to date.

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

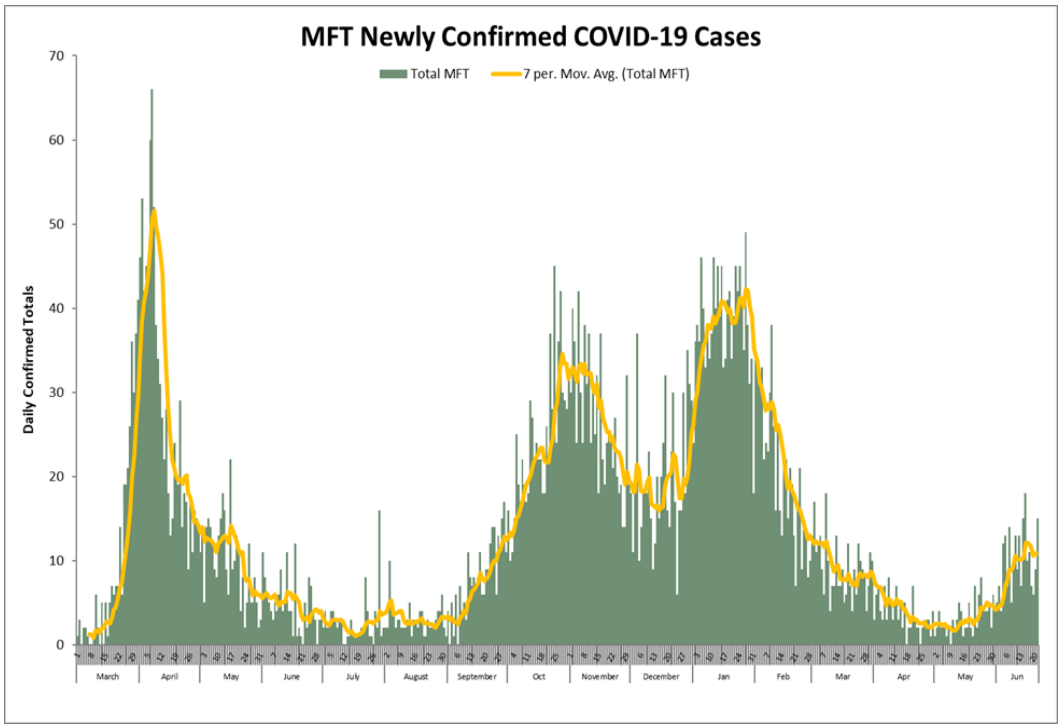


Chart 1- MFT newly confirmed COVID-19 cases presented as MFT total with 7 day moving average, March 2020 – June 2021.

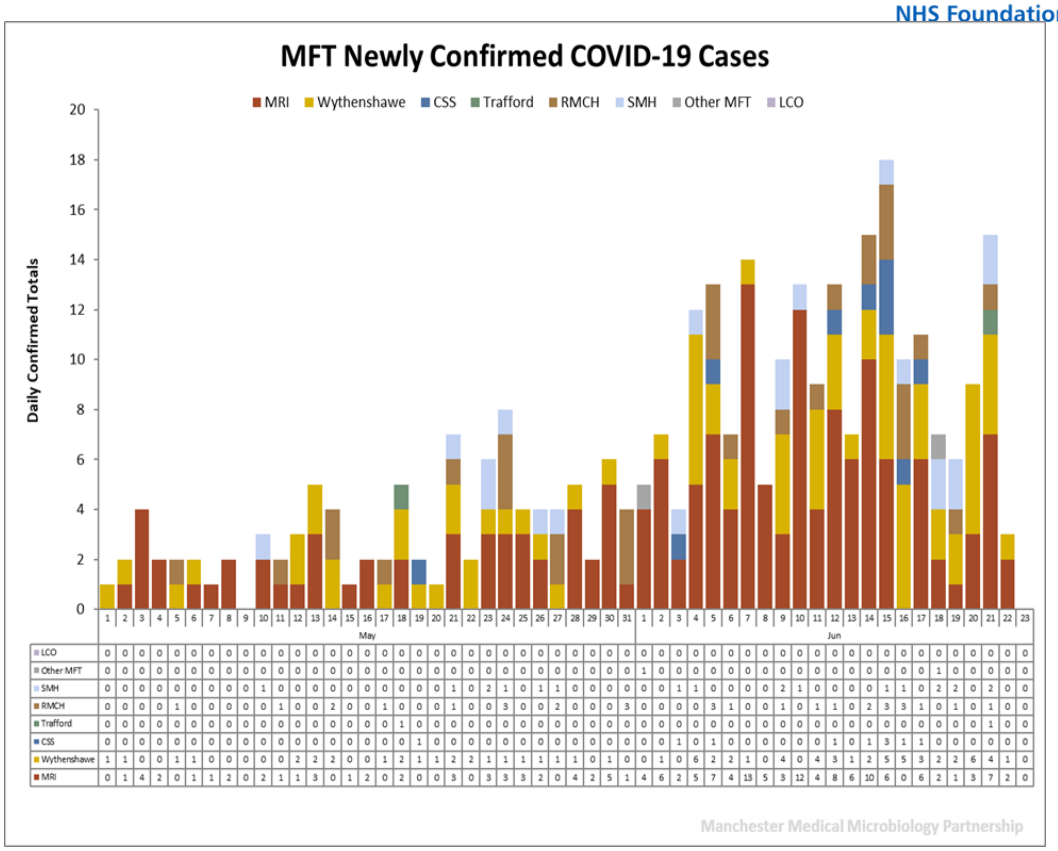


Chart 2 – Daily MFT inpatient burden of COVID-19 cases (laboratory-confirmed cases), May 2021 – June 2021.

5. Nosocomial Outbreaks of COVID-19

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

5.2 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 (24th June 2021).

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

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

March 2021	6
April 2021	1
May 2021	0
June 2021	4

5.3 There is a direct relationship between the transmission of the Delta VOC in the community with the transmission within health care settings as indicated in the recent increase in incidents of HOCI and outbreaks of HOCI in June 2021.

5.4 There are no additional clinical or IPC actions required for patients identified as having a COVID-19 VOC. Staff must adhere to all IPC precautions as per the existing Trust guidance on COVID-19 and use the recommended Personal Protective Equipment (PPE). Vaccination is still the most effective prevention of infection.

5.5 In addition, all staff are encouraged to undertake twice weekly lateral flow testing and all patients should continue to be screened in accordance with local policy, that is on day 1, 3 5-7.

6. FFP3 Resilience in the Acute Setting

6.1 As previously reported the Trust had established a programme of re-fit testing all appropriate staff with a UK manufactured FFP3 disposable respirator and aligning local records with a central data base on the Trust learning hub. The requirement was for each member of staff to be fit tested with one single brand of FFP3 respirator.

6.2 On 17th June 2020 the Department of Health and Social Care (DHSC) issued updated guidance on FFP3 resilience in the Acute setting.

6.3 In order to strengthen the current position, whilst the system tackles the current pandemic, responds to new demands due to changing guidance and prepares for any future uncertainties, the DHSC has developed a set of resilience principles and performance measures.

6.4 The most significant update is that staff are now required to be fit tested for at least two (preferably three), alternative brands of FFP3 disposable respirator.

6.5 Trusts are asked to consider these principles and work with clinical and information teams to adopt and embed the following actions:

Actions	Trust Update
Identify an FFP3 resilience lead/champion within the trust and develop an implementation plan	Assistant Chief Nurse, IPC/TV/Clinical DIPC designated by the Chief Nurse/DIPC
If not already doing so, start using ESR to record all fit testing outcome and usage data at an individual level. This should include all historical data and be updated with any new changes.	Data is currently in transition from local hospital/MCS level to being uploaded to the Learning hub
Increase the number of masks an individual is fit tested too and ensure the different masks are available to the user to wear interchangeably	Five different brands of UK manufactured FFP3 disposable respirators available across the Trust. Local fit testers have commenced fit testing to at least two brands of disposable respirator for each member of staff.
Implement and support a fit testing solution to enable above principles to be achieved for all existing staff and new staff who will be users of FFP3s.	Task and finish group established. To implement resilience principles and performance measures
Monitor progress against the above principles	Progress to be monitored at Hospital/MCS Infection Control Meetings and reported to GICC

7. Sustaining and Improving the Current Position

7.1 There are risks to patient safety from the emerging COVID-19 VOC. The Delta VOC is highly transmissible and currently the predominate in circulation across the region.

7.2 To maintain patient safety and reduce the risk of infection it is essential to continue adherence to IPC practices by all members of staff. This includes upholding the principles of ‘hands, face, space’ as well as vaccination and lateral flow testing by all healthcare workers.

8. Summary

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

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

8.3 There is evidence that the number of new cases of COVID-19 amongst in-patients is starting to increase due to the Delta VOC. It is therefore essential that practice and attitudes do not return to pre-pandemic practices and all staff must continue to be vigilant.

9. Recommendation

9.1 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.

Appendix 1

Infection Prevention and Control Board Assurance Framework V9 June 2021

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes	• **Clinical Sub-Groups / Clinical Advisory Groups are** in place to oversee adjusted or adapted systems and processes approved within hospital settings. • Patient streaming at access points. Emergency Department is zoned to provide designated areas • Screening of non-elective admissions recorded on ED systems and communicated to bed management team • Pathways in place to screen elective patients prior to surgery • Screening of patients prior to admission to community in-patient facilities and recorded in patients notes – SOP in place. • Development of EMIS template to record patients who are COVID-19	• 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

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

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

	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.		undetermined) in support of flow and ensuring right patient in right place.
• 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 • Sanitization Stations are in place at Trust entrances and exits	• 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.

	• Audit of PPE and hand hygiene are regularly undertaken – actions in place to improve where required • IPC Safety Officer Audit		
• 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 ❖ IPC Operational Group bi-weekly chaired by Hospital Deputy Director of Nursing		• 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 ❖ 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 November 2020. • Weekly meetings with NEDs to keep informed of issues arising through EPRR led by COO • Twice weekly meetings with executive directors provides opportunity to raise issues
• risks are reflected in risk registers and the Board Assurance Framework where	• There is an over-arching Group IPC risk for COVID-19. Hospitals/MCS/LCO have identified	• Disruption to assurance framework by Suspension of	• Sub committees re-instated • Risks reviewed

appropriate	local risks and added them to local risk registers. • Risks managed through Strategic COVID-19 group • Links made to the main Trust BAF, were reviewed at the Board of Directors meeting in November 2020	Sub-board Committees due to COVID-19	formally at substantive groups and weekly through EPRR response due to the need to be responsive and adjust in real time • Subgroups have been re-instated in accordance with Trust governance and recovery programme
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	• Daily alert notifications continued and actioned • Monitoring of incidents of infection • Investigation of MRSA bacteraemia and CDIRCA completion • Accountability meetings with clinical leads re-instated • Hospital/MCS/LCO Infection control committees in place • Extraordinary meetings of COVID expert Group in place • Risk assessments in place address wider HCAI issues for: ❖ 2m social distancing ❖ Contact tracing ❖ Outbreak management ❖ Isolation ❖ Testing	• Three week period of non-toxin testing for CDI due to Aerosol generating procedures (resolved)	• All CDI patients clinically reviewed & PCR tested. • Alternative method for toxin testing implemented • Risk assessment and reports escalated • Investment in environmental mitigation: ❖ A number of Clinell Ready Rooms have been purchased and will be put in place in designated/agreed areas ❖ Enhanced cleaning

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

	sufficient hand wash facilities, sufficient supplies ❖ Signage is clear ❖ Communication channels are in place ❖ IPC staff are present on wards • Various monitoring tools are in place to support compliance with IPC practice; including ❖ 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		
• Monitoring of staff compliance with wearing appropriate PPE, within the clinical setting • consider implementing the role of PPE guardians/safety champions to embed and encourage best practice	• IPC nursing champions are in place in all hospitals /MCS/MLCO; specifically, their work includes: ❖ role modelling best practice ❖ monitoring compliance ❖ sharing good practice, and ❖ challenging non-compliance.		

• Staff testing and self-isolation strategies are in place and a process to respond if transmission rates of COVID-19 increase • Additional requirement • implementation of twice weekly lateral flow antigen testing for NHS patient facing staff, which include organisational systems in place to monitor results and staff test and trace • additional targeted testing of all NHS staff, if your trust has a high nosocomial rate, as recommended by your local and regional infection prevention and control/Public Health team.	• 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	• Access to external test results • Compliance with staff reporting LFT results	• Staff asked to report external test results to absence manager • Communication strategy in place to remind staff to report LFT results • Improvements planned to the way in which compliance with routine PCR testing in high risk areas is monitored • 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

• Training in IPC Standard Infection Control and transmission-based precautions are provided to all staff.	• A series of IPC training packages are included in staff training profiles. • Practical training packages for donning and doffing (both for aerosol generating procedures (AGP's) and non AGP's) are in place via E learning. • An Infection Prevention & Control Development Pathway is newly developed and in place to assist staff development from fundamental awareness of IPC to specialist understanding. The IPCDP is available to registered and non-registered clinical staff.		• Compliance with training is monitored
• IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training.	• The Trust learning hub includes a series of COVID-19 Training Resources. Examples include a series of 'essential skills' training. • Trust wide local induction include COVID-19 IPC measures • Specific COVID-19 training is in place in identified areas, for example the Emergency Department, Respiratory,		
• All staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work.	• The PHE campaign 'Hands Face Space' is visible across the Trust • There is clear signage at all access egress points as well as in all clinical areas • Regular reminders are distributed via trust-wide daily communications		

• All staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance • Additional Requirement • there are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace • national IPC national guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way • changes to national guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	• Staff attend the Trust mandatory training programme at the commencement of employment. • Practical competency training is in place which includes Hand Hygiene, use of PPE, donning and doffing • PPE Stocks are regularly monitored across all areas and there is an escalation procedure for areas where there has been increased demand • The Trust procurement team work closely with the IPC teams to ensure stock levels are maintained • The PHE campaign 'Hands Face Space' is visible across the Trust • National guidance is received by the Trust via EPRR email address and directly to Chief Nurse and Medical Directors. Timely 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		

• 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	reflected in the Board of Directors Board Assurance Framework		
• That Trust Chief Executive, the Medical Director or the Chief Nurse approve and personally signs off, all daily data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner. • This Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board	• The Chief Nurse/DIPC is responsible for all data submissions • The IPC Board Assurance Framework has been reviewed and assessed at each Board of Directors meeting since it was developed. It is also received by Sub-Committee's of the Board of Directors.	• Easily accessible information in one place to support sign off requires development.	• A COVID-19 infection dashboard is under development. Once implemented this will provide Trust, hospital and ward overview of nosocomial infections. The purpose is to provide further clarity of a range of information in order to support nosocomial infection prevention and management.
• Ensure Trust Board has oversight of ongoing outbreaks and action plans • there are check and challenge opportunities by the executive/senior leadership	• 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	• See above	• See above

teams in both clinical and non-clinical areas	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		

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure: • designated teams with appropriate training to care for and treat patients in COVID-19 isolation or cohort areas	• Programme of training for redeployed staff including use of PPE, maintaining a safe environment • Bespoke training programme for Clinical leaders to become PPE expert trainers • IPCT undertake regular reviews/ and provide visible presence in cohort areas • Staffing levels increased	• Redeployed staff may not be confident in an alternative care environment.	• Increase of IPC support to COVID -19 Wards • Use of posters/videos FAQ's • Multiple communication channels – daily briefing/dedicated website • Increased Microbiologist and ICD support • Expert Virology support • 7 day working from IPC/Health and Wellbeing

• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	• Liaison between Trust/PFI partners and partnership working • Domestic staff are fit tested and trained in donning and doffing PPE • Use of posters/videos FAQ's • Staff training records and roster allocations available as evidence of this for all areas. • Hospital Estates & Facilities Matron provides oversight of training and standards of practice (NMGH)	• Anxiety of staff working in COVID-19 Wards.	• Domestic staff have access to EHWB services • Increase of IPC support to COVID -19 Wards • (see access to environmental investment)
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE national guidance • Assurance processes are in place for monitoring and sign off terminal cleans as part of outbreak management	• PHE guidance is adhered in line with decontamination in outbreak situation. • Use of HPV/UVC in addition to PHE guidance • Group Estates and Facilities Decontamination Policy is in place and available via the Trust intranet • E and F/PFI partners and IPC Team have reviewed cleaning frequencies in line with updated guidance • Terminal clean sign-off processes are in place	• Anxiety of staff working in COVID-19 Wards.	• Domestic staff have access to EHWB services • Increase of IPC support to COVID -19 Wards • Use of posters/videos FAQ's • Walk rounds led by IPC to review cleanliness of hospital facilities - undertaken with cleaning management teams.
• increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination	• PHE guidance is adhered in line with decontamination in outbreak situation.		• Review of domestics rota by facilities to ensure staff rosters are sufficient to cope with the increased

rates as set out in the PHE national guidance	• 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		demand and that the service provision includes all clinical and non-clinical areas.
• attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas	• additional frequency of cleaning schedules in place • staff are trained to respond to revised cleaning requirements and additional cleaning in place for sanitary and high touch areas.		• Domestic cleaning in ED and assessment areas 12 hours a day after every patient use of facilities

• cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine,as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	• Routine cleaning in all areas (clinical and non-clinical undertaken using a combined detergent and Chlorine 1,000 parts per million solution. • Used in accordance with manufacturers recommendation as described in the Trust Cleaning Policy, adhered to, as per COSHH data sheet held by facilities.	• Cleaning Policy Requires updating (pending new national guidance on cleaning standards)	• Cleaning policy to be updated once National Standards agreed. Current policy is appropriate and in use.
• manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products as per national guidance	• See above		
• 'frequently touched' surfaces, eg door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids • electronic equipment, eg	• Enhanced cleaning specifications in place for clinical and non-clinical areas • Trust Policy for working safely based on PHE guidance is in place • Increased cleaning in public areas for high touch points (e.g.		

mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily • rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	stairwell hand rails / lift call buttons) have ben put in place across all sites to meet PHE guidance. • staff are trained to respond to revised cleaning requirements and additional cleaning in place for sanitary and high touch areas		
• linen from possible and confirmed COVID-19 patients is managed in line with PHE national guidance and the appropriate precautions are taken	• Linen managed according to national guidance for foul/infected linen, Trust Policy in place – updated July 2020 • Staff in COVID-19 areas are wearing 'scrubs' – laundered through Trust laundry • Guidance on how to care for uniform published on Trust intranet		
• single use items are used where possible and according to Single Use Policy	• Single use items used according to local policy based on national guidance.	• Policy due for review in January 2021 pending review of National Cleaning Standards	• Policy will be updated by IPC Team
• reusable equipment is appropriately decontaminated in line with local and PHE national policy	• Re-useable equipment decontaminated in line with national guidance • Decontamination group is sub-group of Group ICC		• Decontamination group meeting re-instated from May 2020

• Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission	• No mechanical ventilation system in waiting areas, use of electronic fans discouraged	• Old estate unable to provide good ventilation in areas • Local weather conditions may make it difficult to maintain internal temperature if door and windows are open	• Considering use of window and other air filtration systems of ventilation in older estate
• Ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air • monitor adherence environmental decontamination with actions in place to mitigate any identified risk • monitor adherence to the decontamination of shared equipment	• Air filtration units (filtrex and Dentair unit) deployed in areas following AGP's in ENT and dental • Use of micro-motors in dentristry to reduce AGP procedures • Windows opened where possible • Monitoring of cleaning is in place, following suspension at the height of the pandemic this is gradually being reinstated • Systems and processes are in place for decontamination of shared equipment	• Old estate unable to provide good ventilation in areas • Local weather conditions may make it difficult to maintain internal temperature if door and windows are open	• Considering use of window and other air filtration systems of ventilation in older estate

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

			Cleanliness Charter. To be in place by October 2021

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

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

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

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

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

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

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

• Triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible.	• Staff are trained in the use of triage questions		
• Face coverings are used by all outpatients and visitors	• Written information is available for patients and visitors • There is signage across all areas of the hospitals, including PHE campaign 'hands face space' messages. • Entrances and exits have manned hygiene stations to guide and challenge visitors /staff if appropriate	• Not all patients/visitors are willing/able to comply	• Risk assessment undertaken. • Local escalation process is in place
• Face masks are available for patients and they are always advised to wear them	• FRSM available for all patients and visitors • 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

• Provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients (particularly when moving around the ward) if this can be tolerated and does not compromise their clinical care. • monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so)	• All patients are requested to wear a facemask when moving from their bed unless there are clinical indications otherwise	• As above	• Consideration of the process of monitoring patient compliance with wearing face masks into an existing audit document - April 21
• For patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative.	• All patients with new onset symptoms are tested and isolated. Risk assessment undertaken of all potential contacts		
• Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly. • there is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document	• All patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly. • Regular audits of patient testing guidance takes place, with actions in place to improve where required		• Regular reports to be received by the Trusts COVID Testing Strategy Group to ensure robust monitoring of compliance

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

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

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

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

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

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

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

• Clear visually displayed advice on use of face coverings and facemasks by patients /individuals, visitors and by staff in non-patient facing areas.	• Written information is available for staff and visitors • There is signage across all areas of the hospitals, **including PHE campaign 'hands 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	• Reliance on staff reporting Pillar 2 test results	• Staff requested to report external testing results to absence manager

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

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

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

8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individual	• UKAS accredited PHE laboratory conducting testing for NW of England • Posters to support training for staff on how to take a swab		• Frequency of testing ensures staff competence
• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	• Screening of non-elective patients in place • Hospitals/MCS putting in place pre 48 hour testing for elective admissions • Policy for staff screening developed • MFT site of PHE host laboratory and has capacity for extensive screening • See previous on testing	• Lab capacity	• New equipment on line for full functionality December 2020 .
• screening for other potential infections takes place	• Screening for alert organisms continued in line with trust policy.		
• Ensure screens taken on admission given priority and reported within 24hrs.	• Tracking system on electronic records systems, chameleon and Allscripts, prompts screening • DNA Nudge used for rapid assessment in agreed emergency department locations		

• Regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available.	• Turnaround times measured -planned programme of monitoring.	• Travel time for specimens from site to laboratory dependent on Transport	• Additional transport runs put in place where the laboratory is not on site
• Regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data). • screening for other potential infections takes place • that all emergency patients are tested for COVID-19 on admission. • that those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise. • that those emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission.	• The Staff and In-Patient COVID-19 Testing Guidelines reflect national guidance in routine and responsive testing. • Screening for other potential infections has continued throughout the pandemic • Testing is undertaken through PHE laboratory in accordance with PHE guidance	• Trust Testing Strategy Group to receive regular reports to monitor compliance – under development.	

• 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			

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	• 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.

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

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

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

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

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

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

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

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Finance Officer
Paper prepared by:	Karen Brown, Programme Finance Director Rachel McIlwraith, Operational Finance Director
Date of paper:	June 2021
Subject:	Financial Performance for Month 2 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:	• 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 total underpin the plan submitted to GM / NHSI 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 Control Total**	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 – the underpinning budget profiles are largely flat across the full financial year however there are three key exceptions to this; 1) actual delivery of the Full year WRP where an element of backloading is to be expected, 2) 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. 3) 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 several significant provisions at the end of 2020/21 including annual leave and the HCSW pay banding review.
1.2	**Run Rate**	The Trust is in the first quarter of a new financial year and strong financial governance and control remains essential, particularly in the face of an extraordinary and challenging operating environment and a revised financial framework for 2021/22. 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. A top down forecast will also be prepared on a monthly basis based on the YTD run rate and key known changes and this will be compared to the more detailed hospital and department forecasts on a monthly basis. 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.
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 previous financial regime will largely remain in place at least for H1 of 2021/22. 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.

1.4	**Cash & Liquidity**	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 HCSW pay review.
1.5	**Capital Expenditure**	The capital plan reflects the result of negotiations across Greater Manchester to bring the total planned spend across Greater Manchester into line with the new capital envelope. 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.

Financial Performance

Income & Expenditure Account for the period ending 30th May 2021

	NHSI Plan M2	Year to date Actual - M2	Year to date Variance
INCOME	**£'000**	**£'000**	**£'000**
Income from Patient Care Activities			
Commissioner Block Payments - CCGs / NHSE	290,716	290,850	134
NHSE - Cost passthrough drugs (increase above threshold)	13,310	10,557	-2,753
GM System Funding 1-6 £85.846m M7-M12 £15.710m / £43.0m	28,615	28,616	1
GM System Funding 1-6 £5m	1,667	1,666	-1
Other (Other devolved / IOM / NORs & Wales)	1,266	1,142	-124
Additional Funding outside financial envelope	427	801	373
Local authorities	6,422	6,408	-14
Sub -total Income from Patient Care Activities	**342,424**	**340,040**	**-2,384**
Private Patients/RTA/Overseas(NCP)	1,670	1,193	-477
Total Income from Patient Care Activities	**344,094**	**341,233**	**-2,861**
Training & Education	11,874	11,874	0
Training & Ed Non HEE	484	641	157
Training & Ed Notional	447	417	-30
Research & Development	11,007	11,431	424
Misc. Other Operating Income	15,009	14,988	-21
Other Income	**38,820**	**39,350**	**530**
Total Income	**382,914**	**380,583**	**-2,331**
EXPENDITURE			
Pay	-223,840	-223,727	113
Non pay	-146,168	-143,342	2,826
Training & Ed Notional Spend	-447	-417	30
Total Expenditure	**-370,455**	**-367,486**	**2,969**
EBITDA Margin (excluding PSF)	**12,459**	**13,097**	**638**
Interest, Dividends and Depreciation			
Depreciation	-5,633	-5,848	-215
Interest Receivable	0	0	0
Interest Payable	-6,826	-6,825	1
Loss on Investment	0	0	0
Dividend	0	0	0
Surplus/(Deficit) Adjusted performance re system achievement	**0**	**424**	**424**
Technical Adjustments	**0**	**0**	0
Surplus/(Deficit) Adjusted Performance - Outturn	**0**	**424**	424
Surplus/(Deficit) as % of turnover		**0.1%**	
PSF / MRET Income		**0**	**0**
Transfers by Absorption		**0**	**0**
Impairment	**-14,479**	**-12,112**	**2,367**
Non operating Income	**204**	**61**	**-143**
Depreciation - donated / granted assets	**-176**	**-154**	**22**
	-14,451	**-11,781**	**2,670**

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 income is slightly front loaded across the year given the inclusion of system funds in H1. The current activity recovery trajectory is expected to increase spend on clinical consumables over the next 4 months as activity is increased. Equally pay and non pay spend would exceed 2/12 of the annual budget, however this is not unexpected given the potential backloading of WRP plans and delivery.

As at month two against the profiled YTD budget the key point to note on income is an under recovery of drugs related income with an associated underspend on drugs. Further work is ongoing to reconcile the level of income and budgeted expenditure at category level for drugs, bloods and devices given the changes to the income regime and the transfer of elements of spend to a block basis. The Month 2 report includes an accrual of income which was expected as a result of the NMGH transaction, however it is now understood that this was already included within the System funding, and so a negative variance will be shown from Month 3 onwards.

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

Pay costs are showing an apparent minimal underspend of £113k although this masks larger variances between substantive pay (underspent) compensated for by the use of bank and agency staff.

The underspend on non pay largely reflects the underachievement of Drugs and devices CPT income.

As stated 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.

Key Run Rate Areas

1. Waste Reduction Programme

Within the Hospital/MCS/LCO and Corporate Control Totals for the year is a Waste Reduction target totalling £50m, this target is increased slightly for areas that have experienced additional pressures deemed to fall within their control. The tables below outline the progress to date in planning and achieving those savings. Hospitals/MCS/LCO/Corproate Depts are forecasting £15.5m achievement against schemes that have progressed to L3 or higher on WAVE, with a further £8.4m in development. .

MFT Summary

Workstream	Savings to Date				Forecast 21/22 Position			
	Plan (YTD) £'000	Actual (YTD) £'000	Variance (YTD) £'000	Financial BRAG	Plan (21/22) £'000	Act/F'cast (21/22) £'000	Variance (21/22) £'000	Financial BRAG
Hospital Initiative	36	8	-28	23%	484	183	-301	38%
Contracting & income	448	547	99	122%	3,067	3,215	148	105%
Procurement	549	498	-51	91%	4,748	4,242	-506	89%
Pharmacy and medicines management	94	86	-8	92%	535	528	-7	99%
Length of stay								
Outpatients	21	21	-	100%	163	163	-0	100%
Theatres	68	68	-	100%	448	448	0	100%
Workforce - medical	215	215	-	100%	1,579	1,552	-27	98%
Workforce - nursing	219	486	267	222%	2,332	2,321	-11	100%
Admin and clerical	228	230	2	101%	1,396	1,393	-3	100%
Workforce - other	182	182	-	100%	1,244	1,244	0	100%
Blood Management	2	2	-	100%	12	12	-	100%
Budget Review	2	2	-	100%	9	9	-	100%
Integration	147	-	-147	0%	885	196	-689	22%
Total (L3 or above)	**2,211**	**2,346**	**135**	**106%**	**16,902**	**15,506**	**-1,396**	**92%**

Summary against Target M1-2	YTD
Target	8,333
Actuals (L3 or above)	2,346
Variance to Target	-5,988
Lost opportunity (value of schemes below L3)	740
Variance to target if all schemes delivered as plan	-5,248

Summary against Target 21/22	Act/F'cast (21/22)
Target	50,000
Actuals/Forecast (L3 or above)	15,506
Variance to Target	-34,494
Value of schemes below L3 (M3-12)	8,421
Variance to target	-26,073

Financial BRAG

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

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

Hospital / MCS / Division targets and forecast for schemes at L3

Hospital/MCS	21/22 Target	21/22 Actual/Forecast	21/22 Variance	% Variance
MRI	7,630	4,345	-3,285	-43%
RMCH	5,424	1,686	-3,738	-69%
ST. Mary's	4,855	1,983	-2,872	-59%
CSS	9,522	1,849	-7,673	-81%
Corporate	2,857	1,966	-891	-31%
WTWA	10,223	3,012	-7,211	-71%
Eye&Dental	1,707	436	-1,271	-74%
LCO	3,947	155	-3,792	-96%
NMGH	3,836	74	-3,762	-98%
Grand Total	**50,000**	**15,506**	**-34,494**	**-69%**

This report matches the external submission to NHSI for Month 2, further progress is included in the Waste Reduction report itself prepared at a later date with values of £17.1m at L3+ and a further £8.3m below L3.

2. Agency spend by Staff Group and Hospital / MCS

There is a substantial increase in the values for M1 and M2 v previous quarterly / monthly values - - this relates to the inclusion of the values for NMGH. Some of the additional spend will be coded directly within other areas, such as corporate, SMH,CSS, MRI and SMH etc however the second table shows the spend within the retained NMGH services at c£0.8m per month. The total spend in M1/2 excluding the NMGH spend would have been £1,542k and £1,935k, considerably closer to the prior year's run rate.

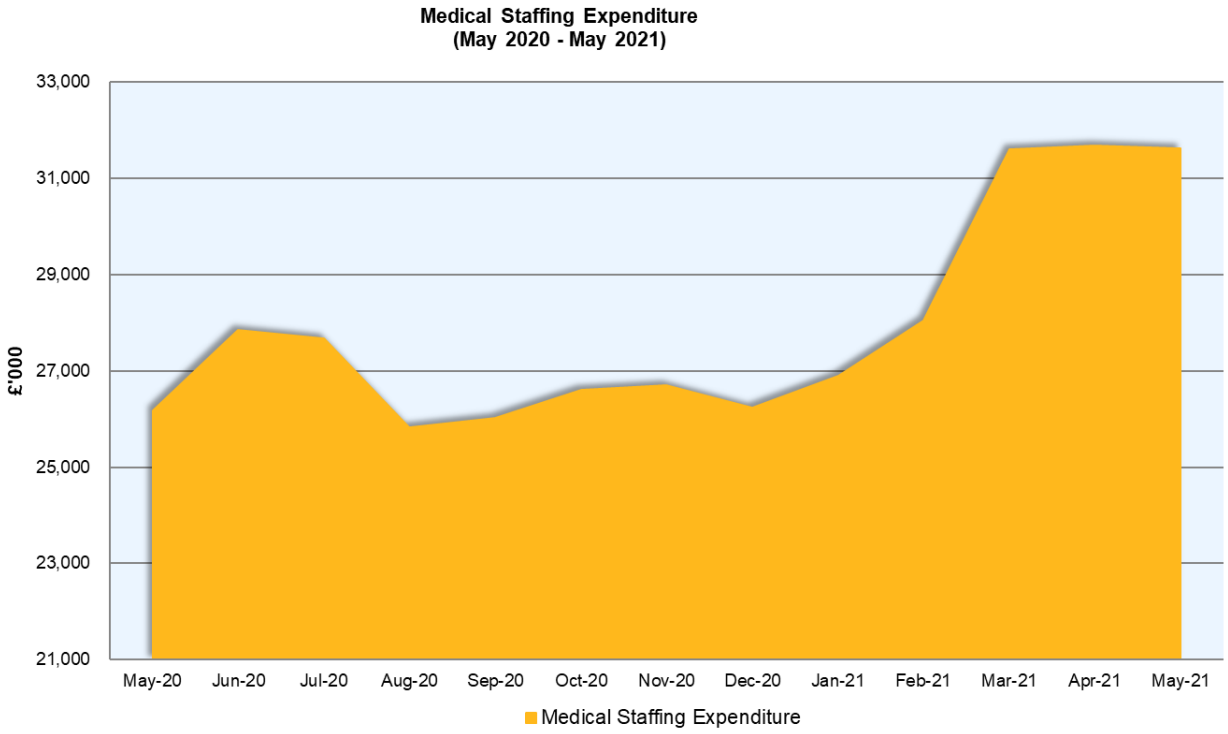
Staff Group	Average M1-3 (20/21) £000's	Average M4-6 (20/21) £000's	Average M7-9 (20/21) £000's	Mth 10 (20/21) £000's	Mth 11 (20/21) £000's	Mth 12 (20/21) £000's	Average M10-12 (20/21) £000's	Mth 1 21/22 £000's	Mth 2 21/22 £000's
Consultant	-333	-261	-244	-187	-244	-611	-347	-572	-615
Career Grade Doctor	-35	-29	-49	-20	-28	-36	-28	-44	-74
Trainee Grade Doctors	-72	-104	-119	-188	-293	-146	-209	-656	-849
Registered Nursing Midwifery	-303	-266	-311	-173	-273	-282	-243	-458	-411
Support to Nursing	-15	-34	-46	-98	-86	-118	-101	-74	-96
Allied Health Professionals	-64	-172	-192	-199	-388	-99	-228	-233	-302
Other Scientific and Theraputic	-72	-14	-45	-39	-35	54	-7	-19	-32
Healthcare Scientists	-62	-72	-110	-41	-64	-298	-134	-67	-124
Support to STT / HCS	-17	-16	-6	28	7	-8	9	-17	3
Infrastructure Support	-117	-104	-77	-83	-375	-339	-266	-215	-201
Grand Total	**-1,090**	**-1,071**	**-1,198**	**-999**	**-1,780**	**-1,883**	**-1,554**	**-2,355**	**-2,703**

Hospitals	Average M1-3 (20/21) £000's	Average M4-6 (20/21) £000's	Average M7-9 (20/21) £000's	Mth 10 (20/21) £000's	Mth 11 (20/21) £000's	Mth 12 (20/21) £000's	Average M10-12 (20/21) £000's	Mth 1 21/22 £000's	Mth 2 21/22 £000's
Clinical & Scientific Support	-101	-219	-304	-202	-464	-367	-345	-329	-457
Manchester LCO	-152	-94	-77	-45	-81	-137	-88	-31	-122
MRI	-286	-223	-370	-262	-479	-655	-465	-384	-523
NMGH								-803	-767
REH / UDH	-23	-11	-50	-26	-45	-50	-40	-60	-84
RMCH	-130	-101	-94	-69	-102	-81	-84	-106	-140
Saint Mary's Hospital	-18	-34	-53	-60	-68	-41	-56	-180	-125
WTWA	-199	-265	-217	-245	-443	-256	-314	-369	-404
Corporate	-182	-116	-7	-85	-85	-268	-146	-84	-81
Research	1	-8	-25	-5	-13	-29	-16	0	0
Total	**-1,090**	**-1,071**	**-1,198**	**-999**	**-1,780**	**-1,883**	**-1,554**	**-2,345**	**-2,703**

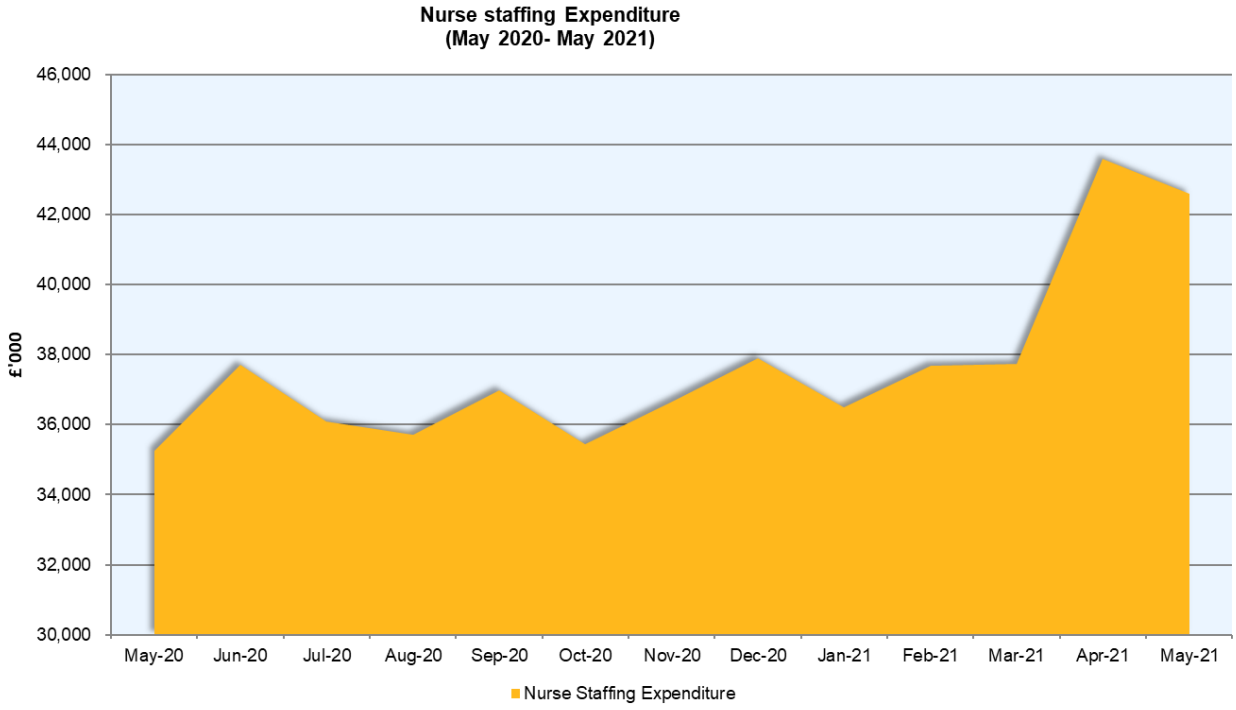
The forecast from the hospitals show increased substantive pay and reducing bank and agency spend over the forthcoming months and this will be closely monitored albeit in the context of recovering activity. Agency spend remains an area of scrutiny.

The graphs below in section 3 also reflect the pay costs within medical and nursing relating to services transferred in for NMGH, including pay costs incurred under other MCS, as such the prior year comparators are weakened.

3. Medical Staffing:

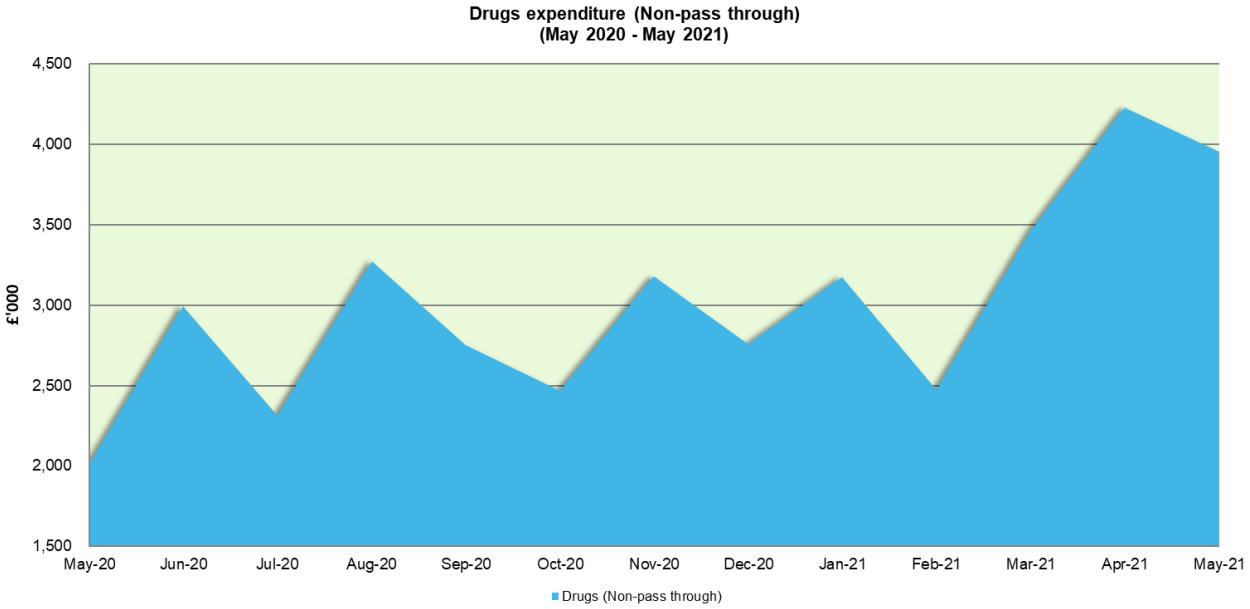


4. Nurse staffing:



5. Prescribing:

As for pay spend the chart below includes spend on NMGH services from 1.4.21 which weakens the prior period comparisons.



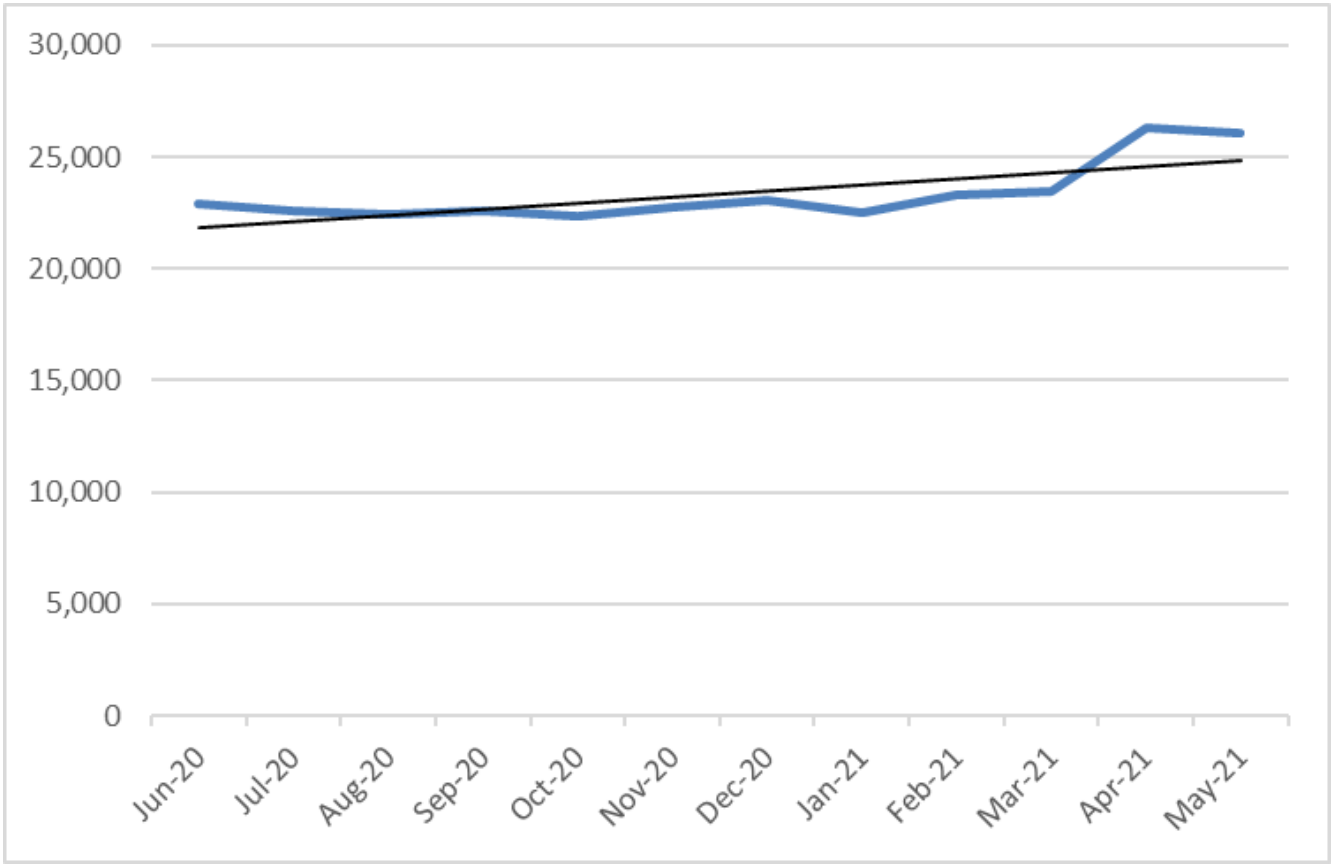
6. Staffing numbers

Staffing numbers have increased to reflect the transfer of NMGH services both retained within NMGH and dispersed across other MCS e.g. CSS and SMH.

	Whole Time Equivalent (WTE)											
	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Allied Health Professionals	1,288	1,272	1,296	1,279	1,283	1,271	1,287	1,298	1,276	1,301	1,306	1,410	1,416
Career Grade Doctor	328	317	311	333	339	355	363	373	361	449	447	485	458
Consultant	1,171	1,206	1,190	1,218	1,222	1,242	1,252	1,217	1,222	1,241	1,240	1,368	1,426
Healthcare Scientists	950	944	945	932	944	958	965	978	950	974	983	993	997
Infrastructure Support	2,339	2,352	2,328	2,369	2,366	2,381	2,439	2,475	2,533	2,633	2,624	3,027	3,097
Other Scientific and Theraputic	861	903	925	929	947	948	953	970	938	959	949	947	941
Registered Nursing Midwifery	7,302	7,399	7,241	7,080	7,350	7,274	7,586	7,742	7,380	7,840	7,785	8,814	8,487
Support to AHPs	144	144	141	131	131	131	129	128	126	129	128	154	155
Support to Clinical	2,672	2,676	2,682	2,698	2,695	2,692	2,692	2,710	2,642	2,737	2,722	3,031	2,986
Support to Nursing	3,078	3,533	3,518	3,522	3,293	3,101	3,108	3,190	3,085	3,175	3,367	3,942	3,933
Support to STT HCS	712	841	762	730	734	735	739	757	742	740	746	751	741
Trainee Grade Doctors	1,196	1,335	1,275	1,209	1,314	1,226	1,242	1,191	1,222	1,141	1,178	1,392	1,420
Grand Total	**22,040**	**22,922**	**22,613**	**22,431**	**22,618**	**22,315**	**22,754**	**23,029**	**22,477**	**23,319**	**23,474**	**26,315**	**26,058**

	Whole Time Equivalent (WTE)											
	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
RMCH	2,209	2,305	2,327	2,268	2,231	2,211	2,259	2,321	2,214	2,311	2,285	2,427	2,370
CSS	3,774	3,808	3,753	3,778	3,863	3,896	3,947	3,992	3,880	3,999	4,061	4,316	4,343
Corporate Services	1,316	1,542	1,344	1,330	1,365	1,371	1,457	1,469	1,517	1,614	1,784	1,659	1,694
UDHM	255	257	248	252	253	260	253	244	244	257	247	249	244
Facilities	299	302	303	302	301	313	313	316	318	330	324	657	675
MLCO / TLCO	2,510	2,557	2,541	2,512	2,528	2,497	2,527	2,516	2,524	2,564	2,596	2,574	2,561
MRI	3,786	3,964	3,956	3,942	3,995	3,902	3,981	4,039	3,909	4,090	4,060	3,950	3,743
NMGH												1,803	1,937
R&I	534	539	540	532	534	534	536	535	544	556	549	563	563
MREH	524	537	536	534	567	558	542	557	527	547	544	538	532
SMH	2,177	2,246	2,263	2,213	2,181	2,133	2,196	2,210	2,124	2,229	2,197	2,531	2,503
WTWA	4,656	4,865	4,803	4,767	4,799	4,639	4,743	4,830	4,676	4,824	4,828	5,049	4,894
Total WTE	**22,040**	**22,922**	**22,613**	**22,431**	**22,618**	**22,315**	**22,754**	**23,029**	**22,477**	**23,321**	**23,475**	**26,315**	**26,058**

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

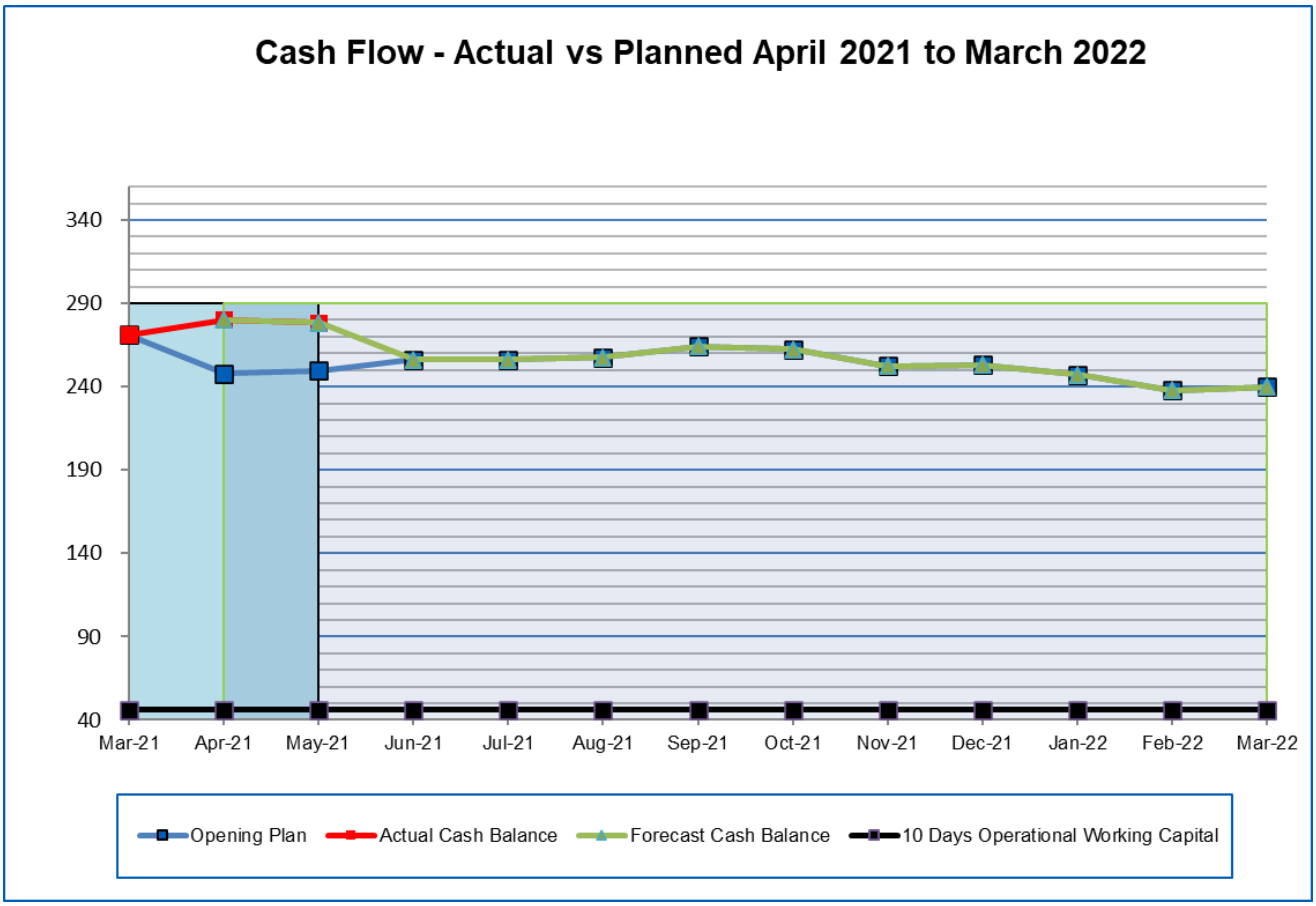


Statement of Financial Position

	Opening Balance 01/04/2021 £000	Actual Year to Date 31/05/2021 £000	Movement in Year to Date £000
Non-Current Assets			
Intangible Assets	4,665	4,220	(445)
Property, Plant and Equipment	642,394	638,860	(3,534)
Investments	1,498	1,498	0
Trade and Other Receivables	5,645	5,644	(1)
Total Non-Current Assets	**654,202**	**650,222**	**(3,980)**
Current Assets			
Inventories	21,892	21,599	(293)
NHS Trade and Other Receivables	61,707	90,583	28,876
Non-NHS Trade and Other Receivables	46,854	32,341	(14,513)
Non-Current Assets Held for Sale	210	210	0
Cash and Cash Equivalents	271,199	278,366	7,167
Total Current Assets	**401,862**	**423,099**	**21,237**
Current Liabilities			
Trade and Other Payables: Capital	(33,594)	(29,195)	4,399
Trade and Other Payables: Non-capital	(287,755)	(307,041)	(19,286)
Borrowings	(20,290)	(20,235)	55
Provisions	(24,875)	(26,778)	(1,903)
Other liabilities: Deferred Income	(35,084)	(49,975)	(14,891)
Total Current Liabilities	**(401,598)**	**(433,224)**	**(31,626)**
Net Current Assets	**264**	**(10,125)**	**(10,389)**
Total Assets Less Current Liabilities	**654,466**	**640,097**	**(14,369)**
Non-Current Liabilities			
Trade and Other Payables	(2,598)	(2,599)	(1)
Borrowings	(374,948)	(372,805)	2,143
Provisions	(16,622)	(16,622)	-
Other Liabilities: Deferred Income	(3,817)	(3,471)	346
Total Non-Current Liabilities	**(397,985)**	**(395,497)**	**2,488**
Total Assets Employed	**256,481**	**244,600**	**(11,881)**
Taxpayers' Equity			
Public Dividend Capital	258,929	258,829	(100)
Revaluation Reserve	63,492	63,492	0
Income and Expenditure Reserve	(65,940)	(77,721)	(11,781)
Total Taxpayers' Equity	**256,481**	**244,600**	**(11,881)**
Total Funds Employed	**256,481**	**244,600**	**(11,881)**

The balance sheet values shown above relate to the previous MFT balances adjusted for in year transactions such as depreciation. The opening balances for NMGH have not yet been finalised and are retained within Pennine at this point in time. This is consistent with the report submitted to NHSI by both organisations for Month 2.

Cash flow

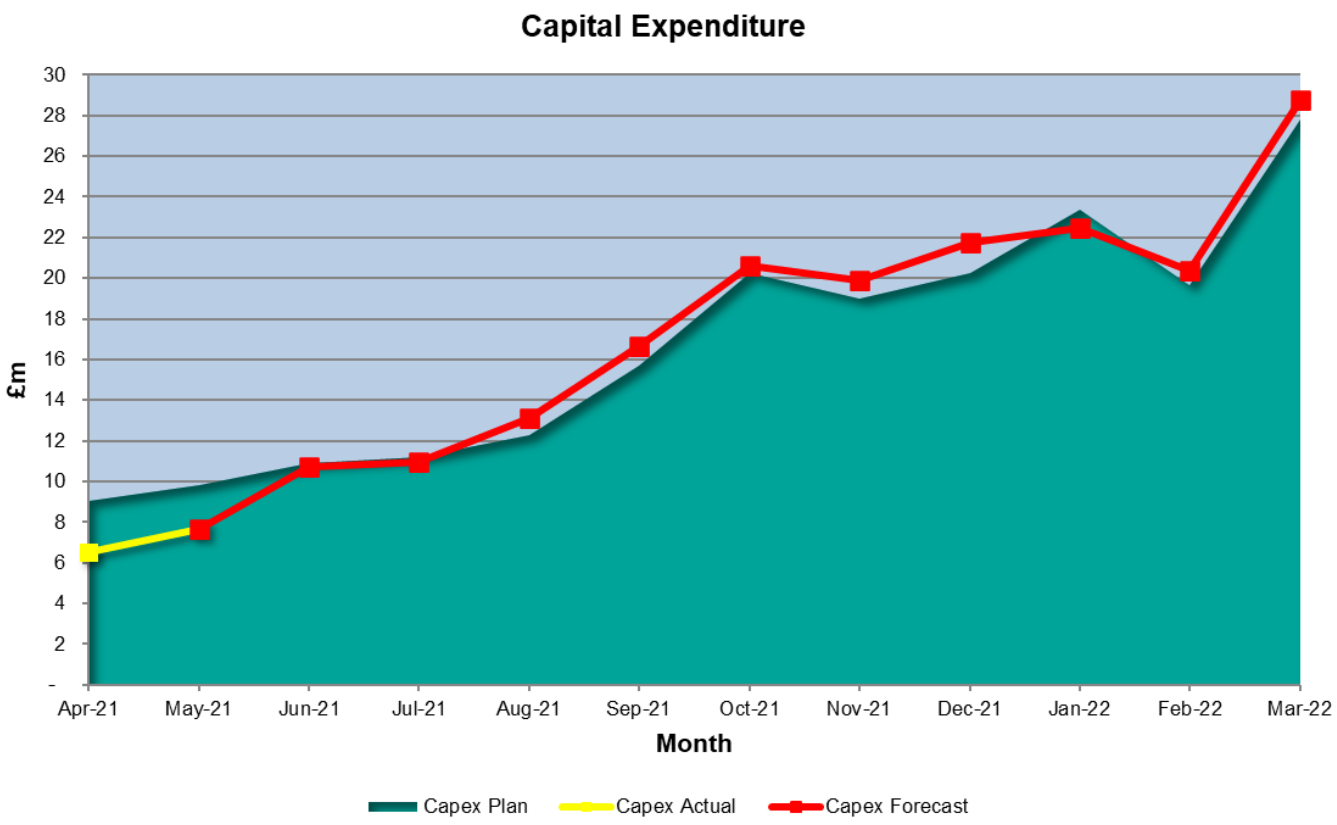


As above, the cash balances do not yet reflect any changes for the NMGH transaction opening balances however the Month 1 / 2 spend and income are reflected in the cash position and balance sheet above e.g. payroll has been processed from the MFT cash balances.

The Trust is working closely with Pennine to finalise the cash balances for transfer, this will be facilitated by the closure of the 2020/21 accounts relating to Pennine, it is anticipated this will be resolved in time for Q1 reporting.

The cash balances held by the Trust at the end of May 2021 were £278.4m. This is higher than plan, largely due to payments to creditors falling below plan for the two months to 31st May 2021, in particular payments to capital creditors.

Capital Expenditure



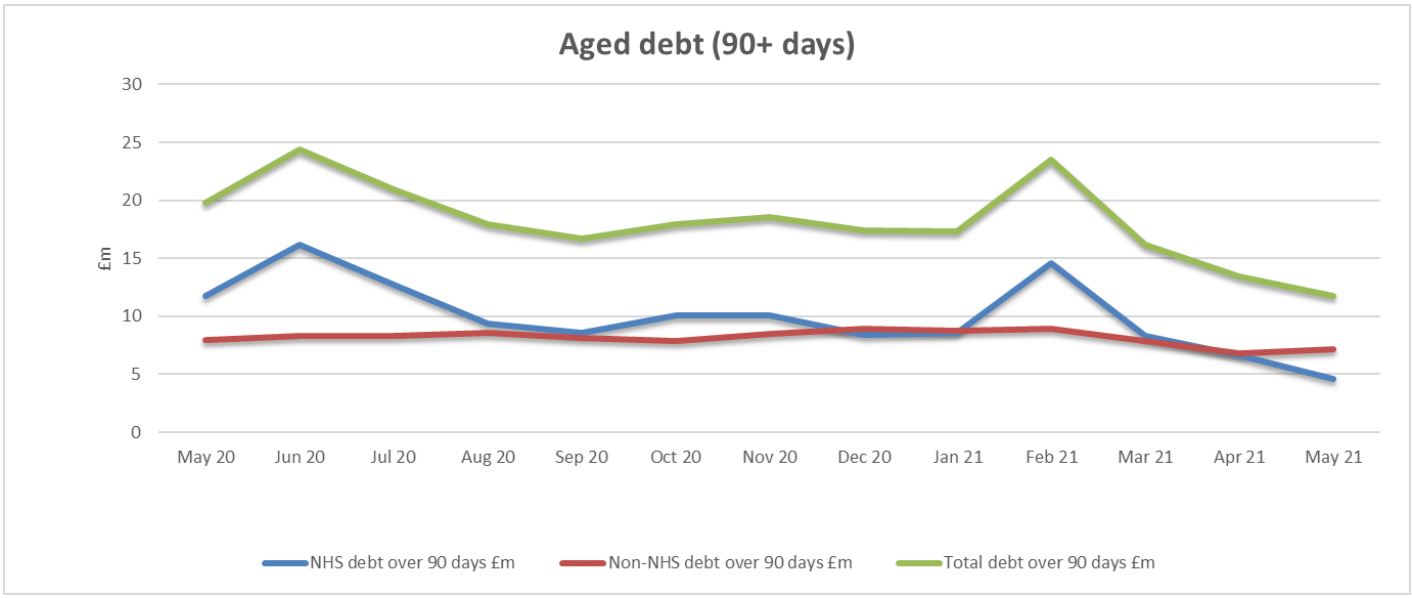
The chart above reflects a forecast of £199.196m, in line with the agreed GM envelope, as stated above the potential outturn is £208.494m although it is expected that the actual spend and the agreed plan will become aligned during the course of the year, due to a combination of slippage and additional funding approvals.

Aged debt

Aged Debt was a focus of the Finance Workplan during 20/21 and the level of outstanding debt will continue to be subject to close scrutiny.

Total invoices raised that remain unpaid at the end of May 2021 stands at £26.1m a reduction from the April position of £27.7m. Of that balance, 45.1% of the invoiced value was raised over 90 days ago, with a total of £6.1m over 1 year old.

	0-30 days (£)	30-60 days (£)	60-90 days (£)	90 DAYS + (£)	Grand Total (£)	% 90 DAYS +
Apr	5,413,809	6,875,015	1,989,813	13,418,313	27,696,950	48.4%
May	7,574,955	2,407,143	4,362,763	11,780,730	26,125,590	45.1%
Movement	2,161,146	- 4,467,872	2,372,949	- 1,637,583	- 1,571,360	



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:	June 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 Design Framework

The White Paper 'Integration and Innovation: working together to improve health and social care for all' described the need for all of England to be covered by Integrated Care Systems (ICS) from April 2022. NHS E/I has now published the Integrated Care System (ICS) design framework which provides further detail on the proposed structure and functions of ICSs. It covers:

- the functions of the ICS Partnership which are to align the ambitions, purpose and strategies of partners across each system
- the functions of the ICS NHS body which are to plan to meet population health needs, allocate resources, ensure that services are in place to deliver against ambitions, facilitate the transformation of services, co-ordinate and improve people and culture development and oversee delivery of improved outcomes for their population
- the governance and management arrangements that each ICS NHS body will need to establish to carry out those functions - these will include the flexibility to operate in a way that reflects the local context through place-based partnerships and provider collaboratives
- key elements of good practice that are essential to the success of ICSs – these include strong clinical and professional leadership, deep and embedded engagement with people and communities, and streamlined arrangements for maintaining accountability and oversight
- the key features of the financial framework that will underpin the future ambitions of systems – this will include the freedom and mechanisms to use resource flexibly to better meet identified needs and to manage financial resources at system level
- the roadmap to implement new arrangements for ICS NHS bodies by April 2022 to establish new organisations.

The guidance describes the membership requirements for the NHS board of each ICS. Boards will require at least 10 mandatory members, the minimum of which include:

- Four executives – the chief executive and finance, nursing and medical directors.
- Three independent non-executives: a chair and at least two others who will normally not hold positions or offices in other health and care organisations within the ICS footprint.
- Three additional partner board members, one member drawn from local NHS trusts, one member from general practice and one member drawn from the local authority.

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.

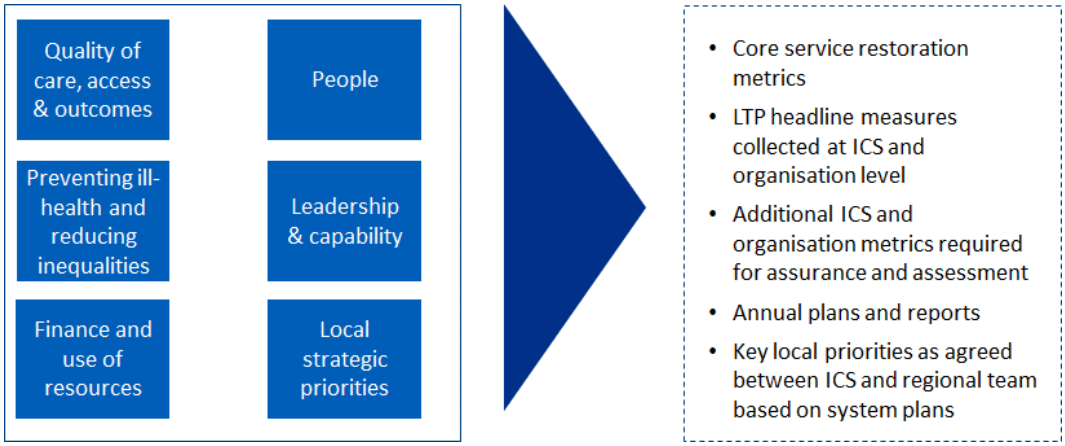
If the government health bill, due to be published in draft around the end of this month, is passed, CCGs will be abolished and ICSs created in law in April next year.

NHS System Oversight Framework 21/22

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 scope of the oversight framework is set out in the graphic below.

Oversight Framework Themes



Performance will be assessed using oversight metrics against the six oversight themes shown in the graphic; a range of 70 individual performance metrics sit under the six themes.

Systems, as well as individual organisations, will be put into one of four segments. The segment indicates the scale and general nature of support needs, from 'no specific support needs' for segment 1 to a requirement for' mandated intensive support' for segment 4.

Systems and organisations in the fourth segment will be subject to a 'recovery support programme'. The Recovery Support Programme (RSP) replaces the previously separate quality and finance 'special measures' regimes.

3. MFT issues

MFT Annual Plan

The MFT Annual Plan, setting out an overview of key priorities and plans from across the organisation has been developed. It has been shaped by input from the Council of Governors and is to be approved by the Board this month.

RMCH accelerator

The Royal Manchester Children's Hospital has successfully bid for just under £3m of funding as part of NHS England's 'elective accelerator' initiative, designed to address waiting lists and develop a blueprint for elective recovery across the NHS. The bid was made in conjunction with other specialist Children's Hospital 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.

CDHs

A business case has been submitted to NHS England covering plans to develop Community Diagnostic Hubs 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, dependant on funding.

4. Actions / Recommendations

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

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Strategy
Paper prepared by:	Caroline Davidson, Director of Strategy
Date of paper:	June 2021
Subject:	MFT Annual Plan 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:	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: ▪ Approve the MFT Annual Plan 2021/22. ▪ Note that further work will be brought back to the Board to show how progress will be monitored.
Contact:	Name: Darren Banks, Group Executive Director of Strategy Tel: 0161 276 5676

1. Introduction

The purpose of this paper is to seek approval from the Board of Directors for the MFT 2021/22 Annual Plan.

2. Background and Context

An Annual Plan sets out what an organisation 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.

The MFT annual planning process has elements of both top down and bottom up planning. Each Hospital, Managed Clinical Service (MCS), Local Care Organisation (LCO) and corporate team within the Group develops their own annual plan; they decide what their priorities for the coming year should be based on their own individual circumstances, but these are also aligned to the overall MFT vision and strategic aims (see attachment A).

Our plans take account of the national and local context, in particular the priorities described in the Priorities and Operational Planning Guidance published by NHS England and NHS Improvement (NHS E/I) and the areas for focus identified by the Greater Manchester Health and Social Care Partnership.

In terms of finance, the financial settlement for 2021/22 was set for the first half of the year only. The financial envelope and control total for MFT, as part of GM, is fixed now for the first six months of 21/22, but we have had 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, we have therefore had to make an assumption about the level of funding that we will receive for the second half of the year.

The MFT Annual Plan (attachment B) brings together, at a summary level, the Hospital, MCS, LCO plans and the plans of the corporate teams. It is formatted to show the contribution made by the each to the Trust strategic aims.

3. MFT Annual Planning Process 2021/22

The annual planning process was steered by an Annual Planning Core Group made up of representatives from Finance, HR, IT and from the Hospitals / MCSs / LCOs. The role of this group was to ensure that activity, financial and workforce planning was aligned.

Hospital / MCSs / LCO operational priorities and key plans were shared internally through the MFT Resiliency and Recovery Committee so that all Hospitals / MCS / LCO Directors of Operations were made aware of and had an opportunity to question each other's plans. Similarly, Hospital / MCSs / LCO strategic priorities were shared through the Group Service Strategy Committee.

Draft Hospital / MCS / LCO priorities were presented to the Council of Governors in an Annual Planning session on 25 May where the Governors had an opportunity to input their views and comments.

Plans were finalised taking into account the comments of the Governors. A draft MFT Annual Plan document pulling together plans from across the Hospital / MCS / LCO and corporate teams was produced. This was circulated to members of the CoG for comment. Any further Governor feedback has now been considered and the attached is the final draft to be approved by the Board of Directors.

4. Monitoring Delivery

The objectives described in the Annual Plan will be monitored in various ways; some through the Board Assurance Report, others through less formal mechanisms. Further work is to be undertaken to map for each initiative how progress will be monitored and reported.

5. Recommendations

The Board of Directors is asked to:

- Approve the MFT Annual Plan 2021/22.
- Note that further work will be brought back to the Board to show how progress will be monitored.

Attachment A

MFT Vision and Strategic Aims

Our vision is to improve the health and quality of life of our diverse population by building an organisation that:

- Excels in quality, safety, patient experience, research, innovation and teaching,
- Attracts, develops and retains great people, and
- Is recognised internationally as leading healthcare provider

This is underpinned by our strategic aims, which are:

- To complete the creation of a Single Hospital Service for Manchester/ MFT with minimal disruption whilst ensuring that the planned benefits are realised in a timely manner
- To improve patient safety, clinical quality and outcomes
- To improve the experience of patients, carers and their families
- To develop single services that build on the best from across all our hospitals
- To develop our research portfolio and deliver cutting edge care to patients
- To develop our workforce enabling each member of staff to reach their full potential
- To achieve financial sustainability

Manchester University NHS Foundation Trust

2021/22 Annual Plan

CONTENTS

Glossary of Abbreviations

AOF	Accountability Oversight Framework
ARC-GM	Applied Research Collaboration Greater Manchester
ATMP	Advanced Therapy Medicinal Products
BAU	Business as Usual
DoN	Director of Nursing
CDSU	Clinical Data Science Unit
CHD	Community Diagnostic Hub
CQC	Care Quality Commission
CYP	Children & Young People
DH	Department of Health
DHSC	Department of Health and Social Care
DiTA	Diagnostics and Technology Accelerator
ED	Emergency Department
EPR	Electronic Patient Record
E&T	Education & Training
FBC	Full Business Case
F&F	Friends & Family Test
F&PP	Fit & Proper Person
GM	Greater Manchester
HInM	Health Innovation Manchester
H1	Half 1 – April 2021 – September 2021
H2	Half 2 - October 2021 – March 2022
ICS	Integrated Care System
IPC	Infection Prevention and Control
IQP	Improving Quality Programme
KLOE	Key Lines of Enquiry

LCO	Local Care Organisations
LD	Learning Difficulties
MCS	Managed Clinical Service
MFT	Manchester University NHS Foundation Trust
MIC	Medtech and In vitro diagnostics Co-operative
MREH	Manchester Royal Eye Hospital
MRI	Manchester Royal Infirmary
NHS E/I	NHS England / Improvement
NIHR	National Institute for Health Research
NMAHP	Nursing, Midwifery and Allied Health Professionals
NMGH	North Manchester General Hospital
NWAS	North West Ambulance Service
PAHT	Pennine Acute Hospitals NHS Trust
PbR	Payment by Results
PDC	Public Dividend Capital
PED	Paediatric Emergency Department
PFI	Private Finance Initiative
PMO	Project Management Office
PSIRP	Patient Safety Incident Response Plan
PTIP	Post Transaction Implementation Plan
QCR	Quality Care Round
RAG	Red, Amber, Green
RMCH	Royal Manchester Children's Hospital
R&I	Research & Innovation
SHS	Single Hospital Service
SLA	Service Level Agreements
SMH	Saint Mary's Hospital
SNCT	Safer Nursing Care Tool

SRFT	Salford Royal NHS Foundation Trust
UDH	University Dental Hospital of Manchester
VCSE	Voluntary, Community & Social Enterprise
WCH	Withington Community Hospital
WMTM	What Matters To Me
WRP	Waste Reduction Programme
WTWA	Wythenshawe, Trafford, Withington & Altrincham

1. Introduction

The purpose of the annual planning process is to develop a set of coordinated plans for the coming year from across the organisation that describe how, over the coming 12 month period, we are going to:

- Progress our vision and strategic aims
- Implement our clinical service strategies
- Respond to the priorities set by NHS England / Improvement.

Plans for this year will be dominated by the need to recover from the COVID-19 pandemic.

The MFT Annual Plan sets out:

- Who we are, describing the sites and services that we provide (page 7)

- The context within which our plans have been developed, in particular
    - What we want the organisation to become over the coming 5 years – Our vision and strategic aims (page 8)
    - The values and behaviours that underpin all that we do – Our Values (page 9)
    - The changes that we plan to make in order to achieve the benefits of having now created the Single Hospital Service - Our Clinical Service Strategies (page 10)
    - The principles that underpin recovery (page 11), and
    - Externally, the priorities set for us by NHS England / Improvement (NHS E/I) - NHS E/I Priorities for 2021/22 (page 12)
    - The priorities for the Greater Manchester Health and Social Care System (page 13)

- What we want to achieve in 2021/22 - our key priorities and plans for 2021/22 (pages 14 – 27). We have set out for each of our strategic aims, plans for 2021/22, who will lead them and when we expect they will have been achieved, and a description of the financial plan for delivering all of this within budget.

- How we will ensure that we stay on track – our performance monitoring and risk management arrangements (page 30).

2. Manchester University NHS Foundation Trust - who we are

Manchester University NHS Foundation Trust (MFT) is one of the largest NHS trusts in England providing community, general hospital and specialist services to the populations of Greater Manchester and beyond. We have a workforce of over 25,000 staff and are the main provider of hospital care to approximately 750,000 people in Manchester and Trafford and the single biggest provider of specialised services in the North West of England. We are a university teaching hospital with a strong focus on research and innovation.

The Trust comprises the following hospitals:

- ***Royal Manchester Children's Hospital (RMCH)*** - RMCH is a specialist childrens hospital providing general, specialised and highly specialist services for children and young people. RMCH and Saint Mary's Hospital deliver joined up services for families from prenatal care through birth and beyond.
- ***Saint Mary's Hospital (SMH)*** - Saint Mary's Hospital provides general and specialist medical services for women, babies and children as well as being a comprehensive Genomics Centre.
- ***Manchester Royal Eye Hospital (MREH)*** – MREH is a specialist eye hospital providing inpatient and outpatient ophthalmic care
- ***University Dental Hospital of Manchester (UDH)*** – UDH is a specialist dental hospital
- ***Manchester Royal Infirmary (MRI)*** – MRI is a large teaching hospital providing general and specialist services including kidney and pancreas transplants, haematology, cardiac services and sickle cell disease.
- ***Wythenshawe Hospital*** - Wythenshawe Hospital is a large teaching hospital providing general and specialist services including cardiology and cardiothoracic surgery, heart and lung transplantation, respiratory conditions, burns and plastics, cancer and breast care services
- ***Altrincham Hospital*** – Altrincham Hospital provides a range of general and specialist outpatient and diagnostic services.
- ***Withington Community Hospital (WCH)*** – WCH is a community hospital providing outpatients, diagnostics, day surgery and community services
- ***Trafford Hospital*** – Trafford hospital specialises in rehabilitation and the care of the senior adult and has an Urgent Care Centre, an Orthopaedic Surgical Centre and as well as providing outpatients and daycase surgery.
- ***North Manchester General Hospital (NMGH)*** - NMGH provides a full range of general hospital services to its local population and is the base for the region's specialist infection disease unit.

MFT also hosts Manchester and Trafford Local Care Organisations. They provide integrated out-of-hospital care for the city of Manchester and Trafford. Services provided include community nursing, community therapy services, intermediate care and enablement, and some community-facing general hospital services.

3. MFT Planning Framework

Our Annual Plan sets out what we want to do in the coming 12 months. It is developed in the light of our existing longer-term plans and strategies; key amongst these are our vison and strategic aims, our values, our group and clinical service strategies and the principles that we have developed that will underpin our recovery from COVID-19. External influences on the plan include national plans and strategies and the priorities set for the year by NHS England / Improvement and the priorities and plans agreed collectively across the Greater Manchester Health and Social Care system.

Our Vision

Our vision sets out what sort of organisation we want to become over the next 5 to 10 years. It is underpinned by seven strategic aims that describe in more detail what we want to achieve over that timeframe. They are set at the MFT group level and are one of the ways in which we ensure that the whole organisation is working to the same agenda.

Our values

Our work is underpinned by our values statement that Together Care Matters and our values and behaviours framework (shown in the graphic below). These values and associated behaviours will drive both the development and the delivery of the plans set out in this document.

Our Vision

Our vison is to improve the health and quality of life of our diverse population by building an organisation that:

- **Excels in quality, safety, patient experience, research, innovation and teaching**
- **Attracts, develops and retains great people**
- **Is recognised internationally as a leading healthcare provider**

Our Values

Together Care Matters

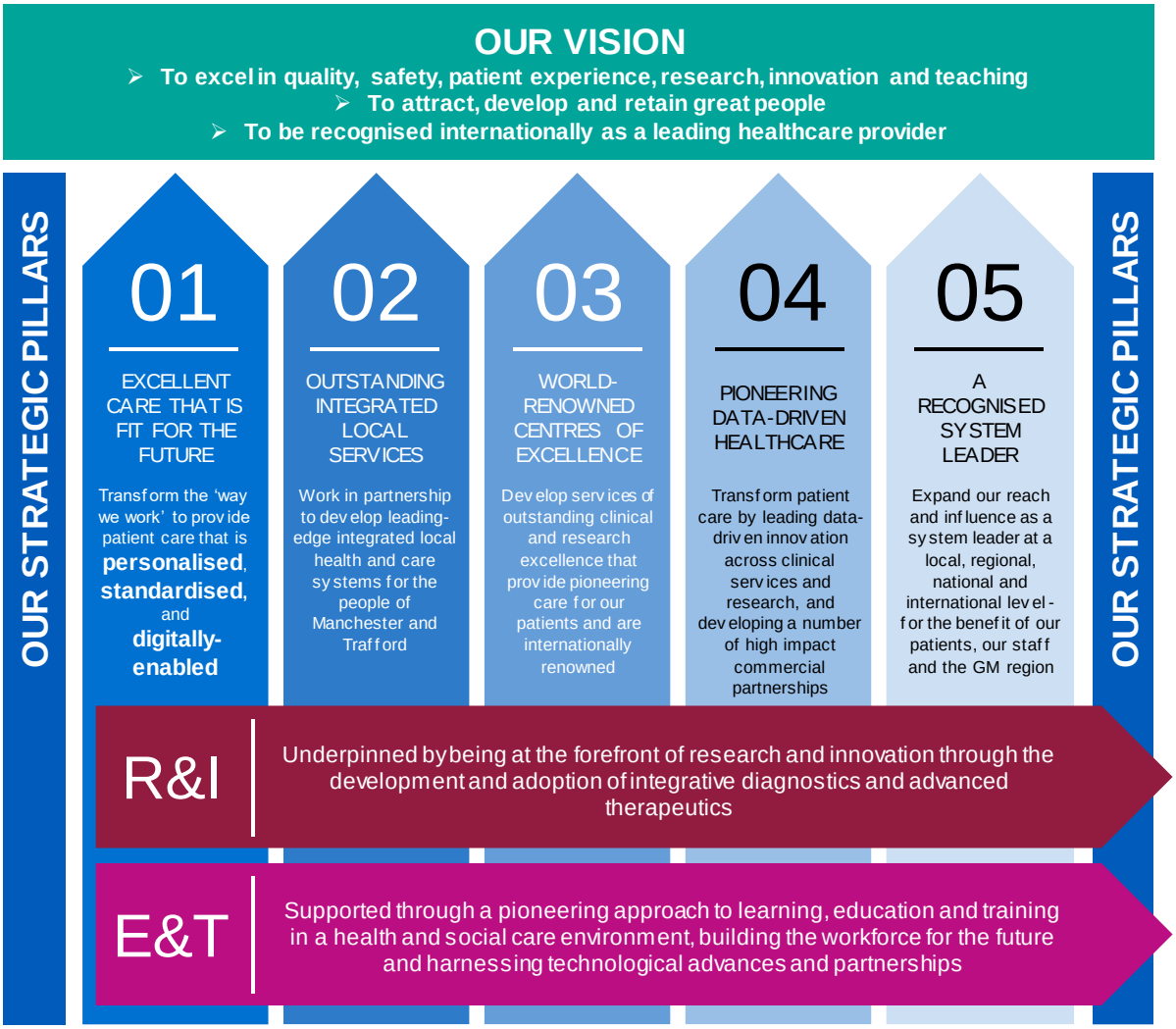
Everyone Matters
Working Together
Dignity and Care
Open and Honest

Everyone Matters √	Working Together √	Dignity and Care √	Open and Honest √
• I listen and respect the views and opinions of others • I recognise that different people need different support and I accommodate their needs • I treat everyone fairly • I encourage everyone to share ideas and suggestions for improvements	• I listen and value others views and opinions • We work together to overcome difficulties • I effectively communicate and share information with the team • I do everything I can to offer my colleagues the support they need	• I treat others the way they would like to be treated – putting myself in their shoes • I show empathy by understanding the emotions, feelings and views of others • I demonstrate a genuine interest in my patients and the care they receive • I am polite, helpful, caring and kind	• I admit when I have made a mistake, and learn from these • I feel I can speak out if standards are not being maintained or patient safety is compromised • I deal with people in a professional and honest manner • I share with colleagues and patients how decisions were made

Our Group and Clinical Service Strategies

The Single Hospital Service for the city of Manchester, which was completed with the incorporation of North Manchester into MFT in April 2021, was created to improve services for patients and create rewarding roles for our staff. In order to agree how best to reshape our services and our clinical teams to deliver these benefits, we produced an MFT ***Group Service Strategy*** and a series of individual ***Clinical Service Strategies.*** The strategies were developed through extensive engagement with internal and external partners and stakeholders.

The ***Group Service Strategy*** sets out, at a high level, our vision for how services should develop over the next five years. Five key themes emerged from the engagement and they form the pillars of the strategy. The graphic below shows the pillars and describes for each what we want to achieve and how we plan to get there.



The Group Service Strategy served as the over-arching framework for creating a series of individual ***Clinical Service Strategies***. These describe in more detail the development path for individual services over the next 5 years.

Our Recovery Principles

Recovery from COVID-19 will mean significant changes to the way in which we work and we should not underestimate the demand this will place on our workforce. The graphic below shows the principles that have been developed that will underpin the COVID-19 recovery programme.

Recovery will also be aligned with the implementation of our Electronic Patient Record (EPR), which is a key programme of work for 2021/22. We are currently using more than 750 electronic and paper-based patient record systems. The EPR system will bring all of these together into a fully integrated Trust-wide solution so that we can provide better quality care to patients, wherever they are treated.

The EPR solution is important, but the implementation programme (known as HIVE) means much more than the introduction of a new digital system. It means wide-spread change in every part and process in the organisation, transforming how we work for the benefit of our patients.

The EPR itself and the process to implement the EPR will be important enablers of our recovery.

NHS England & NHS Improvement - Priorities for 2021/22

The national planning guidance issued by NHS England & NHS Improvement sets out six high level priorities for 2001/22 as shown in the table below.

A	**Supporting the health and wellbeing of staff and taking action on recruitment and retention**	1	Looking after our people and helping them to recover
		2	Belonging in the NHS and addressing inequalities
		3	Embed new ways of working and delivering care
		4	Grow for the future
B	**Delivering the NHS COVID-19 vaccination programme and continuing to meet the needs of patients with COVID-19**		Possible COVID-19 re-vaccination programme, seasonal flu vaccination and possibility of COVID-19 vaccination of children. Continue use of home oximetry, 'virtual wards', proactive care pathways in people's homes Maintain the dedicated Post COVID-19 Assessment clinics and Long COVID-19 assessment services. NHS E will conduct a stocktake of physical critical care capacity and workforce All NHS organisations to ensure application of the UK IPC guidance
C	**Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services**	1	Maximise elective activity and transforming the delivery of services
		2	Restore full operation of all cancer services
		3	Expand and improve mental health services and services for people with a learning disability and/or autism
		4	Deliver improvements in maternity care, including responding to the Ockenden review
D	**Expanding primary care capacity to improve access, local health outcomes and address health inequalities**	1	Restoring and increasing access to primary care services
		2	Implementing population health management and personalised care approaches to improve health outcomes and address health inequalities
E	**Transforming community and urgent and emergency care to prevent inappropriate attendance at ED, improve timely admission to hospital for ED patients and reduce length of stay**	1	Transforming community services and improve discharge
		2	Ensuring the use of NHS111 as the primary route to access urgent care and the timely admission of patients to hospital who require it from emergency departments
F	**Working collaboratively across systems to deliver on these priorities**	1	Effective collaboration and partnership working across systems
		2	Develop local priorities that reflect local circumstances and health inequalities
		3	Develop the underpinning digital and data capability to support population-based approaches
		4	Develop ICSs as organisations to meet the expectations set out in Integrating Care
		5	Implement ICS-level financial arrangements

Greater Manchester Health and Social Care System Priorities

Six major programmes of activity and focus have been identified at the Greater Manchester level:

Maintaining physical, social and mental well being

- Delivering the fundamental basics of health and well-being - a home, a job and a family/social support system building on existing partnerships and agreements
- Strengthening the role of health and care organisations as anchor institutions
- Building and delivering a plan for local community engagement and development
- Allocating resources to neighbourhoods and designing services to reduce inequality

Creating more consistent evidence based preventive and proactive primary care

- Improving healthy life expectancy through primary and proactive care
- Capitalising on the development of the neighbourhood model and working at neighbourhood level
- Using and investing in joined up data systems to identify and stratify risk on a real time basis to prevent deterioration of patients

Greater integration of the community based reablement, residential, rehabilitative, palliative and social care services

- Establishing integrated community teams that can manage physical, mental and social health problems by offering holistic services
- Using new methods of providing services to deliver longer periods of independent living and speedier return to employment for GM citizens
- Building on the Adult Social Care transformation progressed in recent years through models such as Living Well at Home

Coordinating and improving the urgent and emergency care service response

- Developing pathways between local urgent care services and specialist emergency care
- Empowering the Provider Collaboratives to work with local organisations, VCSE and NWAS to organise and deliver a consistent approach to urgent care
- Using local groups to train more of the population in first aid
- Enabling the use of NWAS insights and data to predict and prevent acute episodes of care and targeting resources to known areas of need

Delivering more consistent planned care and delivering the planned care recovery programme

- Providers across GM collaborating to lead the planned care recovery programme, addressing health inequalities, offering virtual services and undertaking clinical validation
- System-wide collaboration to better manage the flow of new patients needing diagnosis and treatment
- Reducing unwarranted clinical variation, maximising bed and workforce capacity
- Working across the system to facilitate discharge from hospital and using virtual wards and remote monitoring to accelerate acute care management and rehabilitation at home

Further developing access to and delivery of world class specialised care and building a hugely capable innovation capability in Health Innovation Manchester (HInM)

- Developing GM's range and depth of specialised services to attract new investment and staff, in particular in light of the importance of the life sciences sector to a post Brexit UK
- Utilising HIM to encourage inward investments and partnerships and enable the health and care system to adopt leading edge technologies that will improve outcomes for GM
- Work to create the first prototype virtual health and care system

4. Priorities and Plans for 2021/22

Taking into account all of the internal and external context and drivers, each Hospital / Managed Clinical Service (MCS) and corporate team has developed their own priorities and plans that will enable them to deliver on those priorities for the coming year. The following tables set out, for each of our strategic aims, what we are aiming to achieve and what specifically will be achieved in 2021/22 and by which quarter, and which department or Hospital /MCS is responsible. These are in no way exhaustive but give a flavour of our priority plans for 2021/22.

To improve patient safety, clinical quality and outcomes

MFT wide plans

What we are going to do	Who is going to do it	What will be achieved in 2021/22	By when
Implementation of National Patient Safety Strategy	Hospitals/MCS/ MTLCO with Corporate Clinical Governance Team support	Site and Trust wide Safety Strategy developed	Q4
		Site and Trust wide Patient Safety Incident Response Plan (PSIRP) developed	Q4
		Patient safety specialist network developed	Q4
		Human Factors Academy created to deliver – Integration of safety I and safety II concepts in patient safety response – Training and education opportunities for all staff – Enhanced simulation and a future proof simulation strategy – Patient safety culture assessment tool – Alignment of Human Factors principles to transformation work	Q4
		Existing approach to safety oversight enhanced through site level development	Q4
		A 'patient safety partnership forum' developed and implemented as an enabler for meaningful patient and public involvement in patient safety	Q4
		A new framework which captures outcomes, best practice, national audit programmes devised with Medical Directors of Hospitals/MCSs as a base to push performance	Q4
Infection Prevention & Control (IPC)	Clinical services with IPC team and Corporate Nursing	IPC Board Assurance Framework actions intended to protect patients, staff and public during the COVID-19 Pandemic delivered.	Q4
		Reduction in Healthcare Acquired Infections on 2020/21 levels.	Q4
		New Antimicrobial Reduction Strategy launched.	Q1
		Staff flu and COVID-19 vaccination programme achieved.	Q4
		Effective collection and utilisation of data to monitor and drive improvements	Q2
Re-establish an annual nursing and midwifery staffing establishment review programme to provide assurance that staffing levels are safe	Corporate Nursing Hospitals/MCS Directors of Nursing	Safer Nursing Care Tool (SNCT) re-introduced for all appropriate inpatient areas and Emergency Departments	Q1
		SNCT census collections completed (X3)	Q3
		Baseline establishment review undertaken following 1st census.	Q1
		Establishments re-set following 3rd census.	Q4
		Assessment of midwifery staffing levels (using Birthrate plus) undertaken across maternity sites and community.	Q3

Increase nursing and midwifery workforce pipeline and reduce nursing and midwifery turnover – improve on 2020/21 position	Corporate Nursing with all hospital / MCS / LCO DoNs	Programme of virtual attraction events to increase domestic nursing and midwifery starters continued	Q4
		All 3rd year students undertaking placement at the Trust (due to graduate in September 21) issued with a guaranteed job offer	Q1
		Guaranteed job offer for home grown students entering 2nd year of training introduced to increase future pipeline	Q3
		Minimum 450 International Recruitment nurses recruited to support service transformation programmes attracting staff with specialist skills.	Q4
		Recruitment pipeline improved and vacancies reduced in hard to fill areas e.g. theatres, dialysis, elderly medicine on 2020/21 levels	Q3
Maintain compliance with CQC standards and deliver improvements in readiness to achieve Good and Outstanding ratings across all areas.	Corporate Nursing, Medical Directors' office, All hospitals/MCS/ LCOs CEOs and senior teams	Preparation for CQC inspection of MRI completed	Q3
		Following improvements made from last CQC inspection, all services continue to improve on quality measures (Quality Care Round, What Matters To Me survey and Friends & Family Test)	Q4
		Improved quality of evidence of compliance with regulatory standards	Q3
		Significant assurance found in audits relating to regulatory standards	Q4
Results Acknowledgment – implementing an electronic system to monitor acknowledgment of pathology & radiology test results by the clinicians that ordered them	Group Medical Directors	Full launch and switch off of paper reports - paper test reports will no longer be required as they will be available electronically.	Q1
		Regular performance reporting established	Q2
		Learning from this change used to inform Electronic Patient Record (EPR) Results Acknowledgment design – this will be an early example of the cultural change that will be required on a larger scale as we move to an EPR.	Q1
Ensure that staff are suitable and fit to undertake their role and comply with professional standards so that CQC requirements are fully met.	Corporate Governance	Electronic Fit & Proper Person (F&PP) register established and F&PP checks embedded into appraisal discussions.	Q3
		Code of conduct declarations established as an MFT Mandatory programme and E learning and reporting instituted.	Q3
Implement the Epic Electronic Patient Record (EPR), transforming services to provide better quality care to patients	HIVE Team	Core Epic system build complete. Testing the MFT Epic system started	Q3
		Transformation design completed	Q4
		All specialty clinical content build completed	Q4
Development of strategy for dementia care	Corporate Nursing Hospitals/MCS Directors of Nursing	MFT Dementia Strategy (2019-2022) reviewed and refreshed in readiness to launch a new strategy in 2022.	Q3

Hospital / MCS / LCO plans

What we are going to do	Who is going to do it	What will be achieved in 2021/22	By when
Prepare for CQC assessment	WTWA	Internal Key Lines of Enquiry inspection – self assessment process for CQC inspection readiness developed	Q4
Learning from incidents	NMGH	Systems developed in line with MFT approach to share learning from serious incidents across NMGH	Q4
Focusing on delivering fundamentals of care	MRI	Focus maintained across MRI on nutrition/hydration, documentation, medicine management, management of harm and infection control	Q4
Ockenden review into maternity services	SMH	Recommendations of the Ockenden review into maternity services delivered.	Q4
Reducing delays in monitoring patients	MREH	Greater Manchester pilot to enable 'low risk' glaucoma patients to be monitored in the community led by MREH	Q4
Management of COVID-19 related delays in care	UDH	Clinical validation and risk stratification of patients whose care had been delayed completed	Q4
Improving safety culture	CSS	Moved to Safety II Culture	Q4
Focus on infection control	RMCH	Infection control and policies aligned across the whole of the RMCH Managed Clinical Service (NMGH, WTWA, RMCH)	Q4
Development of urgent care provision	LCO	Community urgent care provision reviewed and developed to support flow, timely discharge and reduced length of stay	Q4

To improve the experience of patients, carers and their families

MFT wide plans

What we are going to do	Who is going to do it	What will be achieved in 2021/22	By when
Re-establish the MFT quality and patient experience programme	Corporate Nursing/DoNs	Accreditation programme recommenced.	Q1
		Senior Leadership Walkrounds recommenced.	Q1
		What Matters to Me programme and surveys consistently undertaken with patient overall satisfaction with quality of service over 85%.	Q1
		Quality of Care Round/What Matters To Me patient survey platform re-tendered and implemented.	Q3
		Integration of quality and safety governance and data, underpinned by digital transformation, with evidence of learning leading to continuous improvement	Q2
		Full Improving Quality Programme rolled out at NMGH.	Q2
	Corporate Nursing/DoNs with Estates & Facilities	Improvements in food provision and nutritional care on 2020/21 levels.	Q4
Develop and implement a programme of excellence in Learning Difficulties (LD) / autism care	Corporate Nursing/Hospitals/ MCS/LCO DoNs	LD/autism strategy for MFT will be developed and implemented through engagement with patients, staff and service user groups.	Q2
		LD/autism continuous improvement programme established across all hospitals/MCS/LCO	Q2
		LD/autism training integrated into management development programmes	Q3
		Training programme for clinical staff developed and rolled out to support the LD strategy - improving skills and awareness of caring for patients with LD and autism	Q2

Hospital / MCS plans

What we are going to do	Who is going to do it	What will be achieved in 2021/22	By when
Learning from complaints	WTWA	Thematic review of complaints undertaken	Q4
Embedding fundamentals of care	MRI	Fundamentals of care embedded and promoted through MRI Always Events	Q4
Engaging patients	SMH	SMH patient engagement approach rolled out to services at North Manchester	Q4
	NMGH	What Matters to Me implemented	Q4

Increasing access	MREH	Diagnostic clinics at evening and weekends increased to maximise opportunities for virtual review	Q4
	UDH	New ways of working (Attend Anywhere, Advice & Guidance, Telephone Review Clinics) further developed and rolled out	Q4
Listening to patients / parents and carers	CSS	Patient experience feedback and metrics captured in service developments and delivery	Q4
	RMCH	Voice of Children & Young People (CYP) and parents / carers embedded in hospital committees and service change including the development of NMGH CYP advocacy and hospital services	Q4
Supporting independence		Improved pathways and patient support delivered through the Better Outcomes Better Lives programme	Q4

To develop our workforce enabling each member of staff to reach their full potential

MFT wide plans

What we are going to do	Who is going to do it	What will be achieved in 2021/22	By when
Launch MFT People Plan	Group Workforce Team	MFT People Plan launched and communicated	Q1
		Delivery Plan agreed	Q1
Develop Workforce Digital Strategy	Group Workforce Team	Workforce Digital Strategy and delivery plans developed	Q2
		Workforce systems eg: job plan, rostering implemented in line with delivery plan	Q4
Develop MFT Putting People First Framework	Workforce, Corporate Nursing and Medical Directors	Disciplinary and Maintaining High Professional Standards policies reviewed and revised to reflect putting people first	Q1
		Training schedule developed	Q1
		Campaign on Bullying and Harassment delivered	Q2
Ofsted inspections	Group Workforce Team	Regulatory rating achieved for: • Apprenticeships service • First Steps Nursery Oxford Road site	Q1
Review of Nursing Assistant roles in clinical settings	Workforce – Corporate Nursing	Review of skill mix required in clinical settings completed	Q3
Revise Policy Development programme	Group Workforce Team	Policy review schedule agreed	Q1
		Revised policies delivered in line with schedule	Q1 – Q4
Refresh MFT Leadership and Culture Plan deliverables as part of the MFT People Plan	Group Workforce Team	MFT Organisational Development Plan developed	Q1
		Staff engagement and recognition platform launched	Q1
		Talent and Development centres delivered	Q3
		Learning & Education Strategy launched	Q2
Develop Reward Strategy	Group Workforce Team	Scoping for potential reward initiatives completed	Q2
		Stakeholders engaged on proposed strategy and delivery plan	Q4
Delivery of workforce COVID-19 recovery programme	Group Workforce Team	Employee Health & Wellbeing Service model including psychological support and enhanced fitness for work services further developed	Q2
		Anti-stigma Mental Health Campaign delivered	Q2
		Targeted recruitment campaigns held to increase workforce availability	Q2
		Key learning programmes made available on-line	Q3

		Compassionate leadership training series held for line managers	Q2
		Staff networks, societies and forums build and expanded to encourage employee voice	Q3
Delivery of ED&I Strategy	Group Workforce Team	Number of staff belonging to ethnic minority groups in senior positions (8a and above) increased	Q4
		Disability confident leader status achieved	Q4
Alignment of workforce services post integration of North Manchester	Workforce/Corporate Nursing/ Medical Director	Implementation of Integration plans achieved	Q4
		Temporary staffing arrangements implemented for all staff groups	Q3
Improve Training Opportunities for Medical and other staff	Group Medical Directors	Manchester Surgical Skills & Simulation Centre pilot launched	Q1
		Pilot reviewed and future model agreed	Q4

Hospital / MCS plans

What we are going to do	Who is going to do it	What will be achieved in 2021/22	By when
Enhancing staff support offer	WTWA	WTWA communications & engagement plan developed and implemented	Q4
	NMGH	Vibrant & inclusive support & development offer built	Q4
	MRI	Staff and teams skilled up and empowered to improve patient care and staff experience	Q4
	SMH	MFT initiatives to help staff recover from pandemic response implemented	Q4
	MREH	Staff well being plan/events calendar for 2021/22 developed	Q4
	UDH	Focussed support provided for staff who were redeployed	Q4
	RMCH	Our people plan - ‘ All here for you’ delivered and health and wellbeing initiatives expanded	Q4
Addressing staff shortages	CSS	Targeted recruitment undertaken for key CSS staff shortages	Q4
	LCO	Community workforce plans developed to address capacity, skill-mix and meet changing demands	Q4

To develop single services that build on the best from across all our hospitals

What we are going to do	Who is going to do it	What will be achieved in 2021/22	By when
Develop MFT Clinical Service Strategies	Group Strategy Team	Clinical Service Strategies reviewed and refreshed following COVID-19 pandemic	Q4
		Commissioner approval achieved for positive service changes implemented in response to COVID-19	Q4
		Commissioner approval achieved for significant service changes within the Clinical Service Strategies	Q4
		Cancer Strategy for MFT developed	Q3
		Site strategy for NMGH developed	Q4
Identify and progress longer term developments	Group Strategy Team	Long term plan for Advanced Therapies developed	Q4
		Long term plan for Genomics developed	Q4
		Business case for Community Diagnostic Hub at Withington Community Hospital completed	Q4
Development of partnerships and joint working	Group Strategy Team	MFT represented on regional and national Networks	Q4
	MREH	New ways of working with primary eyecare services developed to reduce the burden on hospital services	Q4
Clinical Service Strategy implementation	WTWA	Service strategies for cardiac, respiratory, Trauma & Orthopaedics, care of the elderly, stroke, urology implemented	Q4
	MRI	Centres of excellence in individual services created	Q4
	CSS	Implementation of Advanced Therapy Medicinal Products (ATMPs) commenced	Q4
	RMCH	Development of Advanced Therapies for children to be the Northern Hub for research and specialist commissioned treatments	Q4
	CSS	Community Diagnostic Hubs implemented	Q4
	SMH	Rare Conditions Centre launched	Q4
Development of NMGH	NMGH	NMGH site redevelopment Full Business Case progressed	Q4
	LCO	Community service leadership provided to development of North Manchester and the well-being hub	Q4

To develop our research portfolio and deliver cutting edge care to patients

What we are going to do	Who is going to do it	What will be achieved in 2021/22	By when
Get back to business as usual and resume non-COVID-19 research	Research and Innovation	Non-COVID-19 research income achieved of at least 80% that achieved in 2019/20	Q4
		Number of open non-COVID-19 studies to be greater than 80% of the number open in 2019/20	Q3
Develop research partnerships with commercial organisations from the healthcare and biotech industry	Research and Innovation	Individual R&I projects developed with QIAGEN (MFT biotech partner)	Q4
		A further partnership developed with healthcare / biotech company	Q4
		MFT campus developed through working with Bruntwood, Manchester Science Parks and Alderley Park, and further commercial partners attracted	Q4
Develop our capacity and capability to undertake analyses on large scale patient data for research through our Clinical Data Science Unit (CDSU)	Research and Innovation and IM&T	Appointments made to key positions in the team	Q1
		Terms of reference drafted and approved to clarify remit and governance arrangements for the CDSU	Q2
		Exemplar projects identified	Q3
Develop the Electronic Patient Record to support research	Research and Innovation	R&I input to design of EPR	Q2
		Research module of EPR built	Q4
Prepare a bid to NIHR* for a Medtech and In vitro diagnostics Co-operative (MIC) in Manchester - MICs are centres of expertise and bring together patients, clinicians, researchers, commissioners and industry based in leading NHS organisations	Research and Innovation	MFT Diagnostics and Technology Accelerator (DiTA) Director and Manager appointed	Q1
		Steering Group re-established	Q1
		MFT strengths / themes for MIC bid identified	Q3
		Online presence increased through, for example website, webinars, and social media.	Q4
Support our NIHR infrastructure	Research and Innovation	Support 2022 bid to NIHR to renew our Biomedical Research Centre *	Q4
		Support 2022 bid to NIHR Clinical Research Facility*	Q4
		Lead 2022 bid to NIHR* for a Manchester MIC (see above)	Q4
Encourage involvement in research through “research is everyone’s business” campaign	Research and Innovation	Named clinical links between R&I and the Hospitals / MCSs staff identified	Q4
		Resources produced for MFT staff to highlight importance/ value of invention capture & commercialisation;	Q3
		Provide guidance on research related objectives in appraisals for non-R&I staff to raise awareness of how their work related	Q3

		to the research agenda	
Improve the efficiency and scope of clinical trials	Research and Innovation	Working group convened to explore taking on sponsorship of “first-in-human” trials	Q1
		Metrics achieved for NIHR* Performance in Initiation and Delivery: ○ League 1 for number of trials ○ Top 5 for first patient recruitment speed (initiation) and recruitment to time and target (delivery)	Q4
		Metrics achieved for NIHR Clinical Research Network for Greater Manchester (GM) performance ○ MFT in top 2 Trust recruiting patients to all trials in GM ○ MFT top Trust recruiting to commercial trials in GM ○ MFT top Trust recruiting to CUE-TIP (COVID-19) trials in GM ○ MFT top 10 Trust recruiting patients to all trials in England	Q4
Continue to build on Nursing, Midwifery and Allied Health Professionals (NMAHP) research activity	Corporate Nursing with hospitals/ MCS/LCO DoNs	Delivery of NMAHP research strategy continued and 2022 -2025 strategy developed.	Q4
		’Paper to Practice’ programme (An introduction to implementing research-informed change in health care settings in collaboration with the Applied Research Collaboration Greater Manchester (ARC-GM)) will have been reviewed and extended to support research implementation with a focus on oral care, falls, nutrition and wound care.	Q4
		4th round of NMAHP fellowships appointed and commenced.	Q2
		NMAHP grant income increased on 2020/21 levels	Q4

*National Institute for Health Research (part of the Department of Health and Social Care, https://www.nihr.ac.uk). NIHR is the largest funder of health and care research in the UK and provides the people, facilities and technology that enables research to thrive, funded primarily by the Department of Health and Social Care.

To complete the creation of a Single Hospital Service for Manchester with minimal disruption whilst ensuring that the planned benefits are realised in a timely manner

What we are going to do	Who is going to do it	What will be achieved in 2021/22	By when
Coordinate and manage ongoing disaggregation of NMGH services from PAHT service models (including withdrawal from Service Level Agreements), and support progressive integration into MFT, ensuring consistency with NMGH capital scheme and single service development plans.	Collaborative effort between SHS Team and NMGH Redevelopment Team, through new matrix working arrangements	Specified Service Level Agreements (SLAs) terminated, services disaggregated, and staff/etc transferred.	Q4
		Well established plans in place for all other SLAs, for termination/ disaggregation on an agreed timescale.	Q4
Complete the integration management and post transaction planning processes, including PTIP v3, suitable legacy/archiving arrangements and transition to business as usual (BAU)	SHS Team	Day 100 integration objectives achieved	Q2
		PTIP v3 approved	Q2
		On-going issues transitioned to business as usual processes	Q2
Deliver the statutory transaction to complete the transfer of residual NMGH assets and liabilities to MFT, alongside the acquisition of Bury/Oldham/Rochdale by SRFT, and the dissolution of PAHT.	SHS Team	Suitable legal arrangements (inc Transfer and Dissolution Orders) negotiated and executed	Q2
		Statutory transaction completed and PAHT dissolved	Q2
Continued development of the North Manchester Strategy (previously the "NM Proposition"), including work on service transformation, the Wellbeing Hub and the Healthy Neighbourhood/Placemaking.	North Manchester Strategy PMO, with NMGH Redevelopment Team and SHS Team	Refreshed North Manchester Strategy developed and approved.	Q2
		Plans for Placemaking Partnership developed.	Q4
		NM Service Transformation exercise completed and outputs contributing to FBC	Q4
		Wellbeing Hub plans developed and contributing to FBC.	Q4

To achieve financial sustainability

Financial Planning

Planning for 2021-22 has been extremely complicated and unusual in comparison to other years. The financial regime put in place in response to the pandemic in 20/21 has been rolled forward for the first half (H1) of 21/22 and funding levels agreed for the first half of the year only.

We have developed a financial plan for the full year 21/22, making significant assumptions in relation to funding levels for H2, which represent a potential risk to the Trust. As in previous financial years, the Trust is required to deliver a surplus of £23m, which in turn provides funding for capital investments identified in the business case for the merger, which created MFT.

The Payment by Results financial regime is no longer in place and it will not be brought back in future years, as Aligned Payment Incentives and blended payments contracts will be introduced. For H1 there is a requirement to manage funding across the whole GM system within a specified revenue funding envelope, and therefore there have been negotiations with the other Providers and Commissioners in the system as to the level of funding each Trust and CCG receives.

Similarly, there is now a GM capital system envelope, which has been negotiated between Providers to arrive at a plan.

This overall move to system-working is in line with the move to working as an Integrated Care System, which will be established formally from 1st April 2022. Thus, it is expected that similar negotiations will be required on an annual basis in future.

Income and Expenditure Plan

The table below shows the Income & Expenditure financial plan for 2021/22.

Enlarged MFT 2021/22 £m	**Enlarged Trust position**
Income	
Patient Activity	2,000
Non-patient Activity	237
Total Income	**2237**
Expenditure	
Pay	-1,321
Non-pay	-1,006
Total Expenditure	**-2,327**
Total Net Operating Position	**-90**
Non-operating Income / Expenditure	-41
Net position	**-131**
Control Total Adjustments	134
Technical Adjustments	20
Net Position on Control Total Basis	**23**
Waste Reduction Requirement (WRPs)	**50**
%	2.6%

Each Hospital / MCS / LCO and Corporate Department has been set an indicative Control Total and a Waste Reduction Programme target. Year-end and month by month forecasts will be monitored on a monthly basis as part of the Trust's overall Accountability Oversight Framework. Each area will be held to account based on their forecast variance from their Control Total.

Capital Planning 2021/22

The total capital programme for MFT for 2021/22 is £198.3m.

The capital plan has been the subject of extensive discussions internally and across GM to agree the share of the envelope to deliver the necessary capital plan for MFT. The table below shows the main categories of spend and how the programme is being funded.

MFT 2021/22 Capital programme - £m

MFT	2021/22
EPR	18
IM&T	10
Equipment	-
Project RED	12
Backlog maintenance	10
Wythenshawe theatres	8
Trafford theatres	6
Project PED	0
Estates	25
PFI	11
MFT	**100**
NMGH	
IM&T disaggregation	12
IM&T	2
EPR	7
Equipment - clinical due diligence requirements	8
Backlog maintenance	11
Estates – redevelopment	59
NMGH	**99**
Total - Enlarged MFT	**199**

MFT 2021/22 Funding for capital programme - £m

MFT	
PDC	12
Loans - to be approved	25
Internally Funded	47
PFI	11
Loans other (e.g. Salix)	3
Charity	2

MFT	**100**
NMGH	
PDC	60
Emergency PDC	31
Loans - to be approved	8
NMGH	**99**
Total - Enlarged MFT	**199**

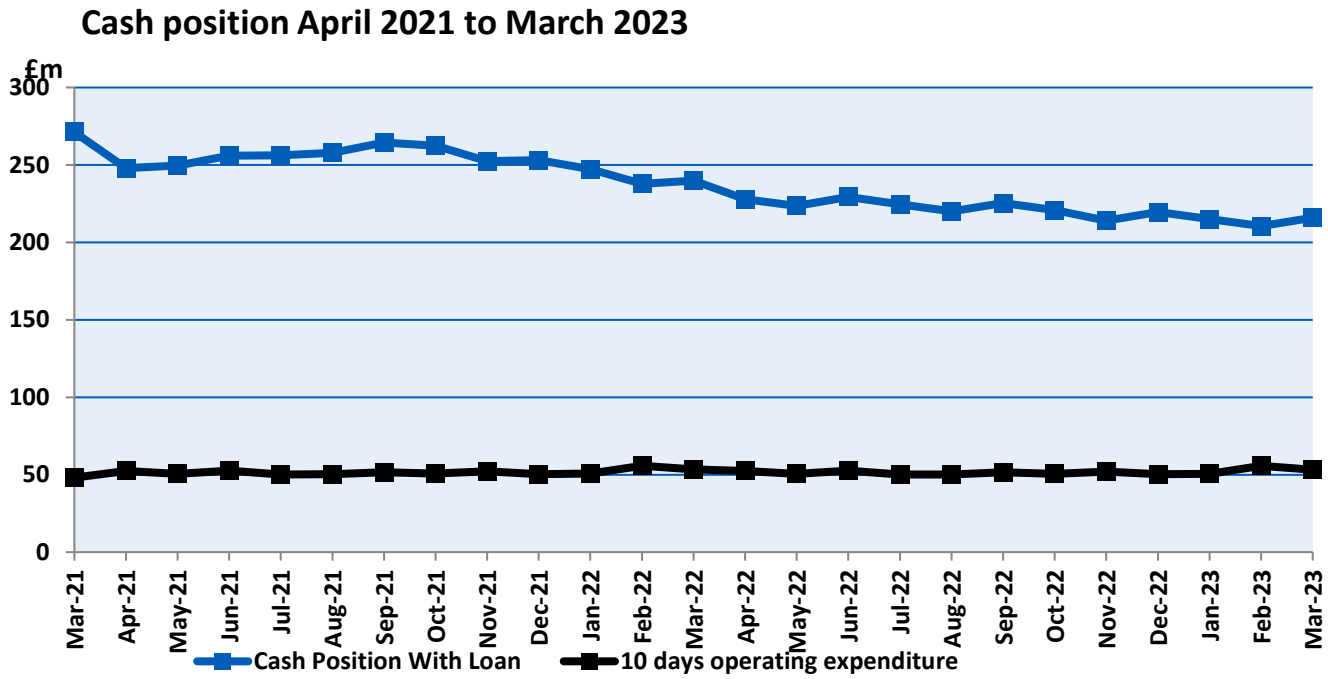
NB - Internally and loan funded capital spend is subject to final agreement of capital envelope at GM level.

It should be noted that although within the plan there is no funding for equipment, this is because a significant amount was spent on equipment at the end of 2020/21 which has reduced the risk of equipment failure. Should an urgent need for capital spend arise which is not in the plan, a re-prioritisation would be undertaken within the financial year to ensure the spend remains risk-based.

Cash and Balance Sheet

The Trust's planned cash flow for 2021/22 and 2022/23 recognises repayment commitments against existing DH loans and PFI liabilities, and investment in the capital programme. Whilst the cash flow plan shows a relatively strong level of cash is maintained through the year, there is an overall cash deterioration of £32m to a closing cash position as at the 31st March 2022 of £239m. The cash flow continues to deteriorate in 2022/23 reducing to a closing cash position of £216m as at the 31st March 2023. This is due to the significant investment in capital expenditure in each of these financial years. In arriving at this position, we have assumed a £23m surplus in both years and that WRP will be achieved.

The Trust closed the 20/21 financial year with a higher than forecast cash balance, in part due to the financial regime during the pandemic, but also due to the level of accruals and creditors at the year end. The chart below shows the cash profile of the Trust over the coming two years, which reduces due to the significant capital programme planned over those two years. The £23m surplus contributes to this chart by offsetting some of the capital spend. Also supporting the cash balance is the continued intention to access loan funding from DHSC to deliver some of the capital programme.



Key Risks associated with the 2021/22 financial plan

The delivery of the financial plan for 2021/22 carries a significant level of risk, one of the most material risks being the achievement of the Waste Reduction Programme target of £50m which in itself is driven by the assumed amount of system funding to be received for H2. A full register of risks has been developed and will be managed in line with the Trust risk management processes.

5. Risk and Monitoring Arrangements

Risks to Delivery

Risks to delivering the plan are monitored and managed through the established Trust risk management processes. All risks across the organisation are identified and assessed using a common framework. The management of high-level risks is escalated to the Group Risk Management Committee.

High-level risks are those that present a significant threat to the Trust objectives or that score 15+. Detailed plans are developed to mitigate these risks and they are reported bi-monthly to the Group Risk Management Committee.

Risks to the delivery of the organisational strategic aims are mapped on the Board Assurance Framework. This is reviewed by the Board on a regular basis.

Monitoring Delivery

Delivery of the plans will be monitored throughout the year through the following mechanisms.

Accountability Oversight Framework (AOF)

The Accountability Oversight Framework is the way in which MFT ensures that each of the constituent Hospitals, MCS and LCOs are delivering on their plans so that MFT at the Group level is achieving its targets. Key metrics are distilled from the Hospital/MCS/LCO Business Plans and form the basis of the AOF. Progress against each of the indicators is monitored each month and reviewed by executive directors. Where targets are not being met, a support package is developed to improve performance.

Board Assurance Report

The Board Assurance Report monitors MFT delivery of targets and key performance indictors at the Group level. It is presented at each formal meeting of the Board of Directors.

Hospital / MCS / LCO Review

A more in-depth review of delivery of the Hospitals / MCS / LCO plans takes place twice a year between the Executive Director Team and the senior leadership team from each Hospital / Managed Clinical Service / LCO.

Annual Review

A year-end review of the Annual Plan will be undertaken in December. Through this process, progress to date is used to project year end performance and RAG rate achievement. This is presented to the Council of Governors at the Annual Planning development session.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Mrs Kathy Murphy, Director of Nursing & Midwifery Saint Mary's Hospital Mrs Dympna Ebah, Group Associate Director of Clinical Governance and Patient Safety
Date of paper:	July 2021
Subject:	To update the Board of Directors of the progress against the Ockenden Report IEA'S and set out the extended governance process to ensure compliance with the actions within a group model
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Patient Safety and Clinical Quality
Recommendations:	The Board of Directors is asked to approve the extended governance infrastructure which is aligned to the perinatal quality surveillance model being adopted in Saint Mary's MCS.
Contact:	Name: Kathy Murphy, Director of Nursing & Midwifery, Saint Mary's Hospital Tel: 0161 276 6623

1. Background

1.1. 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 the trust immediate response was reported to the Board of Directors in March and May 2021.

1.2. The response of the Immediate and Essential Actions (IEA's) for Saint Mary's Managed Clinical Service (SM MCS) demonstrated no major non-compliance

1.3. 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 NW Regional Office on the 15th February 2021. This demonstrated the level of compliance with all 7 IEAs

1.4. A detailed analysis of each of IEA's has been developed by SM MCS and this includes an assessment of current position and actions required to demonstrate full compliance where needed.

1.5. In responding to the IEA's, the maternity services have not identified any high-level patient safety risks.

1.6. The SM MCS overarching action plan includes 83 actions of which 36 currently remain open with the last action due to close on the 31st December 2021. Progress against these actions is monitored by the MFT Quality & Safety Committee.

1.7. A submission of evidence related to areas of compliance is currently being uploaded via a National portal. The final submission date has been extended from 14th June 2021 to 30th June 2021.

1.8. Extensive evidence has been collated and reviewed with support from the Group Governance team to provide assurance and quality assessment. To date over 100 individual pieces of evidence have been uploaded to demonstrate compliance with the IEA's. The LMS has provided standardised evidence for some criteria across GM. It is expected that SM MCS will submit all evidence by 25th June 2021

1.9. In line with the national announcement of investment into maternity services to support the implementation of the recommendations of the Ockenden report, SM MCS submitted its financial submission bid on 26th April 2021 via the GMEC LMS. The submissions were expected to cover gaps against Midwifery workforce establishments / Medical workforce establishment and MDT Training.

1.10. The initial submissions were revised in line with the regional request to only model midwifery staffing against Baseline BirthRate plus establishments and not to provide data linked to Continuity of Care (COC) modelling. The revised document was submitted to GMEC LMS on the 3rd June 2021 the outcome of which is still awaited.

1.11. As previously reported to the Board, a new National Perinatal Quality Surveillance model for governance has been developed in maternity services to improve oversight for perinatal clinical quality. The Saint Mary's MCS leadership team have reviewed the current governance processes in place and will integrate a local model of Perinatal Quality surveillance providing clear lines of responsibility and accountability for addressing any clinical concerns at each level from the Obstetric Division across the MCS to the Board of Directors.

1.12. This is intended to create a maternity safety infrastructure which links the Obstetric Division to Saint Marys Hospital Management Board and provides assurance through Saint Mary's MCS and the relevant quality and governance Boards and committees within MFT. This assurance will be based upon a combination of data. The Perinatal Quality surveillance model will enable MFT to discharge its duties and provide a safety net for issues to be identified and addressed.

1.13. This paper outlines the Saint Mary's MCS proposal and includes roles, responsibilities, and contributions of the Board Safety Champions, it outlines key quality and safety metrics which will be regularly reviewed at relevant committees as part of the oversight element in this model.

2. Principles of Quality Surveillance

2.1. In keeping with the NHS England Perinatal Quality Surveillance model, Saint Mary's MCS have proposed 5 principles of quality surveillance:

Principle 1: **Strengthening Executive and Board oversight of perinatal clinical quality**

- Saint Mary's MCS will provide a quarterly report to the Board of Directors regarding perinatal safety.

Principle 2: The MFT Board Safety Champions have a role in perinatal clinical quality oversight

- MFT has a nominated executive board safety champion to act as a conduit between staff and frontline safety champions (Obstetric, midwifery and neonatal) service users, Local Maternity System (LMS) leads and the North West Region and the Board of Directors
- MFT has a designated Non-Executive safety champion whose role is to act as a support to the MFT Board safety champion. The non-executive Director meets quarterly with Saint Mary's Medical Director and Director of Nursing & Midwifery to provide challenge and support reflection on the quality of safety on maternity service
- The MFT Board Safety champions will attend the Saint Mary's Quality and Safety Committee quarterly and will discuss the Saint Mary's Quality surveillance dashboard
- Quarterly Safety Champion walk arounds will take place across each site of the Saint Mary's Managed Clinical Service (MCS)
- Saint Mary's MCS Medical Director will meet as a minimum bi-monthly with the MFT Group Medical Director at which maternity safety issues are discussed
- Saint Mary's Director of Nursing & Midwifery will meet as a minimum bi-monthly with the MFT Group Chief Nurse to discuss maternity safety issues

Principle 3: Perinatal clinical quality is routinely reviewed at MFT Group Quality and Safety Committee

- The Group Quality and Safety Committee has a specific responsibility for perinatal quality oversight. The Group Chief Nurse, Group Joint Medical Director, the Saint Mary's MCS Director of Nursing & Midwifery and Medical Director are core members of the committee.
- Saint Mary's MCS Quality and Safety Committee minutes are shared and reviewed as a standing item on the Group Quality and Safety agenda

Principle 4: Saint Mary's MCS Obstetric Divisional governance will be aligned to reflect the revised perinatal quality surveillance model

- To ensure issues and concerns are integrated into Saint Mary's MCS quality and safety structures, the obstetric Clinical Head of Division and Heads of Midwifery and the obstetric governance leads will be core members of the Saint Mary's MCS Quality and Safety Committee
- Saint Mary's MCS Obstetric Divisional Quality and Safety Committee will provide monthly reports on performance to the Saint Mary's MCS Quality and Safety Committee
- Saint Mary's MCS Divisional and Hospital Committees will review the Obstetric Quality Surveillance dashboard to monitor performance.

Principle 5: There are agreed metrics which underpin the perinatal quality surveillance model

- Saint Mary's MCS has a local Quality surveillance dashboard which incorporates both clinical performance data and quality surveillance safety data. Having data all in one place will enable immediate identification of any patterns or issues arising in order to flag any early concerns. The dashboard will utilise information provided by:
  - The national maternity survey
  - Compliance against national maternity safety metrics-
    - Healthcare Safety Investigation Branch (HSIB)
    - Number of STEIS reportable incidents
    - NHS Resolution Clinical Negligence Scheme for Trusts maternity incentive scheme (CNST)
    - Saving Babies Lives care bundle version2 (SBL2),
    - Continuity of Care
  - Clinical performance data – for example: Rate of Stillbirths /Hypoxic Ischemic Encephalopathy (HIE) /Neonatal death/Maternal Death
- Data in the Quality Surveillance dashboard will include narrative as well as metrics to frame the context
- The Saint Marys MCS Dashboard will link to the GMEC Quality Surveillance tool developed on Tableau
- Saint Marys MCS Local data relating to complaints, claims and incidents
- Feedback from women's experiences

Please see appendix 1- examples of metrics for inclusion in the dashboard / graphic to illustrate

3. Clinical quality oversight and assurance

3.1. The key element of the model set out in this paper is the role of the Board of Directors in relation to oversight of the clinical outcomes for maternity services within Saint Mary's MCS. This will include:

- Attendance of the Board Safety Champions at the Saint Mary's MCS Quality and Safety Committee which is chaired by Saint Mary's Medical Director
- Information on Serious Incidents provided to Saint Mary's MCS Board of Directors every three months (safety champions in attendance)
- Information on Serious Incidents provided to the Board of Directors quarterly and more frequently to the Group Quality and Safety Committee
- Saint Mary's Senior Leadership Team will take timely and proportionate action to address any concerns identified within the quality surveillance dashboard and escalate any concerns to the Group Quality and Safety Committee
- Saint Mary's MCS will build on local transformation plans
- Saint Mary's MCS will request additional support when required

3.2. Saint Mary's MCS will undertake systematic reviews on incidents, complaints, claims and Freedom to Speak Up. Analysis will be used to identify cause, make recommendations, and develop actions to address any concerns and to provide safer care for service users.

3.3. Saint Mary's MCS Quality and Safety Committee and Risk Committee will monitor the completion and effectiveness of these actions with appropriate escalation to the Hospital Management Board.

3.4. Saint Mary's MCS Obstetric Divisional dashboard will be reviewed at the Obstetric Divisional Quality and Safety Committee and at the Saint Mary's MCS Hospital Quality and Safety Committee. Information will also be shared and discussed at the Greater Manchester & East Cheshire Maternity Strategic Clinical Network (GMEC SCN) which includes membership from the Saint Marys MCS Heads of Midwifery and Obstetric Clinical Head of Division.

3.5. In line with the National Patient Safety strategy and the National Patient Safety Incident Response Framework (PSIRF), Saint Mary's MCS will continue to involve and support patients and families throughout any investigation process and work in partnership with HSIB.

3.6. Saint Mary's MCS will have in place an annual audit calendar. Outcomes from audits will be monitored via the Saint Mary's MCS Quality and Safety committee. Evidence based quality improvements will be adopted and embedded in a timely fashion as part of Saint Mary's MCS overall safety strategy to ensure appropriate actions are taken in a consistent and sustainable way. Saint Mary's MCS will be actively involved in the National MatNeo safety improvement programme.

3.7. Saint Mary's MCS will collaborate with the GMEC MVP (Maternity Voice Partnership) to gain knowledge and understanding from women regarding their experience of care at Saint Mary's MCS.

3.8. Saint Mary's MCS will monitor and report on perinatal support for vulnerable women including Black, Asian and ethnic minority populations and those from areas of deprivation.

3.9. The effectiveness of the model will be reviewed every 6 months by the Saint Mary's MCS Quality and Safety Committee [*Please see appendix2/3 – for committee structures and diagrammatic representation of the Perinatal Quality Surveillance Model]*

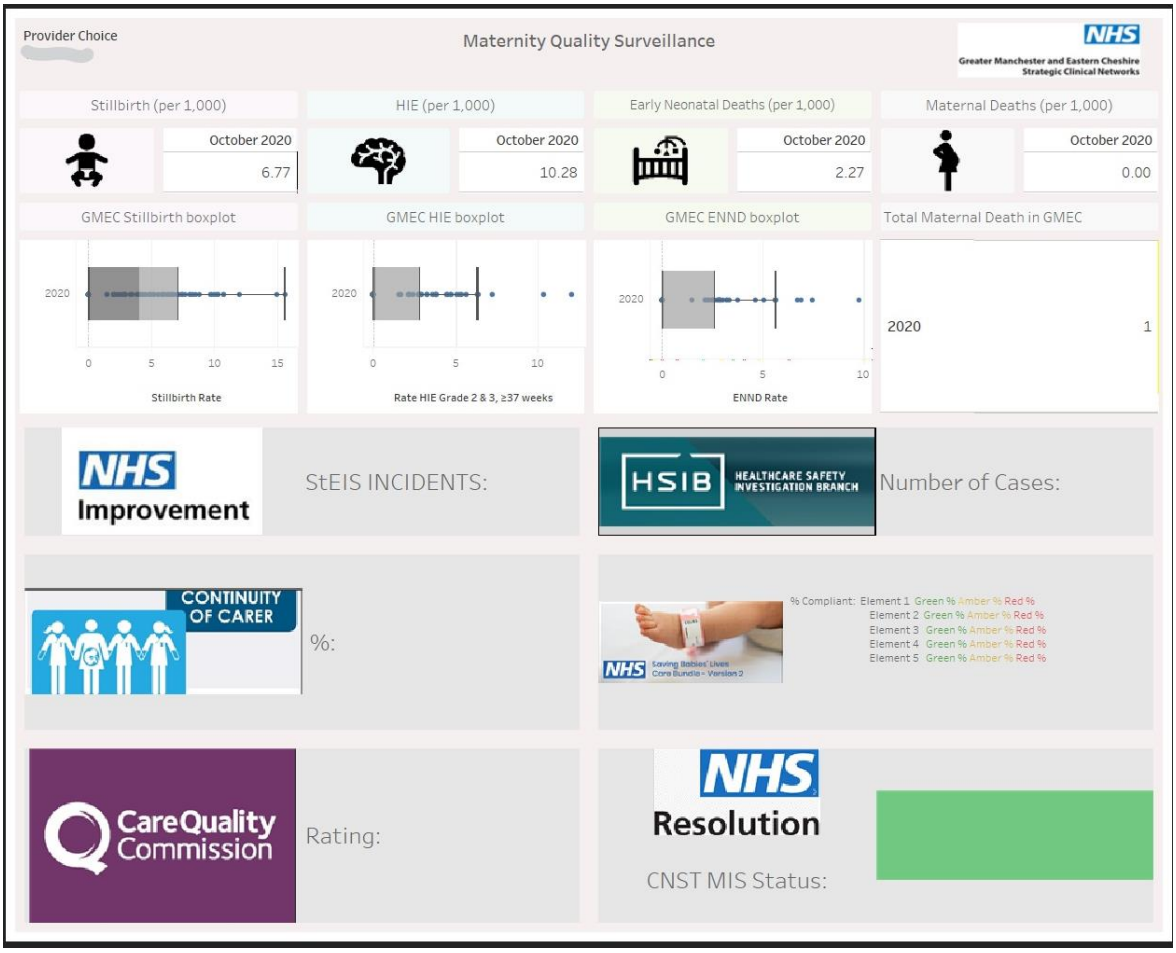
4.0. Summary and Conclusion

4.1. The Board of Directors is asked to approve the extended governance infrastructure which is aligned to the perinatal quality surveillance model being adopted in Saint Mary's MCS.

Appendix 1- Metrics for inclusion in the dashboard

- Number of StEIS /serious incidents/claims/complaints
- Number of HSIB cases
- CNST MIS compliance
- NHS Resolution
- CQC rating
- SBL CB compliance
- Continuity of Carer %
- Rate of Stillbirths/ hypoxic ischaemic encephalopathy (HIE)/Neonatal death/maternal death
- Percentage of vulnerable women booked
- MAT Neo SIP
- Maternal Deaths
- Clinical performance data e.g. caesarean section rate, Postpartum Haemorrhage (PPH), F2SU
- Workforce data

A draft workup of the Quality Surveillance Dashboard is demonstrated below which will be operational from July 2021.



Appendix 2- Committee Structures

Indicates assurance meetings

Board of Directors

Group Management Board
(Chair: Group CEO)

BAF

GMB MEMBERSHIP

- Group CEO (Chair)
- Group Executive Directors
- Hospital/MCS/LCO CEs
- Hospital /MCS Medical Directors
- Assoc Medical Director (Research)
- Assoc Medical Director (Education)
- Chief Informatics Officer
- Director of Corporate Services / Trust Secretary

Remuneration Committee

Audit Committee

Finance Scrutiny Committee

Quality & Performance Scrutiny Committee

Patient Safety Scrutiny Meeting

Manchester Health Academy

Integrated Governance and Risk Committee

Group Strategic Health & Safety Committee

EPR Scrutiny Committee

EPR Implementation and Benefits Realisation Programme Board

NMGH Scrutiny Committee

LCO Scrutiny Committee

Service Strategy Committee
(Chair: Group Director of Strategy)

Clinical Advisory Committee
(Chair: Joint Group Medical Director)

- Medical Directors Forum
- Nursing, Midwifery & AHP Professional Board
- Human Tissue Act Steering Group
- Organ Donation Committee
- Resuscitation Committee
- Acute Care Board
- Ethics Committee
- Transfusion Committee
- Clinical Effectiveness Committee

Quality & Safety Committee
(Joint Chairs: Joint Group Medical Director/Group Chief Nurse)

- Hosp/MCS/LCO Q&S Committees
- Patient Safety Committee
- Medicines Management Committee
- Group Equality, Diversity & Human Rights Committee
- Learning from Deaths Committee
- Patient Environment of Care Group
- Complaints Scrutiny Group
- Smoke Free Steering Group

Workforce & Education Committee
(Chair: Group Director or Workforce & Corp. Business)

- Mandatory Training Steering Group
- Apprenticeship Steering Committee
- TJNCC & JLNCC
- Medical Education

Safeguarding Committee
(Chair: Group Chief Nurse)

- Quality & Learning Group
- Early Help and Neglect Group
- Complex Safeguarding Group
- Domestic Violence & Abuse and FGM Group
- Looked After Children Group
- Learning Disability Group

Chief Executives Forum
(Chair: Group COO)

- Corporate Directors Group
- Group Estates & Facilities Management Board
- Operations & Transformation Oversight Group
- EPRR Group

Infection Control Committee
(Chair: Group Chief Nurse)

- Hospital/MCS Infection Control Committees
- Infection Control Expert Advisory Group
- Antimicrobial Stewardship Committee
- Decontamination Group
- Water Safety Group

Group Informatics Strategy Board
(Chair: Joint Group Medical Director)

- Group Informatics Portfolio Board
- Group Architecture Design Authority
- Group Information Governance Board

Cancer Committee
(Chair: Group COO)

- Trust Cancer Group

Capital Management & Monitoring Group
(Chair: Group Deputy CFO)

Research Governance Committee
(Chair: Joint Group Medical Director)

- Sponsorship & Governance Oversight Committee
- Early Phase Safety Committee

EXAMPLE COVID-19 ACTIVITIES

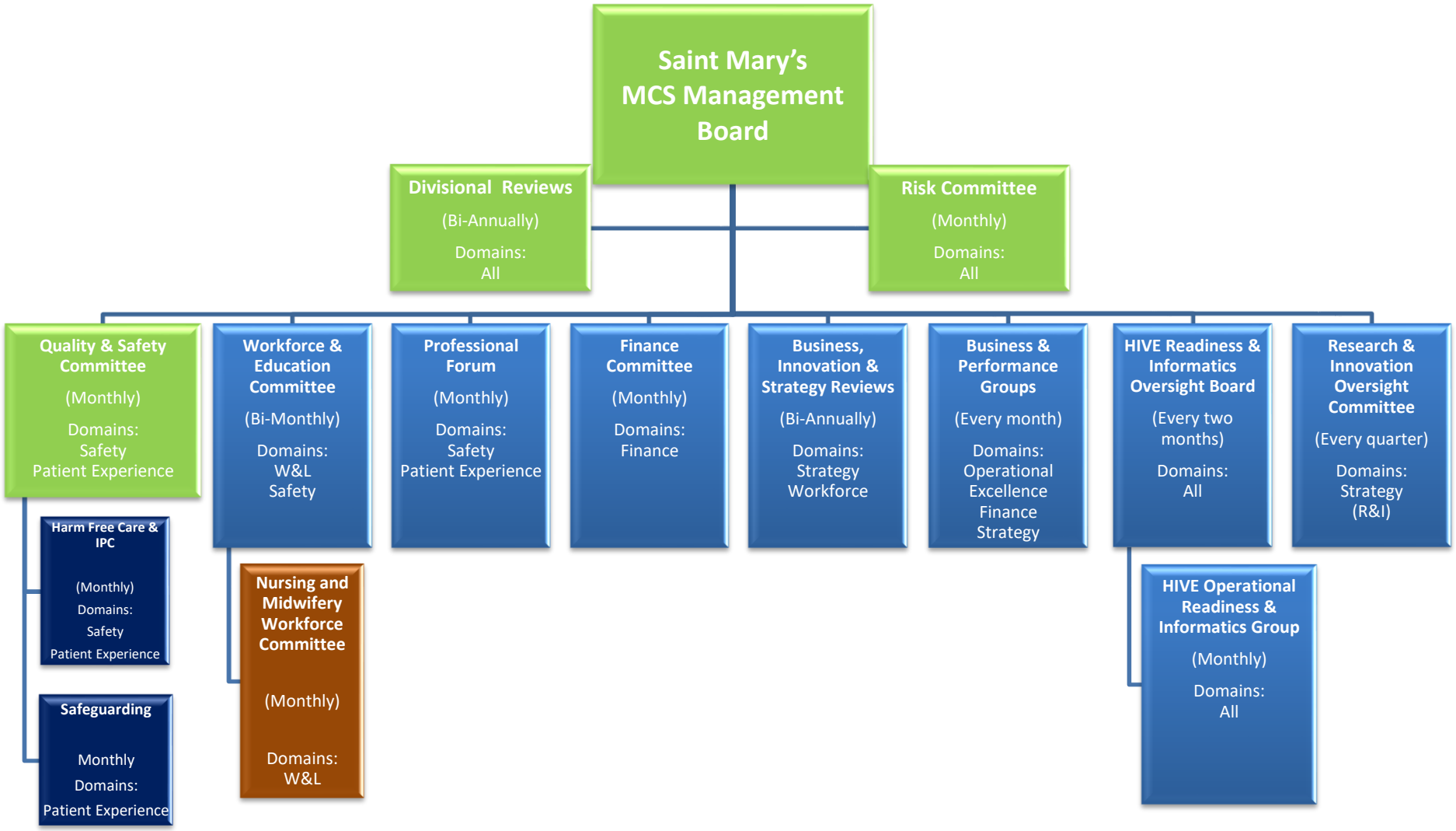
- Strategy Meetings
- MFT COVID-19 Recovery Group
- Exec Wash-up Meetings
- BAME Reference Group
- BAME Engagement Group
- Leadership & Culture Recovery

Hospital / MCS / LCO Management Boards

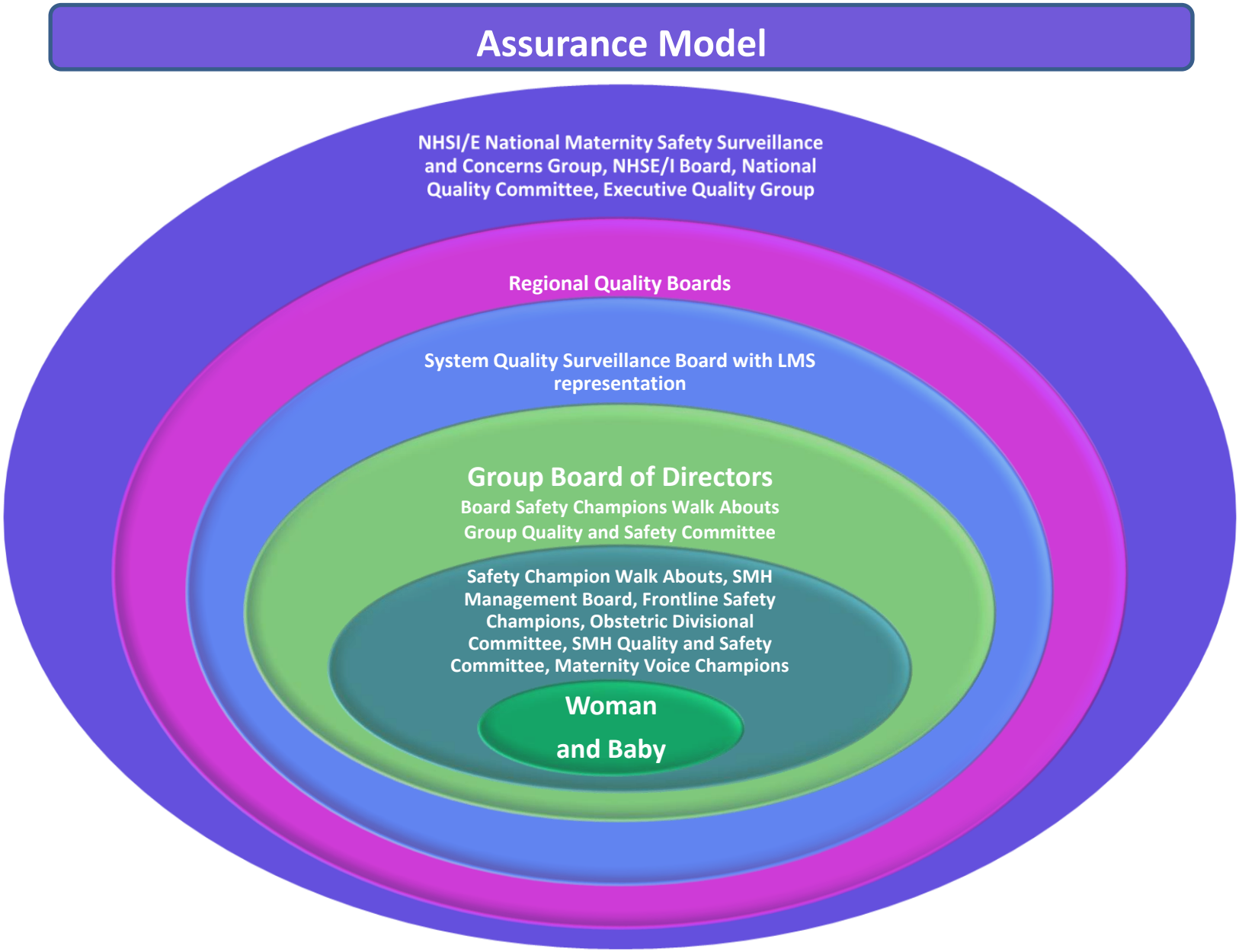
- Manchester Royal Eye Hospital — Hospital/MCS Management Board
- Royal Manchester Children's Hospital — Hospital/MCS Management Board
- Manchester Royal Infirmary — Hospital Management Board
- Wythenshawe, Trafford, Withington & Altrincham — Hospital Management Board
- Local Care Organisation
- North Manchester General Hospital (from 01/04/20)
- University Dental Hospital Manchester
- Clinical & Scientific Services
- Saint Mary's Hospital

AOF
Meetings

Saint Mary's Managed Clinical Services Committee Structure



Appendix 3 – Assurance Model



MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Joint Group Medical Director
Paper prepared by:	Sarah Fallon, Chief Operating Officer
Date of paper:	June 2021
Subject:	**Clinical Research Network Greater Manchester Annual Report** This submission includes the NIHR Clinical Research Network annual report. It also includes an impact report which further includes local and region areas of work and contributions.
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 2020/21 CRN Greater Manchester Annual Report provides a summary assessment of the network'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.
Recommendations:	Approve and acknowledge the annual report.
Contact:	Name: Sarah Fallon, Chief Operating Officer Tel: 07557804526

CRN Greater Manchester 2020/21 LCRN Annual Report

2020/21 LCRN Annual Reports consist of two parts; (1) a four page Annual Report which will be included in the CRN Annual Report to the Department of Health and Social Care, and (2) a number of data tables (which you are asked to update) which will contribute to the LCRN Fact Sheet.

The provisional deadline for LCRN Annual Reports is **12 noon on Wednesday 23 June.** Please email crncc.performance@nihr.ac.uk to indicate that both parts of the LCRN's Annual Report have been completed**.** Permissions have initially been set as per the 2021/22 LCRN Annual Plan.

Part 1: Four Page Summary (maximum)
Please provide a summary report of 2020/21 in the following six areas, with a total length of no more than four pages (guidance including length per section is provided below). Please
A. reference the 16 'Working Principles' as set out in A.3. of the 2020/21 Performance and Operating Framework, where relevant (e.g. 'Patient involvement', 'Partnership working', 'Collaborative national working', etc), and
B. frame the report in the context of how the LCRN contributed to/achieved success in very difficult circumstances due to COVID-19 (i.e. the CRN recruited approximately 1.5m people in 2020/21, notably more than previous years).

Sections and guidance
1. The LCRN's contribution to the national delivery of three Category 1A or Category 1B Priority studies of your choice (approximately one page in length)
- 'Contribution' here is intended to be broader than recruitment, and could include intellectual property, systems and/or processes established to maximise recruitment, provision of operational and/or other support, etc.

2. Challenges recruiting to Urgent Public Health Prioritised studies (approximately half a page in length)
- What measures did the LCRN put in place to maximise recruitment to badged studies. Please separate/differentiate your response by primary care, secondary care, vaccines, social care etc.
- Did the LCRN have some areas/Trusts that were not able to recruit to any UPH badged studies? If so, what was the problem and what can be learned?

3. Workforce (approximately half a page in length)
- What measures or activities did the LCRN undertake in relation to the workforce in terms of maintaining or increasing the capacity (numbers and location) or capability (skill, skill mix, knowledge or training) in order to maximise delivery of UPH badged studies. Were there any specific employment practices or relationships you benefited from? Please link case studies/materials if you have them
- Did the LCRN manage to mitigate the impact of redeployment of staff to the frontline or adapt to high levels of sickness / shielding. If so how was this achieved?
- What lessons have been learned and what might be the implications for future practice in terms of recruitment, retention, skill mix or training /development of the future workforce? Please be specific about location for application of these and separate/differentiate your response by primary care, secondary care, vaccines, social care etc. if appropriate

4. Restart and Partner organisation engagement (approximately half a page in length)
- Was the LCRN able to support non-badged (COVID and non-COVID) studies and badged studies? If so, please share any learnings as to how it managed to balance this?

5. Patient and Public Involvement and Engagement (PPIE) (Approximately half a page in length)
- Please provide an update on how the LCRN supported public involvement in Urgent Public Health studies (including vaccine studies), and how it has adapted the Participant Research Experience Survey (PRES) and Research Champions programmes within the context of COVID-19

6. Selected non-COVID-19 LCRN achievements (approximately half a page in length)
- This is an opportunity to highlight selected non-COVID-19 related achievement from 2020/21

Style guidance:
- Please use Arial font size 11
- Please do not include any tables or images
- Please refer to the LCRN by name (e.g. CRN Eastern) or 'the network' (please note lowercase) rather than 'we' or 'the LCRN'

- Please avoid reference to personally identifiable individuals by name, instead referring to role(s)
- Please reference study IDs using CPMS ID, e.g. Resolute (CPMS ID: 41222)
  - Reference of CPMS ID of Priority 1A and 1B study names and CPMS IDs
- Please expand in full any abbreviation which is not well embedded in health or clinical research, including those which are ambiguous (e.g. CI could be Chief Investigator or Continuous Improvement) the first time the abbreviation is used

Data guidance:

- Please use the '2020-21 CRN Performance Standards.qvw' ODP app as the source of data references (data references will be checked by the CRNCC Business intelligence team for accuracy). Please contact NIHR CRN Info Request (inforequest@nihr.ac.uk) with any questions on data or data sources
- As LCRNs were not performance managed on their performance against HLOs in 2020/21, please avoid reference to ranking your LCRN against that of others. Rather, please report absolute rather than relative figures. Should you wish to present comparative data please do so at the LCRN's Annual Performance Review Meeting

Part 2: Update of Data Tables which contribute to the LCRN Fact Sheet

General guidance:

- Please update the yellow-highlighted cells within this Google Sheet. Several yellow cells have been pre-filled with information from the LCRN Fact Sheet 2019/20, please ensure that this data is checked and updated if necessary
- Please do not edit any formulas or change any formatting options
- The full LCRN Fact Sheet will be made available to the LCRN Leadership Team for reference and comment as required ahead of the LCRN Year-end Review Meeting.

Data guidance:

- The data is intended to be a snap-shot of the LCRN at the end of the reporting year 2020/21, therefore please provide data accurate **as of 23:59 on 31 March 2021** (or as near as possible before this time). Please do not reflect any changes that occurred in 2021/22 to date

Section 1: CRN Greater Manchester recruited over 80,000 participants across 580 studies. This included almost 52,400 participants who took part in Urgent Public Health studies looking at, among other things, treatments, diagnostics and vaccines**.** Three of Greater Manchester's senior researchers sat on the Urgent Public Health research panel and were Chief Investigators for COVID-19 studies, leading critical research delivered nationwide to find treatments, diagnostics, and vaccines. Professors Andrew Ustianowski, Paul Dark and Rick Body oversaw eight such studies, some of which have already proven successful and helped save lives. In addition Professor Kathryn Abel chaired the national group examining the potential impact of the COVID-19 pandemic on mental health, and making recommendations for prevention and recovery.

Led Research Delivery: ***Clinical Characterisation Protocol for Severe Emerging Infection (CPMS: 14152)*** CRN Greater Manchester led this first study which opened in response to the Pandemic, activated on 24th January 2020. The local and national CRN teams worked closely to plan & execute delivery solutions for sites across the country. Regular country-wide engagement calls were quickly established, and management proformas were developed which have since been used in subsequent UPH studies. 15 sites across Greater Manchester NHS organisations recruited to this study and supported access for 20,664 people in 2020/21. The CRN Greater Manchester core delivery team were instrumental in supporting recruitment, and providing expertise across the partner organisations.

Rapid Response: ***FALCON C-19 (Workstream B) (CPMS:47296)*** There were more than 200 Greater Manchester participants in the MOONSHOT arm of the FALCON study. The CRN Greater Manchester core delivery team were instrumental in the Etihad stadium site up and expedited local recruitment, which received high praise from the coordinators at Thames Valley and South Midlands and the Chief Investigator. It was a remarkable achievement to recruit so many individuals to this study, rapidly over the short five week period and CRN Greater Manchester's delivery team worked deep into the weekend to consent the first two participants to the MOONSHOT study. Overall, the study was set up and recruitment initiated in just 80 hours.

Rose to the Challenge: ***Novavax COVID Vaccine study (CPMS:46787)*** More than 1,760 participants were part of COVID-19 vaccine trials. This was possible thanks to a 'One Greater Manchester' vaccine research strategy, which provided participation opportunities across five geographic sectors. CRN Greater Manchester created a Vaccine Capacity and Capability Tool, with the objective of providing users with a single view of the region's delivery capabilities. This included capabilities of each individual site, including the number of staff and estimates for personnel and equipment study requirements, inclusive of venue availability and socially distanced capacity limits. In addition to supporting sites to deliver, CRN Greater Manchester led a large-scale public awareness campaign to recruit participants for COVID-19 vaccine trials and secured significant media coverage across all TV, radio, print and online channels. Every local authority area in Greater Manchester had over 1,000 people sign-up to the registry, with some areas having over 3,500 volunteers. The network engaged with underserved communities who have traditionally not taken part in research as much as those who identify as 'White British'. The network worked with community leaders and trusted local media, broadcasting adverts in Arabic, Urdu, Bengali and English. Novavax was the first COVID-19 vaccine trial to be undertaken in Greater Manchester with over 1,240 Greater Manchester volunteers participating. Two local NHS organisations carried out the trial in community settings. Stockport NHS Foundation Trust was the second highest recruiting site to the study in the UK with 762 participants. The delivery of the Novavax COVID-19 vaccine trial involved input from NHS staff across a wide variety of local NHS organisations as well as with support from CRN Greater Manchester core delivery team. The network reflected on the vaccine delivery models to continually improve and share best practice. As a result of this, CRN Greater Manchester celebrated the work undertaken which established new relationships with media and non-NHS sites, created a successful sector based model, developed a process to assess capacity, and established positive relationships with local underserved community leaders.

Section 2: It became clear in April 2020 that the current method of expressions of interest and feasibility were contributing to the increased workload of Partner Organisations and were simply not fast enough to rapidly respond to emerging UPH studies. To support the local research community CRN Greater Manchester developed an automated site identification tool to proactively work with sites to identify studies and express interest without repeat requests and removing the need for endless form completion. As a result, the CRN GM Study Support Service provided study sponsors with required information faster and paved the way for urgent COVID-19 research to be identified for the right sites and local people, at pace. This has been widely shared with all national and local teams.

Delivered Together: The challenge with the UPH portfolio was primary due to the local fluctuation in Covid cases and the impact this had on sites and staff. When COVID cases were high, the health services and staff were under unprecedented levels of pressure, meaning research was challenging to deliver. However, when COVID cases were reduced, there was a reduction in eligible local participants. This became a challenge with the RECOVERY Trial (CPMS: 45388). CRN Greater Manchester care organisations experienced reduced recruitment, despite increased local COVID cases and admissions in autumn 2020. The core management group responded effectively and quickly. Following engagement with local Investigators, management and delivery staff the network established daily 'stand up' scrum meetings with organisations to share best practice and increase awareness. Intelligence from these meetings was collated and shared. Simultaneously, the Senior Leadership, supported by the CRN GM Executive Lead, escalated the logistical barriers to Greater Manchester Gold Command. Together, these actions contributed to local organisations surpassing the national target, recruiting above 10% of COVID admission rates, and providing valuable support for organisations which had experienced difficulties with participant enrolment. The benefits of this approach shone through particularly in February and March 2021, when Greater Manchester accounted for the highest performing trusts in the country. 2,588 Greater Manchester participants were involved in the trial and a reflective slide set was presented at local operational and specialty meetings summarising the experience.

Enhanced Primary and Social Care Delivery: ***The PRINCIPLE trial (CPMS: 45457)*** PRINCIPLE was widely shared with organisations across the public, private and third sectors in Greater Manchester, to offer as many people as possible the opportunity to take part. A total of 120 primary care sites registered to recruit, along with North West Ambulance Service and organisations such as local Age UK charities, who helped direct potential participants to the study website. However, these efforts were not supporting increased recruitment. To address this, the local specialty leads and Research Champions in CRN Greater Manchester developed a dedicated video to raise awareness of the study. This, together with core team support, enabled CRN Greater Manchester to increase recruitment and share recent success with other regions. Also, community care home research initiatives were disrupted during the pandemic. However, through local intelligence & contacts, CRN Greater Manchester were able to successfully deliver the Vivaldi Study (CPMS: 45953) through collaboration with 14 Greater Manchester care homes, including independent care homes, and recruited more than 300 residents and staff in 2020/21.

Section 3: CRN Greater Manchester team, clinical and non-clinical experts supported hospital sites and community settings such as care homes, schools, primary care and non-NHS settings. Their roles became increasingly flexible during 2020/21 as staff covered shifts seven days a week, outside traditional hours, in order to respond to COVID-19 challenges. In immediate response to the first wave, non-clinical staff with nursing backgrounds undertook refresher training, and were placed on standby and non-clinical staff with non-clinical backgrounds supported administrative tasks at site, such as data entry and appointment booking. The core team played a vital role in planning and undertaking COVID-19 research at Nightingale Hospital North West, including a research induction for all staff and in vaccine trials at three sites. Research for the Future diversified their offering and provided alternative support. For example, the team supported telephone screening of participants for UPH studies. Workforce intelligence was also gathered, and recorded via a weblink to be transferred to a national dataset.

Delivered Differently: The CRN Greater Manchester Workforce Team collaborated with local care organisations to set up a new service that provided research teams with fast additional, flexible staffing to cope with COVID-related pressures. The 'Research Workforce Hub provided a new digital application process and this initiative made it easy for organisations to recruit additional staff by offering short-term employment opportunities in a range of roles. As part of the Hub pilot project, a minimum of 198 shifts were covered across four organisations, via NHS Professionals, with additional shifts continuing into 2021/22. The network produced a short report on the pilot phase. Additionally through a resource website, the network supplied information, such as, job descriptions, policies and processes for partners to utilise to temporarily expand their workforce and make decisions about skill mix, which included how to deploy research naive staff, volunteers and healthcare students. This boosted the regional workforce resilience needed to meet the demands of the pandemic. The network worked efficiently to ensure resources were shared quickly to respond to the need for extra staff. The planned staff whole time equivalent for 20/21 was 364.51, but the total reported was 536.66. This increase of 172.15 throughout 20/21 was achieved through successful careful and collaborative workforce plans.

Met development needs: CRN Greater Manchester continued to promote use of NIHR Learn to support the regional workforce at all levels to ensure training was available 24 hours a day, 7 days a week. Adaptations were made to increase the range of online and virtual classroom learning for research novices, primary care and Investigators. In addition to national online courses within NIHR Learn, 182 staff attended 8 local virtual learning sessions related to delivering and supporting research. From August 2020, the CRN Greater Manchester facilitator community was able to safely return to a limited range of face to face education events, with 175 attendees across 13 events. In total, 357 training attendances were facilitated in addition to NIHR Learn online learning.

Shaped the Future: In terms of lessons learnt, CRN Greater Manchester had a working group for Nightingale activation and Vaccines delivery. Both proved critical to rapid regional decision making and intelligence sharing. Through the development of the Greater Manchester Research Workforce Hub, there are local systems for long-term utilisation to adapt and tailor future workforce availability demands. 'Research reservists' offer a transferable skill set, particularly in the area of clinical trial administration, where only proportionate research training is required to ensure research data quality. The workforce experience through 2020 drove accelerated strategic planning and intelligence locally and nationally. This led to the development of a Health Education England North West Nursing, Midwifery and Allied Health Professionals Strategy, led by NHS R&D Northwest, but more significantly, the decision to collaborate Supra-regionally and combine the workforce function of both LCRN Greater Manchester and North West Coast. Also, CRN Greater Manchester launched a new initiative to further acknowledge the important role played by GM Investigators. The new scheme involved the dissemination of 'appreciation letters' to Investigators leading on regional delivery and was introduced to reflect the valuable leadership and oversight role they undertake.

Section 4: When it was safe and practical to do so, Greater Manchester care organisations were efficient in restarting research activities paused by COVID-19.

Inspired Trust: A CRN Greater Manchester Women and Children's Health Research Team were able to recruit their first patient within just two days of re-opening the C-STICH study. An achievement that was held up nationally as an example of best practice and ensured that patients could be offered this research opportunity as part of their care. Local research group too, found innovative ways of keeping sites up to date. A Greater Manchester-led ENT study POP-T (CPMS: 44633) created a Whatsapp group containing local Investigators and delivery staff from sites participating in the study. This enabled the Assistant Research Delivery Manager to keep the group up to date with study delivery, easily address any concerns sites may have had and to stimulate conversation around best practice and innovation about recruitment beyond COVID-19. By the end of 2020/21, only 10% of trials in Greater Manchester remained paused due to the pandemic, and under 1% were cancelled mainly due to targets either already exceeded or very close to being met. Since May 2020, there has been a progressive improvement in the number of open studies and study sites in CRN Greater Manchester. Over 1,000 studies had opened by the end of 2020/21, equivalent to 65% of the total number on the portfolio.

Valued the Community: CRN Greater Manchester produced a video to thank the local residents who participated in research. The video featured numerous staff members from across all departments and organisations. It was viewed over 3,000 times. Then, to mark International Clinical Trials Day on 20 May 2020, CRN Greater Manchester co-produced a video to thank all research and support staff who had contributed to recruiting to UPH studies. In November 2020, the network acknowledged the efforts of the core team during a special team meeting which included the presentation of certificates of special commendation to every staff member. Each certificate was bespoke, featuring three examples of individual contributions to research during the pandemic. At the same time, CRN Greater Manchester wrote to all partner organisations to acknowledge their efforts in the fight against the pandemic thus far and made an editable version of the certificate available to encourage recognition of the wider local workforce. CRN Greater Manchester also wrote to congratulate study teams following the delivery of particularly challenging UPH studies. In addition to supporting the NIHR's national 'thank you' campaign in March 2021, the network recognised local achievements made in 2020 with a dedicated, weeklong celebration, titled Greater Manchester Research Celebration Week. More than 20 specially co-produced videos were shared on social media and watched over 12,600 times. Together, along with regular calls and issue resolution frameworks, CRN Greater Manchester formed stronger and healthier local care organisation relationships. Finally the CRN Greater Manchester Impact Report 20/21 demonstrated how the region played a significant part in the development of vaccines, treatments, and diagnostics which are already allowing millions of people to be safely tested, treated, and protected from the virus.

Section 5: Over 22,000 people across Greater Manchester signed-up to the Vaccine Registry after CRN Greater Manchester led a large-scale public awareness campaign. In addition to paid-for advertising, the campaign secured significant media coverage across TV, radio, print and online channels. Every local authority area in Greater Manchester had over 1,000 people sign-up, with some areas over 3,500. CRN Greater Manchester worked with a range of media partners, including an Islamic radio station which is a trusted local source of news and information. Adverts and interviews on the station addressed vaccine hesitancy and sought to tackle misinformation and rumours. Greater Manchester's proportion of sign-ups from diverse ethnic minority communities to the registry was above the national average.

Made a Difference: Greater Manchester participants shared their experiences with CRN Greater Manchester to encourage others to consider stepping forward. Their personal stories, captured in these videos, were shared across multiple platforms, including local media, social media, and with Partner Organisations, to provide an insight into why they chose to volunteer and what participation involved. In addition, participants in the PRINCIPLE trial encouraged people with mild COVID symptoms to be part of this urgent community trial.

Recognised Experiences: In light of the pandemic more research participants were encouraged to complete the Participants in Research Experience Survey (PRES) digitally, through a link that was provided to each Partnership Organisation. Over 1,100 participants in Greater Manchester completed the survey. The results showed that over 97% of research participants would take part in research again. A recurring theme in the comments was that participants are proud to be contributing to research that could improve outcomes for future people. For example: *'Being involved in something that could make a difference to the lives of a lot of people is very satisfying. Comprehensive information, friendly professional staff, really well organised, efficient process.'* Research Champions were offered a chance to take part in a virtual workshop 'Understanding the Research Behind the Pandemic', which 5 of them took part in. They were sent information and a film on PRINCIPLE (CPMS 45457) to send out to their wider networks to raise awareness. Research Champions co-designed patient-facing materials with Global US technology company Flatiron including a patient facing leaflet, a website, Frequently Asked Questions, a video and a patient information document, to ensure the information was clear and easy to understand from a public perspective. Research Champions sent Vaccine Community Engagement resources to circulate to their contacts.

Section 6: Over 29,000 participants were part of non-COVID-19 research in Greater Manchester in 2020/21, this equates to 35% of GM's recruitment. The network was able to keep a significant proportion of research studies open and recruiting participants. This ensured many local patients continued to have research opportunities offered as part of their care. For example CRN Greater Manchester continued to provide opportunities to be part of cancer research, with recruitment into over 190 studies still taking place during 2020/21. By winter, The Christie had reopened 92% of trials that were open pre-COVID.

Re-established Opportunities: CRN Greater Manchester continued to provide opportunities to be part of non-COVID research and led nationally to cancer and genetics studies. More than 700 people participated in genetics research. The majority of these participants were enrolled onto the landmark NIHR study, PALoH (CPMS 42086), supported by NIHR Manchester Biomedical Research Centre, looking at a bedside genetic test, developed in Manchester, to predict whether newborn babies receiving antibiotics in intensive care are at risk of irreversible hearing loss. Also,The Christie NHS Foundation Trust recruited its first patient to a clinical trial which is investigating a new technique to treat cancer patients with solid tumours, using the body's own T cells that are genetically modified to fight the cancer .

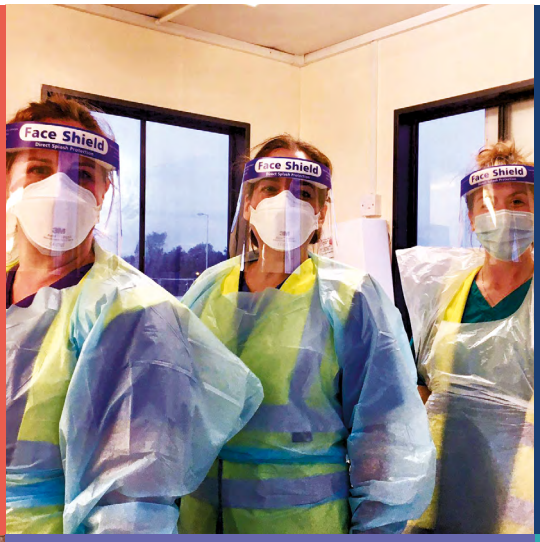
Delivered Relevant Research: CRN Greater Manchester continued to serve local health population needs by supporting 17 studies in Primary Care during the pandemic. Over 1,280 participants were able to access opportunities to be part of research aiming to improve the health and wellbeing of people living with chronic conditions such as diabetes, inflammatory bowel disease and food allergies. Equally relevant, the Greater Manchester Bronchiectasis group was set up in 20/21 to provide an effective forum to help standardise practices, support education and promote research within Non-Cystic Fibrosis bronchiectasis. Its aim is to provide equity of access to treatments and research opportunities for patients across the region and play an active role in reducing the highest rates of Bronchiectasis in the country. Mental Health research continued locally with both Mental Health NHS Trusts, recruiting into large scale observational studies, such as NCISH (CPMS:5655) whilst numerous interventional studies continued within early intervention services and the area of Psychosis, patients in Manchester were offered continued access to psychological therapies to support their recovery and wellbeing; Actissist (CPMS:36418), Youth Engagement in first episode Psychosis (CPMS:37742). Greater Manchester continued to lead the way on improving access to psychological therapies in acute mental health settings with the network supporting the team to identify sites nationally Tulips (CPMS:42145). Research into Autism offered intervention for parents REACH ASD (CPMS:43127) and studies continued to collect observational and biological tissue to evaluate anxiety and mood. GLAD(CPMS:40136) and Moodbooster (CPMS:3992) recruited in Primary Care organisations and local people who suffered trauma were offered participation in STAR (CPMS:48324).

Invested in local people and communities: Opportunities for participation have been enhanced through the development of the unique Research for the Future service which opened in 2020/21 to all adults, enabling wider opportunities for research engagement with the people of Greater Manchester. Investment from the Vaccine Task Force for a bespoke mobile pharmacy unit has been locally designed and built to deliver more accessible local research. Furthermore, utilising Google Script, and later Google AppSheets, processes have been established to effectively record Early Contact and Engagement and Performance Review Lead, both of which have been integrated into the CRN GM ODP application and will continue to make an impact in all specialty areas into 2021/22. To aid the transition from full time home working to allow the core team to work within the office safely, the CRN Staff Resource application was developed using AppSheets, digitally allowing the team to book time in the office, book meeting rooms and access digital resources from their mobile phones. This has been key to bringing the core team together to innovate, create and collaborate.

Summary

CRN Greater Manchester continues to look for every opportunity to provide new and innovative solutions to the health and social care of the local population. The network is proud of the teamwork and engagement; 20/21 was another great year, despite the extraordinary challenges. The network team went above and beyond, supplying inspirational ideas and demonstrating outstanding resilience. Greater Manchester Clinical Research Network is here to serve the local population, support Partner Organisations, and enable access to research for all.

NIHR | Clinical Research Network Greater Manchester



Impact Report
2020/2021

Funded by

Department of Health & Social Care

Contents

Foreword

If the true value of health and care research was ever in doubt, then the past 15 months have demonstrated its transformational impact in no uncertain terms. Research has turned the tide on COVID-19 and it's with great pride I can say that Greater Manchester has played a key part.

Our research community has met the pandemic head-on, amid the most challenging circumstances our health and care services have ever known. Trials were planned and delivered at pace, ensuring our local citizens had opportunities to be part from the outset.

Our teams demonstrated dedication and determination in their response to the COVID-19 challenge. Their roles became increasingly flexible with clinical and administrative functions covering services seven days a week, including many during the evenings and through the night. It is as a direct result of the teams' hard work that we have been able to organise and deliver so many outcome-changing studies.

A total of almost 52,400 people across Greater Manchester, East Cheshire and East Lancashire were part of these coronavirus research trials in 2020/2021. Their unselfish participation, combined with the hard work of our local research workforce, has had a major impact in an incredibly short space of time.

Research carried out here in Greater Manchester has contributed to landmark breakthroughs in the fight against COVID-19; breakthroughs which now allow millions of people to be safely tested, treated, and protected from the virus.

The urgency of the pandemic has also introduced many health professionals to research, some for the very first time. They have played a part in these ground-breaking studies and witnessed, first-hand, how research changes lives. The general public has been more exposed to research than ever before through daily mainstream news. Awareness has undoubtedly grown and the NIHR is now a household name.

The strides made over the past year present us with real opportunities as we continue to deliver research into the evolving threat of coronavirus but also to restore studies across all other disease areas. With your help, we can ensure Greater Manchester makes the most of these opportunities and continues to provide a choice for our local community.

You will find in this report how you can #BePartOfResearch. Whether it's working in research or taking part in it, there are many ways to get involved and we need your help.

On a personal level, I would like to say how grateful I am for the support I have felt in my first six months as Chief Operating Officer. It has been a pleasure and privilege to lead such a dedicated and talented community and collaborate with so many experts across Greater Manchester. Thank you.

Sarah Fallon
Chief Operating Officer

NIHR Clinical Research Network Greater Manchester

1. Putting people and communities first

Leading research delivery

The NIHR Clinical Research Network (CRN) Greater Manchester (GM) has led the way with research delivery, from landmark recruits for Urgent Public Health (UPH) studies to the expertise of our individuals and teams.

In 2020/2021, we:

Invested a total **£20,420,000** in research across Greater Manchester's local care organisations to ensure residents had the best access to research opportunities.

Funded the equivalent of over **530** full-time members of staff. This included over **275** research nurses and midwives, 50 clinical research practitioners, and over **180** coordinators and administrators supporting delivery teams.

Funded **100** sessions of dedicated time to support our Principal Investigators' research.

We received an extra £575,300 in Urgent Public Health funding to deliver research into COVID-19 which enabled us to:

Recruit almost **52,400** participants and Deliver **44** Urgent Public Health studies with **190** sites contributing to this recruitment.

We received £752,300 in UK Government Vaccines Taskforce funding. This was successfully allocated across six partner NHS Trusts to:

Deliver five COVID-19 vaccine trials across Greater Manchester so far, with five in set-up at the end of 2020/2021.

Recruit **1,765** volunteers to participate in these trials.

Create a legacy by investing in bespoke equipment and infrastructure, including a mobile pharmacy unit, and workforce training.

Evaluating fast and accurate diagnostic tests for COVID-19

Accurate diagnosis of COVID-19 infection, identification of immunity and monitoring the progress of the infection are crucial in the national and global response to COVID-19. Without it, our ability to control the spread of infection, ensure the early self-isolation of infected patients and early treatment for those most at risk is severely limited.

The life sciences industry has developed a number of new diagnostic tests and to take advantage of their potential clinical benefit, efficient and robust assessment of the tests is essential. Manchester University NHS Foundation Trust sponsored the **Facilitating Accelerated Clinical Validation Of Novel Diagnostics for COVID-19 (FALCON C-19)** study that plays a crucial part in this assessment by evaluating the accuracy of commercially available tests for diagnosing COVID-19 infection in hospitals.

The evaluations include tests that can be done at the patient's bedside, with results often returned in as little as five minutes. This has helped clinicians turn the tide in the fight against COVID-19 because they can now identify infected patients proactively – and quickly, and therefore significantly reduce the spread of the disease.

Professor Rick Body, a CRN GM Specialty Lead for Injuries and Emergencies, is Chief Investigator for the study, which has over 4,500 participants from 61 centres. Our network accounted for over 1,000 participants, which is one-in-four of the national recruitment total.

The study now has a desired turnaround time of two to three weeks per test evaluation, enabling patients and the NHS to benefit from the best new testing technologies as soon as safely possible.

"The FALCON study could mean that clinicians can make fast, accurate decisions about a patient's care – sometimes within minutes. That includes decisions about which wards or areas a patient can receive care in, rather than the standard laboratory tests, which can take 24 hours or more."

Professor Rick Body

Dedicated celebration highlights Greater Manchester research

CRN GM delivered a week-long digital showcase to highlight the outstanding work and dedication that has been shown by research and support staff across our region during the last year.

The 'Greater Manchester Research Celebration Week' was a collaboration with local partner organisations to create more than 20 videos that were watched over 12,000 times.

Other engaging content included an opportunity to congratulate people who have made a valuable contribution through a Note of Thanks, as well as infographics and a blog.

The celebration recognised the tremendous response the CRN GM has made to setting up and delivering COVID-19-related research that is helping to answer some of the most challenging questions posed by the pandemic. The event also celebrated the 750,000 people in Greater Manchester that have taken part in research over the last decade. Our volunteers are helping to change the future of health and care; without their participation it would be impossible to innovate in the prevention, detection and treatment of illnesses.

Pictured: R&I delivery team members at Manchester University NHS Foundation Trust

Resuming non-Urgent Public Health research during the COVID-19 pandemic

The emergence of the COVID-19 pandemic led to unavoidable disruption to the vast majority of all non-COVID research. In order to support the Government's research response, our focus was placed firmly on the set-up and delivery of COVID-19 research. However, as the year progressed, we were gradually able to resume research activity across our traditional 30 diseases areas.

By the year to April 2021, CRN GM was by far the leading Local Clinical Research Network (LCRN) in the country in terms of the proportion of research studies that were open and recruiting local people. By this time, 36% of studies and sites were open and had recruited participants – with the national average only 20% and the second highest region 27%. The dedication of colleagues across all our sites allowed these research opportunities to be re-opened to communities as part of the high-quality care local people are offered.

Key highlights

Landmark COVID recruits

Our network recruited or treated the first UK participants to six Urgent Public Health studies, and consented the first participant in the world to one of the COVID-19 vaccine trials. CRN GM treated the first patient in the UK as part of the **Otilimab in Severe COVID-19 Related Disease (OSCAR)** trial to understand the impact of the experimental drug Otilimab on severe lung disease related to COVID-19. We also recruited the first UK patients to the Randomised Evaluation of COVID Therapy – Respiratory Support (RECOVERY-RS) study that compares the effectiveness of ventilation methods for COVID-19. CRN GM recruited the first person in the UK to be part of the MERMAIDS ARI study related to COVID-19. The study aimed to discover why some people become much more unwell than others from acute respiratory infections.

GM investigators lead COVID research response

Four Greater Manchester senior researchers fulfilled national lead roles as we played a key part in supporting the early discovery of potential treatments for COVID-19 patients. Professor Andrew Ustianowski, our CRN GM Deputy Clinical Director, was appointed the National Clinical Lead for the UK NIHR COVID Vaccine Research Programme. Professors Rick Body, Paul Dark and Andrew Ustianowski were Chief Investigators for eight COVID-19 studies, leading critical research delivered nationwide to find treatments, diagnostics, and vaccines. Studies have already proven successful and helped save lives, including the discovery that **anti-viral drug remdesevir** can shorten recovery time in hospitalised patients by four days. Professor Kathryn Abel chaired the national group examining the potential impact of the COVID-19 pandemic on mental health, and making recommendations for prevention and recovery.

Professor Andrew Ustianowski

Top recruiters to urgent COVID studies

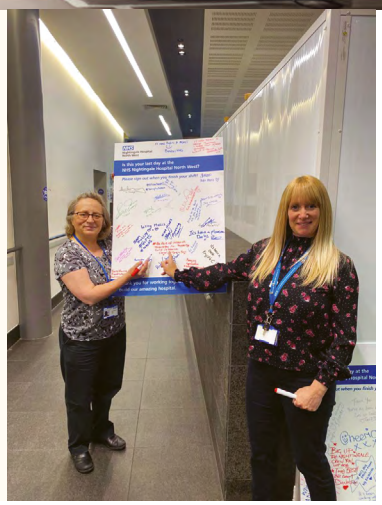
The CRN Greater Manchester is a top recruiter to studies at national and Partner Organisation levels. For example, in Urgent Public Health research, we were the highest recruiting region to the Hospital Onset COVID-19 Infections (COG-UK HOCI) study with 515 participants. CRN GM was also the highest recruiting region to the Novavax COVID-19 vaccine trial, which will lead to a licensed vaccine for deployment across the UK later this year.

Photographer Joel Goodman

Taking research to the Nightingale Hospital

Senior Nurses in our core delivery team led on research at the NHS Nightingale Hospital North West (pictured above), which was urgently set up during the first wave of the pandemic. Health professionals and army staff from across the UK were seconded to operate this 'field hospital' in a central Manchester conference centre. Our team supported staff of all disciplines to deliver research training and formed the focal point for all research patient follow-up queries, providing cover seven days a week.

Carol Beane and Sam Chilcott from the CRN GM delivery team at the Nightingale Hospital



Making a difference

The Clinical Research Network Greater Manchester has continuously made a significant positive difference to people's lives by extensively promoting the opportunities for public involvement in research studies, as well as raising awareness of the experiences of participants. We have also successfully engaged underserved communities in research. These activities help involve more people from more communities in research, so that we can develop better care, prevention and treatment for everyone.

Learning from the experience of participants in research

We put research participant experience at the centre of research delivery and, by learning from the experiences of clinical research patients, improve all our studies. So much so that over 97% of our research participants would take part in research again.

The anonymous **Participant in Research Experience Survey (PRES)** gives as many research participants as possible the opportunity to provide feedback on their experiences, telling us what went well for them and what can be improved. In 2020/2021, over 1,100 participants in Greater Manchester completed the survey, contributing to the overall total of 11,000 responses received nationally across all 15 CRNs.

The survey provides us with a vital insight into the demographics taking part in research in Greater Manchester and helps show where improvements can be made. It is just one way that we demonstrate to research participants that their contribution is valued and can positively impact recruitment to, and retention within, research studies.

A recurring theme in participant comments was that they are proud to be contributing to research that could improve outcomes for future patients:

'It's pleasing to know that any efforts I made might help other people in the future and maybe even myself.'

'Friendly, helpful, very informative and glad I've taken part in the research.'

'Being involved in something that could make a difference to the lives of a lot of people is very satisfying. Comprehensive information, friendly professional staff, really well organised, efficient process.'

The findings of the survey will feed into research studies both locally and nationally to make sure the NIHR is serving the needs of, and helping to improve outcomes for everyone.

Participant in Research Experience Survey key findings:

I would consider taking part in research again:
Strongly agree – 86.6%.
Agree – 10.8%.
Disagree – 0.2%.
Neutral – 2.2%.
Strongly disagree – 0.3%.

The researchers have valued my taking part in the research:
Strongly agree – 87.4%.
Agree – 10.7%.
Disagree – 0.2%.
Neutral – 1.7%.
Strongly disagree – 0.1%.

Is this the first research study you have taken part in?
Yes – 87.9%.
No – 12.1%.

I feel I have been kept updated about the research:
Strongly agree – 66.8%.
Agree – 17.2%.
It's too early to tell – 11%.
Disagree – 0.6%.
Neutral – 3.9%.
Strongly disagree – 0.3%.

PRES 2020/2021. CRN Greater Manchester: 1,140 responses

SCAN ME

Taken part in research in Greater Manchester this year? If so, please complete our latest experience survey.

Being part of research: a patient's story

Systemic sclerosis (scleroderma) is a rare, chronic disease affecting the connective tissues, blood vessels and immune system. The PRedSS study, supported by the CRN GM, aims to discover if the corticosteroid Prednisolone can help relieve the severe pain, itch, and disability in patients.

Kat Dunnicliff of Cheadle Hulme lives with systemic sclerosis and was offered the opportunity to take part in the research.

"Systemic sclerosis is a rare condition where there isn't as much knowledge around medication and treatments. I saw it as a really good opportunity to contribute to research and also, hopefully, get some benefit for me."

Kat recommends all patients to consider participation in research, regardless of their condition.

"The whole process has been a really positive one for me. I would really encourage people to be open-minded about research opportunities and participate if they think it could be of benefit. I've felt a massive benefit from both a personal and health point of view."

Greater Manchester's Research Champions

CRN GM recruited over 60 passionate **NIHR Research Champions** to get more people involved in research. They have volunteered their time to help spread the word about health and care research to patients and the public, and especially those groups who are currently less likely to take part in research. They have also played a critical and strategic role in helping research and healthcare staff understand more about the experiences of those who take part in research.

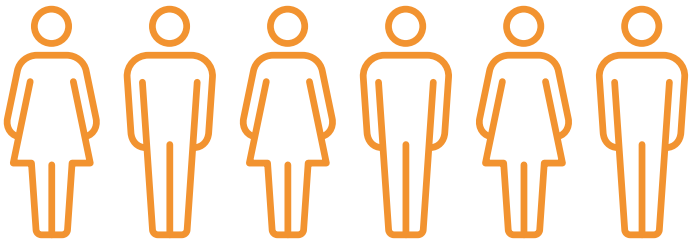
Our Research Champions have also been involved in specific studies and user-testing initiatives, such as:

- Working with NHS England on the Breast Cancer 'Tamoxifen Rapid Uptake Programme' to help reduce the number of women developing breast cancer
- Development of a framework for Patient Safety Partners to improve the way the safety of patients is both viewed and managed
- Testing the use of de-personalised patient information to improve the prescribing of antibiotics

Research Champion John said,

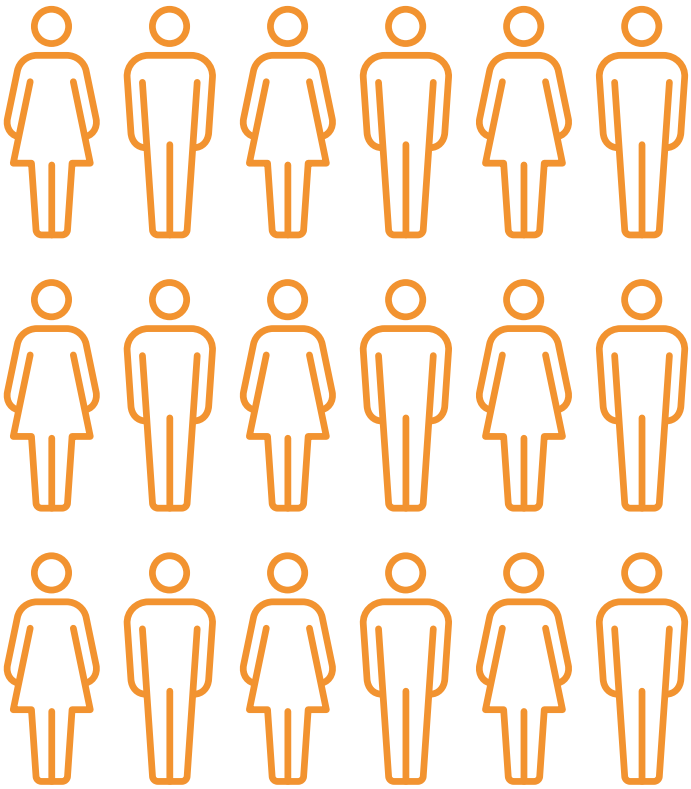
"I became a Research Champion because I wanted to help, and having suffered ill health myself as a multimorbidity patient. I am only here today because of research, without research I wouldn't have a future so anything I can get involved in that will help, I'm happy to volunteer."

Key highlights



Thousands of GM citizens register for COVID vaccine trials

Over 22,000 people across Greater Manchester signed-up to the NHS **COVID-19 Vaccine Research Registry**. CRN GM led a large-scale public awareness campaign to recruit participants for COVID-19 vaccine trials and secured significant media coverage across all TV, radio, print and online channels. Every local authority area in Greater Manchester has had over 1,000 people sign-up to the vaccine registry, with some areas having over 3,500 volunteers. CRN GM registrants make up approximately 50% of the volunteers in the North West, which is one of the top areas in the country for sign ups to the registry.



Addressing vaccine hesitancy in communities

Covid and Me - Vaccine stories

BE PART OF RESEARCH

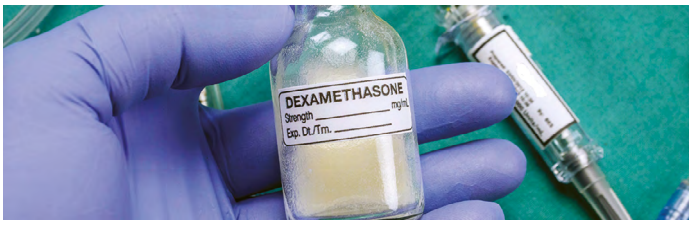
We engaged with underserved communities who have traditionally not taken part in research as much as those who identify as 'White British'. CRN GM now has a higher level of sign-ups from people identifying as 'Minority Ethnic' than the national average. We worked with community leaders and trusted local media, broadcasting adverts in Arabic, Urdu, Bengali and English. Episodes from '**COVID and Me**', the NIHR series of monologues dealing with various cultural hesitancies towards research, were also played. Our local researchers answered questions relevant to the audience, helping to dispel social media myths and encouraging sign-ups to the vaccine registry. This engagement will help protect everyone from health threats.

2.

Rising to the COVID-19 challenge

Urgent Public Health response

As the COVID-19 pandemic hit the UK, funding and support for COVID-19 research became our major priority. The NIHR Clinical Research Network (CRN) Greater Manchester's (GM) focus turned to Urgent Public Health (UPH) research as we made significant and outcome-changing contributions to the nation's rapid research response to COVID-19.



The Clinical Research Network Greater Manchester supported the flagship Randomised Evaluation of COVid-19 thERapY (RECOVERY) trial, recruiting over 2,500 patients across 11 hospitals. The study has led to two life-saving treatments against COVID-19 that have been rapidly adopted as part of standard hospital treatment around the world.

In June 2020, the trial identified the low-cost steroid dexamethasone as the **first drug to improve survival rates** in hospitalised coronavirus patients. Dexamethasone is instantly available and reduces death by up to one third in hospitalised patients with severe respiratory complications of COVID-19.

In February 2021, the trial also demonstrated that in patients with significant inflammation and requiring oxygen, treatment with the anti-inflammatory arthritis drug **tocilizumab reduced the need for invasive ventilation**, saved lives and shortened hospital stays. Combining treatment with dexamethasone reduces the risk of dying by half in patients requiring invasive mechanical ventilation, and by a third for those requiring simple oxygen.

RECOVERY has also informed us of treatments that were being used but that have been found not to work against COVID-19, such as hydroxychloroquine and some antibiotics.

These discoveries mean that a wide range of patients requiring oxygen will benefit from life-saving treatments that are readily available. Participants in the studies have helped us to understand which medicines worked, so that we could develop evidence-based treatment options for COVID-19 patients. The discoveries transformed our ability to treat the sickest patients and have been used immediately to save lives worldwide.

Ellie Watson, Team Lead Clinical Research Nurse NIHR CRN GM, said,

"When I heard the news that the use of dexamethasone resulted in lower 28-day mortality for those on oxygen or ventilated, it brought a tear to my eye to know that my work recruiting participants to the trial had helped get us towards something that would improve outcomes for our most unwell patients in hospital. It was our first step forward in fighting this virus."

Tools accurately predict COVID-19 risks of infection and deterioration

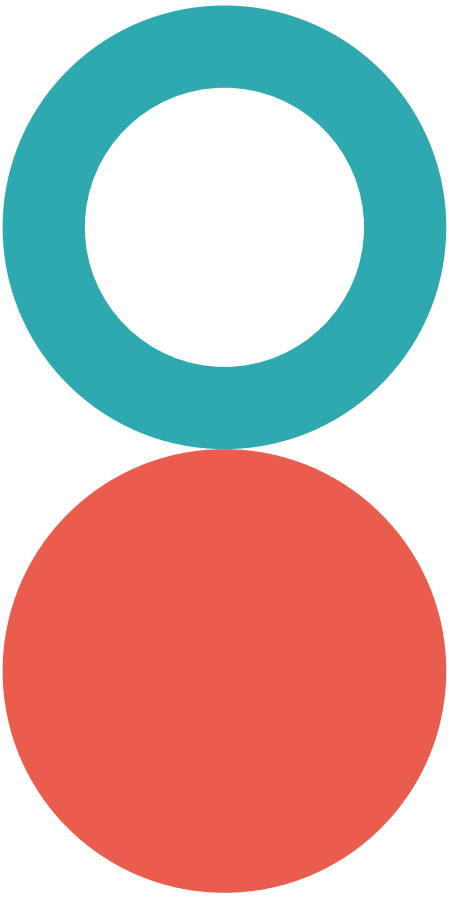
CRN GM was the second highest recruiting region and Lead Local Clinical Research Network (LCRN) for one of the country's highest recruiting Urgent Public Health trials. The ISARIC 4C (Coronavirus Clinical Characterisation Consortium) study was supported by recruitment at 15 of our hospitals, with over 19,650 patients recruited to trials that have resulted in three landmark outcomes.

In August 2020, the study found that **children and teenagers are less likely than adults** to develop severe COVID-19 or die from the disease.

The ISARIC 4C study into COVID-19 mortality found that patients admitted to hospital with COVID-19 can be divided into **four distinct risk groups** using a Mortality Score and offered treatment accordingly. This study was extended to develop the **Deterioration Score** that will provide clinicians with an evidence-based measure to identify those who will need increased hospital support during their admission, even if they have a low risk of death.

With Greater Manchester as lead LCRN, our Research Delivery Manager (RDM) Joanne Collins was the first RDM in the country to steer an Urgent Public Health study. Joanne set a shining example as she helped to coordinate the national response across every region for a study that quickly became one of the country's largest UPH studies, and a critical part of the government's response to COVID-19.

These crucial results will help clinicians determine the most appropriate treatments for patients to improve outcomes, as well as the allocation of hospital resources. They have also helped to inform Government policy on shielding, understanding the spread of COVID-19 and vaccination. Without studies like these, we would not be able to understand who are the most vulnerable people and protect those most at risk from COVID-19.



Evaluating fast and reliable COVID-19 tests

Fast and reliable COVID-19 testing at accessible community venues is at the heart of our ability to control the spread of COVID-19 infection. Led by the CRN GM team, the FALCON-MoonShot project was set up extremely rapidly to evaluate the use of new 30-minute COVID-19 detection devices at testing centres, with the aim of quickening turnaround times of results. The studies are instrumental in helping get pupils back to school, allowing families into care homes, trialling face-to-face events and provide hope for us all to be able to hug loved ones and enjoy leisure activities.

CRN GM's core delivery team led the way by establishing the first of the nation's 14 testing centres in the trial, which is the UK's fastest recruiting COVID-19 testing project, and recruiting over 200 participants – making us comfortably the highest recruiting region to the trial.

The trial resulted in city-wide mass testing evaluations, identifying over 100,000 individuals with asymptomatic disease. As a result of the study, Government policy was changed very quickly from symptomatic to asymptomatic testing and the trial has significantly expanded testing capacity for the NHS Test and Trace program.

Professor Rick Body, Chief Investigator for the FALCON-MoonShot study said,

"Thanks to an incredible effort by the NIHR CRN Greater Manchester, we were able to deliver this large study at the Etihad drive-through testing centre extremely rapidly, exceeding all expectations. Our findings can be used immediately to inform our national testing strategy".

Louise Woodhead, Jo Henry and Miriam Avery from the CRN GM delivery team

Making ground-breaking discoveries with NIHR infrastructure partners

NIHR Manchester Biomedical Research Centre (BRC) redistributed budget to a diverse and wide range of COVID-19 related studies that were peer reviewed. In a high profile announcement in March 2021, a systematic review led by the BRC and University of Manchester scientists found that **hearing loss and other auditory problems are associated with COVID-19**. Further studies will accurately estimate the number and severity of COVID-19 related hearing disorders in the UK.

CRN GM made an instrumental contribution to the **PHOSP-COVID study** in partnership with the NIHR Manchester Clinical Research Facility (CRF). Manchester CRF were the second-highest recruiting site in England for the study, which was delivered in a purpose-built unit dedicated to world-class research.

The trial found that the majority of hospitalised COVID-19 patients who survived did not fully recover five months after discharge, and continued to experience negative impacts on their physical and mental health, as well as their ability to work.

Our crucial contribution will help shape the development of trials of new strategies for clinical care. This research is critical to helping us understand the lasting health effects of COVID-19 and future studies are planned to better recognise the challenges of living with long COVID-19.

Key highlights

We delivered **44 Urgent Public Health studies** across **190 sites**; most of the trials didn't exist pre-pandemic. With nearly **52,400 participants** in Urgent Public Health research, CRN GM was one of the highest recruiting Local Clinical Research Networks (LCRN) in England and our sites were frequently in the top five of all recruiting sites across the United Kingdom for different studies.

Global and UK firsts in COVID research

CRN GM was the leader in many UPH research trials, supporting ground-breaking studies of COVID-19. We recruited the first two UK patients to the ACCORD study that tests potential new treatments for COVID-19. In testament to the expertise and experience of our staff, and the patient care delivered daily, one of our network's patients was the first in the UK to receive a convalescent plasma transfer as part of the RECOVERY trial.

Jo Henry, CRN GM Team Lead Research Nurse, holds a bag of donated blood plasma, ahead of administering the transfusion to the first MFT COVID-19 patient to take part in the convalescent plasma arm of the REMAP-CAP trial.

COVID-19 Vaccines Preparation

Establishing safe vaccines to combat COVID-19 has been one of the key medical challenges the world has faced in modern times. The Clinical Research Network Greater Manchester has made crucial contributions to vaccine preparation as researchers continue to work to secure a range of vaccines to help tackle coronavirus.

The world's first Phase 3 trial of the **Novavax vaccine** was conducted in the UK and has now confirmed a 96% efficacy against the original strain of COVID-19, helping to protect individuals in the UK and the rest of the world from the virus.

The highest recruiting region in the UK to the study in the UK, our region played a vital role in the rapid recruitment and enrolment of volunteers to the Phase 3 trial. More than 1,650 Greater Manchester volunteers took part in the study since September 2020, with our participating NHS Trusts carrying out the trial in community settings.

Stephen, 39, from Edgeley, explained his reasons for participating in the study.

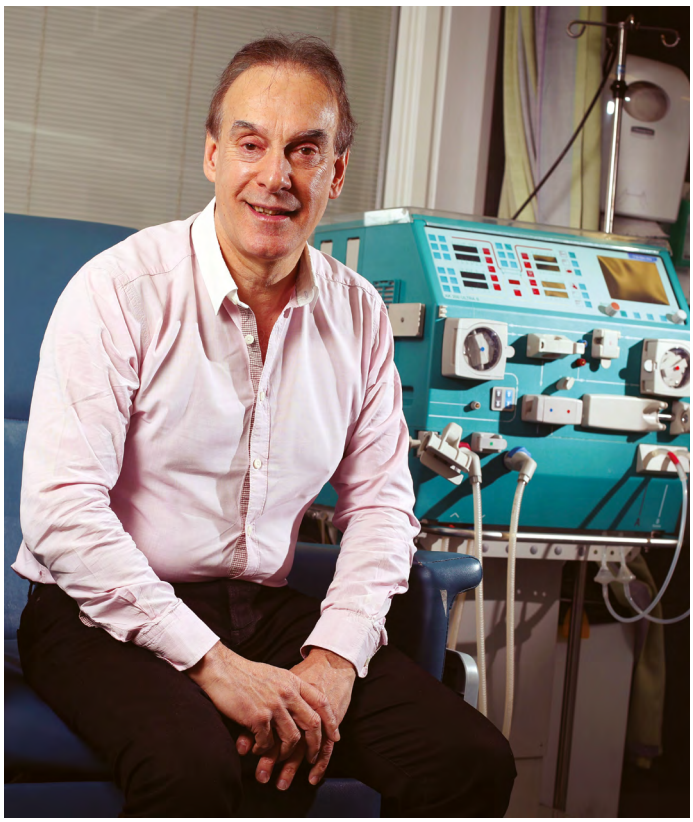
"I've got a few friends and family who have not really left the house since the beginning of the pandemic, so I just thought the sooner we can get back to some variation of normal, the better, and a vaccine could help with that. I was given detailed information at every stage about what the trial involves and why it is taking place."

Dr David Baxter, Principal Investigator for the trial at Stockport NHS Foundation Trust, said,

"We have, in partnership with NHS colleagues from across Greater Manchester, put a great deal of time and effort into carrying out the study and staff should feel very proud of the roles they have played in this significant development. As should the participants who have selflessly volunteered to be part of the study. Without their participation, none of this would have been possible."

Professor Phil Kalra, Principal Investigator for the trial at Northern Care Alliance NHS Group, said,

"Our team has worked incredibly hard to undertake the Novavax trial and we are thrilled to learn of these findings which show such a high degree of effectiveness. We are proud that the Northern Care Alliance, with support from our research colleagues in Greater Manchester, has made a real contribution to this marvellous achievement and we are extremely grateful for the efforts of all our staff and, of course, the volunteers who stepped forward to be part of this vital research."



Professor Phil Kalra

‘One Greater Manchester’ strategy provides rapid study set-up and access for everyone

CRN GM devised a **“One Greater Manchester” vaccine research strategy** in order to maximise the opportunities for Greater Manchester citizens and be ambitious about our local contributions to urgent vaccine preparation. The approach means that:

- Our region was able to undertake multiple different research protocols at the same time while maintaining safe, rapid recruitment
- All communities in Greater Manchester had access to the national vaccine registry and many were invited to participate in trials delivered in easy-to-reach community settings
- CRN GM support reduced logistical and administrative additional requirements for Trust staff as much as possible, allowing them to return to their usual activities

The CRN GM core team oversaw the delivery of this strategy, working closely with NHS Trusts to bring state-of-the-art vaccine research to the region, sponsored by international life-sciences companies.

The plan divided Greater Manchester into five geographic sectors, each with community settings. CRN GM helped to set up and carry out the studies, providing support with publicity, venues and staffing, participant recruitment, workforce, training, and governance. We also worked closely with Health Innovation Manchester, who provide project management support.

More than 2,230 local participants have been recruited to vaccine trials so far. The CRN GM are committed to continuing vaccine research until all our residents have a safe and effective vaccine option.

Dr Claire Cole received her first dose as part of the Janssen Phase 3 COVID-19 vaccine trial at Manchester University NHS Foundation Trust

CRN GM consents first person in the world to new phase 3 COVID-19 vaccine study

It is critical that a range of vaccination options are explored to give us the greatest chance of protecting as many people as possible. One of our Trusts was chosen as a site to deliver the vital phase 3 Janssen ENSEMBLE 2 two-dose trial – and Dr Claire Cole, the Head of Research Delivery at Manchester University NHS Foundation Trust (MFT), was the **first person in the world** to be consented into the study.

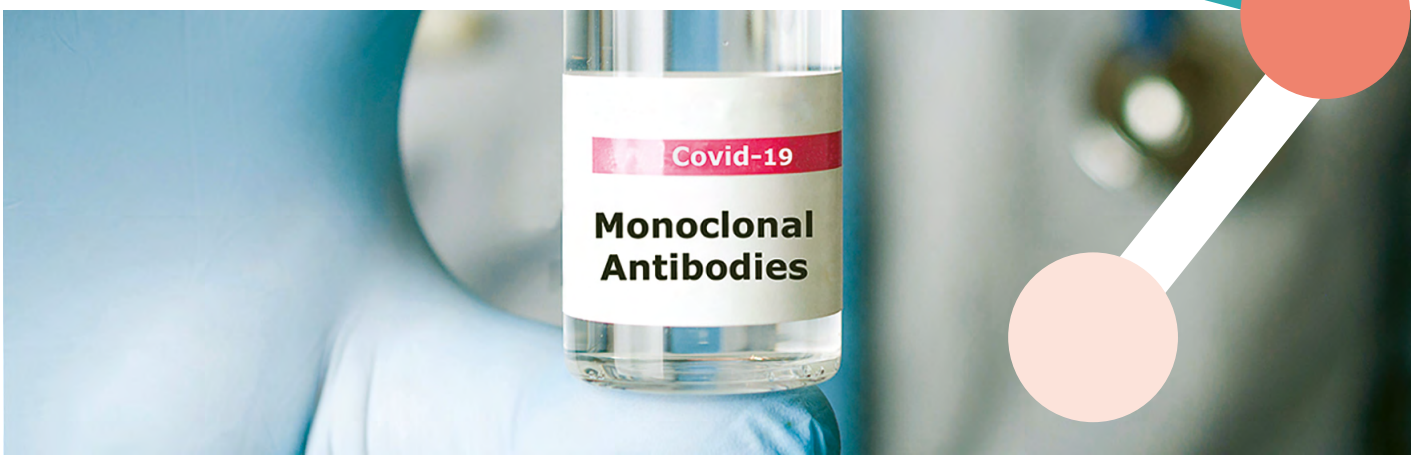
Our participating Trust surpassed its volunteer recruitment target within eight weeks and over 400 Greater Manchester residents are now taking part in the study, helping to form part of the solution to the global health crisis.

The trial is testing the safety, effectiveness and durability of a new two-dose vaccine regimen developed by Johnson & Johnson, as researchers seek to discover a range of vaccine options and to understand which vaccines work best for different people.

Dr Cole said,

"I wholeheartedly believe in the importance of taking part in research and was honoured to be the first person in the world to be recruited to the study, as part of this vitally important COVID-19 vaccine trial.

"But I am especially proud of the resilience of our multidisciplinary study team who managed to recruit the required number of participants and start administering second doses within just two months – an incredible achievement considering the current global landscape."



Finding treatments for people exposed to COVID-19 or with potential inadequate response to vaccination

In people who have been exposed to COVID-19, vaccination does not have time to provide protection from infection. CRN GM is leading the world's first investigation into whether protection can be provided by injecting antibodies that have been shown to neutralise the virus, into the muscle.

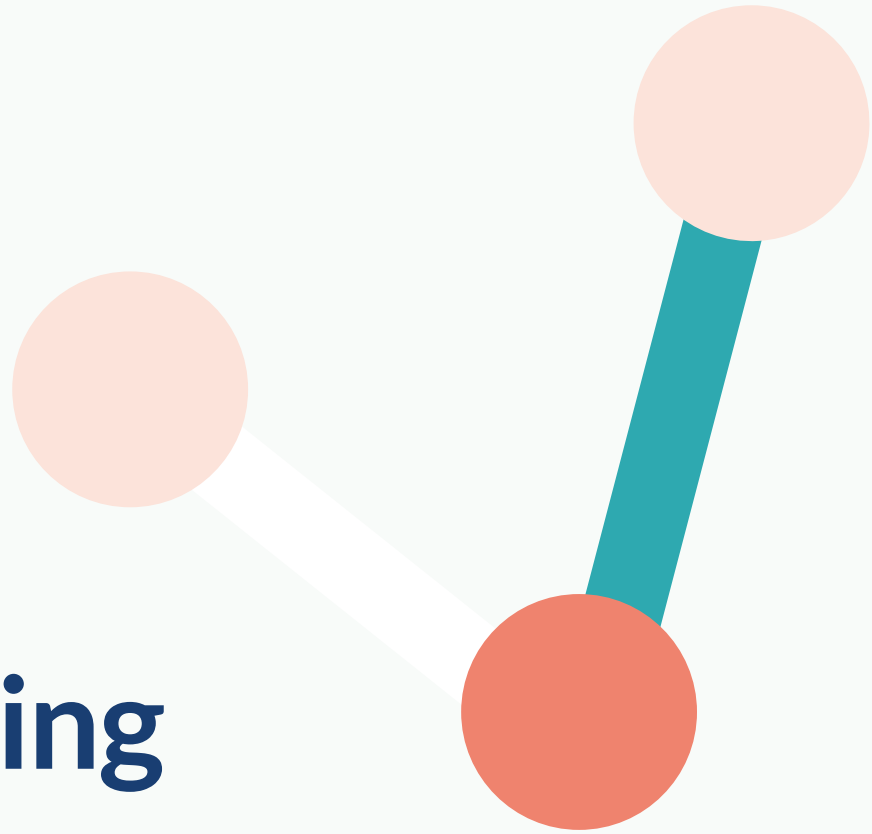
The study, known as **STORM CHASER**, is one of two pioneering monoclonal antibody studies being led by CRN GM. The **PROVENT** study aims to find solutions for some of society's most vulnerable to infection, the people who are immunocompromised and cannot be given vaccinations, and those who do not respond well to vaccines.

CRN GM is the lead CRN for these antibody treatment studies and the second highest recruiting region in the country to the STORM CHASER trial. Prof Andrew Ustianowski, CRN GM Deputy Clinical Director, is Chief Investigator for both these studies.

As treatments for COVID-19 patients are being improved and efficacious vaccines developed, these studies will prove vital in filling the gaps with effective interventions for those people exposed to SARS-CoV2, and people who cannot be or don't respond well to being vaccinated.

Dr Alison Uriel, Principal Investigator for the PROVENT and Storm Chaser trials and CRN GM Specialty Lead for Infection, said:

"Our team has taken great pride in delivering this research as part of the NIHR's commitment to identify vaccines, or vaccine alternatives, for all. Greater Manchester has played a significant role in these sister studies which are looking to provide options for people likely to have a sub-optimal response to a vaccine. We have used innovative methods to recruit participants by taking the research into community settings and utilising targeted social media advertising."



3.

Inspiring trust

Performance pride

The Clinical Research Network (CRN) Greater Manchester (GM) attracts talented research teams and delivers high-quality studies. This is in part due to our world-class infrastructure and the support that we provide, and because of our ability to help the recruitment of participants into trials, including rapid response requirements.

The Clinical Research Network Greater Manchester continues to excel in the provision of practical support to allow high-quality research to take place in NHS, public health and social care settings across Greater Manchester, East Cheshire and East Lancashire.

In 2020/2021, we were the second-highest recruiting Local Clinical Research Network (LCRN) to commercially sponsored studies, with 3,827 recruits across 146 studies. For the sixth year running, CRN GM were also, by some margin, the best performing LCRN for recruitment to time and target on commercially-sponsored studies. In fact, 89% of our sites hit their targets, 13% ahead of the next-highest LCRN.

This success means that commercial sponsors can trust us to help place studies in sites that will deliver, with continued support throughout set-up and recruitment. Local people are also offered opportunities to be part of state of the art research studies as soon as possible.

A total of over 80,000 participants across 581 studies were recruited to CRN Portfolio studies across Greater Manchester, East Cheshire and East Lancashire in 2020/2021, with an equivalent of 25.5 people per 1000 population being a part of research in our region. Of our research volunteers, 52, 400 (64% of our recruitment total) were part of Urgent Public Health studies for COVID-19, **demonstrating our ability to respond to rapid research requirements**.

Roger Spencer (pictured), Chairman of the CRN GM Partnership Board, said:

Greater Manchester can be very proud of the way it has responded to the COVID-19 challenge and made a significant contribution to research outcomes that are now saving countless lives and helping steer us towards a brighter future.

At a time when our health and care services have been under more pressure than ever before, it was a remarkable effort to set-up and deliver over 40 Urgent Public Health studies and provide opportunities for over 52,400 people to be part of this nationally prioritised research. While the pandemic unavoidably disrupted trials in other disease areas, over 29,000 people have still consented to non-COVID research opportunities as part of their care and it is highly encouraging to see that Greater Manchester has a higher proportion of studies open and recruiting than any other region in the country.

Professor Jane Eddleston, Manchester Academic Health Science Centre chair and Group Joint Medical Director at Manchester University NHS Foundation Trust, the host Trust for CRN GM, said:

"I'm extremely proud of the way the Greater Manchester research community has responded to the COVID-19 crisis amid some of the most challenging circumstances I've known during my NHS career. Our network has played a significant part in a number of groundbreaking research outcomes that are not only saving lives in the UK, but across the world. Greater Manchester has certainly delivered on its reputation as an excellent region for pioneering research and innovation and we'll be working hard to build on the success of the past year as we continue to deliver research into coronavirus and bring our full portfolio back up to capacity."

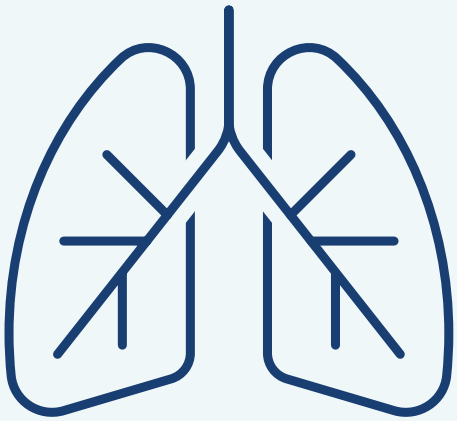
Widening participation opportunities in research

Research for the Future (RftF) is an NHS-supported campaign that is unique to Greater Manchester. The campaign helps people find out about and take part in health and care research and has previously been focused on four disease areas of primary interest.

Opportunities for volunteers have now been widened so that anyone aged 18 years or over and living in England is welcome to register, whether they have a health condition or not.

Involvement extends beyond being involved in a clinical trial and also includes contributing to the design of a study, being part of a discussion group or completing a survey, and helping to test new equipment. People who are interested can easily register on the **Research for the Future website**, to be contacted about any health research.

The CRN GM needs as many people as possible to get involved and also to promote Research for the Future to others, so that we can rapidly connect our communities with research and do our very best to increase research opportunities. Your participation will help us to discover new ways to prevent, diagnose and manage illnesses.



New respiratory research group for uncommon condition

Bronchiectasis is a long-term condition where the airways of the lungs become abnormally widened, leading to a build-up of excess mucus that can make the lungs more vulnerable to infection. It is thought to affect around five in every 1,000 adults in the UK.

The Greater Manchester Bronchiectasis Group has been set-up to provide an effective forum to help standardise practices, support education and promote research within Non-Cystic Fibrosis bronchiectasis across Greater Manchester. The group will help us to ensure equitable access to the provision of care and services for all patients across our region, as well as providing an excellent platform for education and research to prosper.

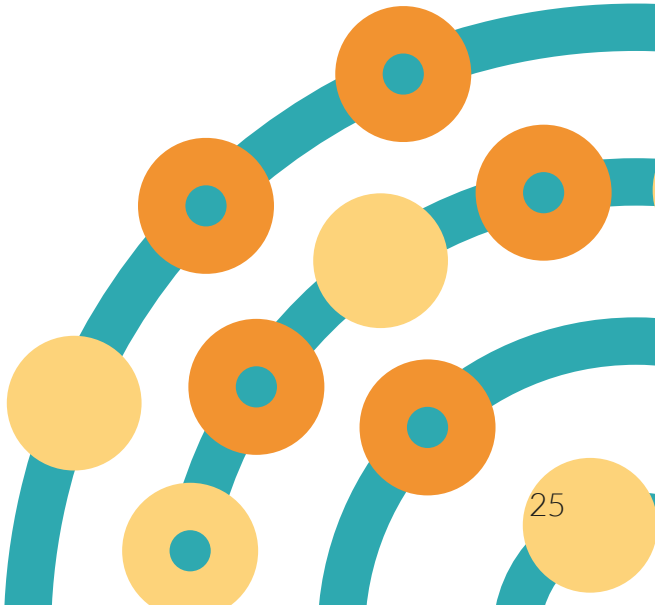
Leading specialist consultants and nurses, physiotherapists, and Allied Health Professionals (AHPs) have joined the group and it is anticipated that the formation of this group will help bring more bronchiectasis studies to Greater Manchester.

New rapid genetic test could prevent antibiotic-related hearing loss in newborns

A study supported by the NIHR Manchester Biomedical Research Centre, in partnership with Manchester-based firm Genedrive and the charity Action on Hearing Loss, could prevent antibiotic-related hearing loss in newborn babies. When newborns are admitted to intensive care they are often treated with the life-saving antibiotic, gentamicin. This can lead to 1 in 500 infants developing irreversible hearing loss due to a genetic predisposition that has previously not been identifiable quickly enough to inform treatment decisions.

Our researchers have begun a **new study** on a world-first 20-minute bedside test that identifies susceptible babies. Administered by a nurse with a bedside machine, the test provides information on an infant's risk of antibiotic-related hearing loss, enabling the prescription of alternative appropriate antibiotics. It is estimated that the new technology will save the hearing of 180 babies in the UK every year, and also save the NHS an estimated £5 million each year in cochlear implantations and other hospital costs.

The genetic test will allow doctors to find the right urgent treatment for each baby without incurring devastating lifelong side effects for the patient and the anguish of a diagnosis of profound deafness for their family.



Resilience, Recovery and Growth

The emergence of the COVID-19 pandemic led to the diversion of resources to support the Government's research responses. New sites or studies, other than for nationally prioritised COVID-19 studies, were paused and some researchers deployed to the clinical 'front line', leading to a rapid and significant reduction in Clinical Research Network research activity across the country. However, as COVID-19 pressures on the UK health system eased, our research began to resume.

29,000
volunteers

The Clinical Research Network (CRN) Greater Manchester (GM) is the leading Local Clinical Research Network (LCRN) in the country in terms of the proportion of research studies that are open and actively recruiting participants, even though many resources were diverted to COVID-19 related research.

1,000
studies

Only 10% of our trials remain paused due to the pandemic, and under 1% were cancelled. This ensured that many of our local communities continued to have research opportunities offered to them as part of their care during the pandemic.

Since May 2020 we have seen a progressive improvement in the number of open studies and study sites as we recover our fully-active portfolio of research. Recruitment to studies has been both complex and challenging but our teams have worked hard to get non-COVID-19 research up and running alongside the recovery of clinical services. This has been achieved in line with the NIHR's Managed Recovery **Framework** and includes commercial and non-commercial trials.

In spite of the disruption to research, over 29,000 volunteers (35%) were part of non-COVID-19 research in Greater Manchester in 2020/2021.

Over 1,000 studies have now opened, equivalent to 65% of the total number on our portfolio. We continue to work in collaboration with others across all sectors of health, social care and public health, as we make a significant contribution to the improvement of the nation's health and wealth.

New service provides flexible research staffing for COVID-19 studies

Finding safe and effective vaccines, treatments and diagnostics for COVID-19 was a high priority for the UK and helped to protect us all more quickly, relieve pressure on the NHS and save lives. Successful research relies on large-scale trials and sometimes it can be difficult to recruit staff to studies.

CRN GM collaborated with health organisations across Greater Manchester to set up a new service that can provide research teams with additional, flexible staffing to cope with COVID-19 workforce related pressures.

The **Research Workforce Hub** has a new digital application process that makes it easy for Trusts to recruit additional staff by offering short-term employment opportunities in a range of roles.

As part of a pilot, six staff were taken on via this model from the NHS Professionals bank. The scheme was initially focused on helping Trusts carry out COVID-19 studies and is now being expanded to provide support with research delivery across all trials

Liam McMorrow, Lead Nurse for Research & Innovation at Northern Care Alliance NHS Group (NCA), said,

"Thanks to this scheme, we were able to facilitate some short-term staffing into my workforce and the process from start to finish has been seamless. My teams across the NCA have benefitted from this initiative especially during this busy period, which has added valuable resource to support our portfolios."

Key highlights

Leading the way in cancer research opportunities

We continued to provide opportunities for local patients to be part of cancer research, with recruitment into over 190 studies still taking place during 2020/2021. In March 2020, our NHS trusts were forced to pause recruitment into trials but by early May 2020, they were able to re-open safely.

By winter 2020, our flagship cancer trust had re-opened 92% of trials that were started pre-COVID-19. The recruitment of over 4,800 participants into these studies made us the highest enrolling LCRN for cancer research in the country when accounting for population size, and the second highest recruiter overall.

Taking COVID research into care homes

COVID-19 has the most serious effect on older and vulnerable people and providing as much protection for them as possible has been a priority for CRN GM. One of our programmes, ENRICH (Enabling Research in Care Homes), was disrupted during the pandemic.

However, because of our local contacts, we were able to deliver the **Vivaldi study**. CRN GM collaborated with 10 Greater Manchester care homes and recruited more than 60 residents and staff. The study has demonstrated that a single licensed vaccine dose was effective at preventing up to 62% of COVID-19 infections.

800
people

400
appointments

Our Public Health research journey begins

We focused on underserved communities in Greater Manchester and delivered the **Virus Watch study** at three sites. Results show that over 80% of people who were uncertain or intending to refuse a COVID-19 vaccine in December 2020 had **changed their mind** by February 2021. This was our first landmark Public Health research study, and we recruited over 450 participants whose contribution is helping monitor and stop the spread of COVID-19. The study shows the importance of making repeated offers of a COVID-19 vaccine as many people have changed their mind over the course of a few months.

Staff diversify to support COVID fightback

The pandemic led to many open research studies being paused, including the majority of research that we expected to support through our bespoke service **Research for the Future** (RftF). The RftF team quickly diversified their service and supported new and rapid response COVID-19 trials.

The Research for the Future team was redeployed to carry out telephone screening of participants and administrative support for the Novavax COVID-19 vaccine trial across two sites. RftF screened approximately 800 people and booked over 400 appointments for those who met the eligibility criteria, providing an excellent participant experience that drew praise from staff and participants alike.

4.

Excelling at relationships

Collaborative working

To deliver the best support that we can provide for the benefit of our communities requires all elements of the Greater Manchester health system to work together. The Clinical Research Network Greater Manchester worked hard to develop excellent working relationships and be innovative in our collaboration with partners, to benefit all our residents and improve lives. The results of our ability to work collaboratively across the Greater Manchester health system have been especially evident as we supported research responses right from the start of the COVID-19 pandemic.

Research nurses Imelda Mayor and Alice Wheeler

Our colleagues at NIHR Manchester Clinical Research Facility (CRF) collaborated with St John Ambulance to play a major part in the **'What's the Story'** project. The project, which studies antibody levels for COVID-19 as well as meningitis and diphtheria, involves young people and was given Urgent Public Health status.

The study was delivered in the first wave of the COVID-19 pandemic. To avoid the need for volunteers to come to hospitals we collaborated with St John Ambulance and using one of their ambulances, we set-up a pop-up clinic in communities. We had a phenomenal response to our call for trial volunteers and our collaboration with St John Ambulance has also meant that families in hard-to-reach communities have been able to take part and add value to this vital research study.

Helen Blackburn, Hospital R&I Manager, Royal Manchester Children's Hospital, said,

"This is a really good example of how our clinical and non-clinical research teams have come together to work on a project and also demonstrates some of the innovative ways in which we work in R&I. We have built up a really good collaboration with St John Ambulance and were able to utilise their ambulance facility which allowed us to make this research more accessible to our local communities."

Collaborating on world-first phase 3 trial of Novavax vaccine

Clinical Research Network (CRN) Greater Manchester (GM) and NHS staff from Partner organisations across our region collaborated in the delivery of the first phase 3 trial in the world of the **Novavax COVID-19 vaccine**.

This was the first COVID-19 vaccine trial to be undertaken in Greater Manchester and required a lot of cooperation across our health system. Staff from different trusts in Greater Manchester and the CRN GM worked together to deliver the study, which was carried out at community sites.

Wieska Woodyatt, Research and Innovation Manager at Stockport NHS Foundation Trust, said, "Right from the background administration and project management, through to pre-screening, then actual on-site delivery with the labs and pharmacy, finishing with the data entry back at the office. It's been a true collaboration. This has not just been about the Stockport team, this has been one, wider network effort. It is a true testament to how we can all come together in Greater Manchester to deliver one study – A One Manchester Approach at its absolute best."

Professor Andy Ustianowski, Deputy Clinical Director at NIHR Clinical Research Network Greater Manchester, and NIHR national Specialty Lead for Infection, said,

"This huge research project has been made possible thanks to a 'One Greater Manchester' approach which involved colleagues from across various NHS organisations working together to ensure local communities had the opportunity to be part of this groundbreaking research. We sincerely thank all the staff and participants whose contribution should now benefit so many people."

More than 1,650 Greater Manchester volunteers took part in the study, making our region the highest recruiting region in the country.

Pictured: The Novavax delivery team at Stockport NHS Foundation Trust

The CRN GM core delivery team of nurses, practitioners and administrators has collaborated, to great effect, with R&I teams across Greater Manchester on a range of studies.

"Our team has shared tears, laughter and rejoiced in achievements that contributed to improving treatments and interventions for those that became suppressed to the COVID-19 virus. We supported our medics and, most importantly, we supported our patients and participants. I take extreme pride in managing a team that not only drives excellence in all research across Greater Manchester, but also promotes and underpins research in order to provide cutting-edge treatment options for service users. At no other time in my career have I felt more humble or proud of my team, myself and the NHS."

Sam Chilcott, Clinical Research Network Greater Manchester Nurse Manager.

Taking research opportunities into the community

CRN GM partnered with local community organisations and locations to widen the opportunities for all our residents to take part in research. This included the phase three trial of the COVID-19 vaccine Novavax delivered at Manchester Rugby Club and Oldham Leisure Centre and the PROVENT antibody study also carried out at Oldham Leisure Centre.

These easy-to-reach settings provided convenient car parking, large indoor spaces, a clear and safe participant pathway from one stage to the next, and a comfortable participant experience away from hospital environments. This approach has helped us to be one of the country's leading CRN's for participant recruitment, as well as ensuring our underserved communities have the opportunity to make a crucial contribution to research.

Pictured: Research participant Stuart Lockwood, Chief Executive Officer of Oldham Active, attending his PROVENT trial check-up at Oldham Leisure Centre, which has hosted a number of COVID studies.

Key highlights

GM hospitals excel in flagship COVID trial

Clinical Research Network Greater Manchester brought together hospital Trusts across our region to share best practice for delivering the flagship COVID-19 RECOVERY treatment trial.

The provision of a regular forum helped our region significantly surpass the national target of recruiting 10% of COVID-19 patient hospital admissions on to the trial. The forum also provided valuable support for trusts that had experienced difficulties with enrolling participants. In February and March 2021, Greater Manchester accounted for the **highest performing trusts in the UK** for COVID-19 patients recruited to the RECOVERY trial. The study has already helped find treatments that improve outcomes for hospitalised patients.

Angela Houghton-Cole (with husband Martin) took part in the PRINCIPLE trial.

GM sites support COVID community treatment discovery

We reached out to organisations across the public, private and third sectors in Greater Manchester in response to the urgent call for volunteers to the **PRINCIPLE trial**. This national priority trial seeks to identify community-based treatments for COVID-19.

A total of 120 primary care sites were registered to recruit volunteers. Partners including the North West Ambulance Service NHS trust played key roles in enrolling participants, and health and care professionals of all types. Organisations such as local Age UK charities helped direct potential participants to the study website. Almost 200 participants in Greater Manchester have contributed to the trial and in a significant milestone, evidence has been found that the widely available drug budesonide is effective as a treatment at home. Angela Houghton-Cole, from East Cheshire, took part in the trial through her local GP practice.

"Ultimately, I felt that if I could contribute towards research that will help us better understand this awful virus and possibly help other people in the future, then it was something I wanted to be a part of."

Your Clinical Research Network Greater Manchester

The year 2020/2021 has obviously been dominated by our response to the COVID-19 pandemic, although we also managed to keep more existing trials running than any other Clinical Research Network in England. Our team have continuously demonstrated their passion for research and their resilience throughout this time, being extremely agile and working closely with our wider network of health and care professionals across Greater Manchester.

The Clinical Research Network Greater Manchester's delivery team – comprising research nurses, practitioners and administrators – supported 20 studies across hospital sites and 9 across community settings such as care homes, schools and primary care during 2020/2021.

To respond to the COVID-19 challenge, their roles became increasingly flexible with staff covering shifts seven days a week and outside of traditional hours.

In an immediate response to support Urgent Public Health trials during the first wave of the pandemic, team members went on indefinite placements across our host trust, Manchester University NHS Foundation Trust (MFT), until summer 2020. Staff bound for new, non-clinical research roles remained in their clinical posts to support research delivery, while non-clinical staff with a nursing background were placed on standby and undertook refresher training.

Members of the CRN GM delivery team working on the Moonshot study

As the pandemic progressed, our delivery team began to support research at other hospitals and organisations across Greater Manchester, and played a vital role in planning and undertaking COVID-19 vaccine trials at three sites.

Janette Dunkerley, Lead Nurse for Research and Innovation at MFT, said,

"I am exceptionally proud of how the Clinical Research Network Greater Manchester's research delivery team have been agile, supportive, adaptive, responsive and flexible to the needs of MFT in supporting us, and all NHS trusts across Greater Manchester, throughout the pandemic. This support has enabled the residents of Greater Manchester to have the opportunity to take part in ground-breaking, innovative research during the COVID-19 pandemic."

Key highlights

Essential training for new and existing research workforces

CRN GM supported the development and introduction of new, national e-learning training programmes for research-naive clinical teams so that clinical research during the first wave of the pandemic could be supported. We also resumed training for our research workforce with virtual sessions, and safely re-started the most prioritised learning events as face-to-face sessions.

A total of 2,685 certificates were issued to local health professionals. Training included courses on Good Clinical Practice, the essentials of clinical research, gaining informed consent from participants, becoming a lead investigator for a study, and showing clinical trainees how to include research in their practice.

Promoting research opportunities via local media

Through our trusted media relationships, we have secured over 100 pieces of free coverage to promote participation in research and raise the profile of NIHR. This has helped us make a significant contribution to supporting the search for COVID-19 vaccines, treatments, and diagnostics. CRN GM gained 20 pieces of publicity for the PRINCIPLE trial alone, with its focus on the search for treatments in the home for patients with mild COVID-19 symptoms. This included **an interview with Dr Sheila McCorkindale**, CRN GM Specialty Lead for Primary Care, on BBC North West Tonight.

Our development of a range of **case studies** with local participants tells the human story of our research and each one explains why volunteers became involved. These **personal stories** demonstrate how research has benefited the health and wellbeing of local people, and have helped attract media attention for NIHR studies, as well as inspiring other people to be part of research.

Automated process for rapid site identification

CRN GM created an innovative, automated research site identification tool that streamlines the process for NHS research teams to register their interest in delivering Urgent Public Health studies. As a result, our Study Support Service has provided trial sponsors with the information they needed faster than other regions. The innovation has paved the way for urgent COVID-19 research in Greater Manchester to be set up and carried out at pace. Other regions are now considering implementing our creative technology solution.

Digital solution for smoother trial set-up

We have helped improve the **interactive Costing Tool (iCT)** that makes it quicker and easier for commercial sponsors to negotiate budgets and set up trials in the NHS.

200 different commercial organisations sponsored studies in Greater Manchester in 2020/2021. This brought a wide range of state-of-the-art research opportunities to all our residents across multiple disease areas.

5.

Investing in our future

What's new for 2021/2022

Our support allows research to take place in NHS, Public Health and Social Care settings. In 2020/2021, we made some fundamental changes to our approaches in response to the urgent COVID-19 challenge. We will build on these experiences and continue to support and invest in the future of research, gathering evidence that leads to new and better care and treatments for patients and the public.

Reaching all communities and increasing the opportunities for research volunteers to access state-of-the-art treatments is one of Clinical Research Network (CRN) Greater Manchester's (GM) priorities.

As a result of our successful funding application to the Vaccine Task Force, in the summer of 2021 we will be launching a new mobile pharmacy that is unique to our region. The 'pharmacy-on-wheels' will be used to take COVID-19 vaccine trials – and other research studies – to easy-to-reach community locations such as community centres and sports halls, rather than participants needing to travel to a hospital or NHS site.

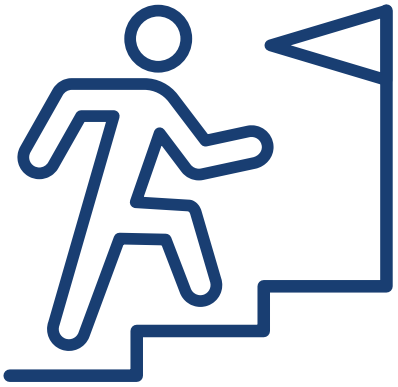
The mobile pharmacy will have built-in facilities to store and dispense trial medications, as well as special features such as advanced freezer technology. This means that even in the community, we will be able to conduct research that requires investigational medicinal products or trial vaccines to be kept at temperatures down to – 70°C

Sarah Fallon, Chief Operating Officer of NIHR Clinical Research Network Greater Manchester, said,

"We are delighted to have secured funding for this new resource which is a key part of our strategy to increase opportunities for people in all parts of our area to be part of clinical research studies.

"The mobile unit will also optimise our resources in the region and provide us with a 'one-stop' facility that can move flexibly between different sites in Greater Manchester. This is a particularly important asset as we continue to deliver urgent public health priority trials to find more COVID-19 vaccines to protect everyone from coronavirus."

Key highlights



Contract extension

We are delighted that The Department of Health and Social Care (DHSC) has confirmed the extension of Local Clinical Research Network contracts, including Greater Manchester's, until April 2024. We feel privileged to be continuing to support research that improves health outcomes for people in our local communities.

North West-wide training department

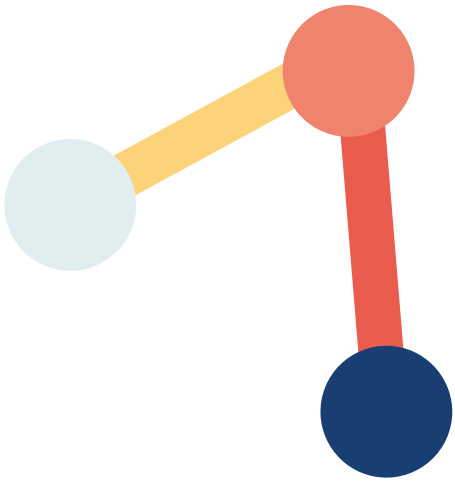
Working in collaboration with our colleagues at CRN North West Coast (NWC), we will launch a new-look Workforce, Learning and Development (WLD) team. The WLD functions of CRN GM and NWC will come together to provide a North West-wide service to deliver the training and development needs of the workforce across our combined areas. This will help both organisations align strategically, and our teams will benefit from wider support for workforce initiatives, including the addition of a dedicated Learning Technologist and a Learning Manager.

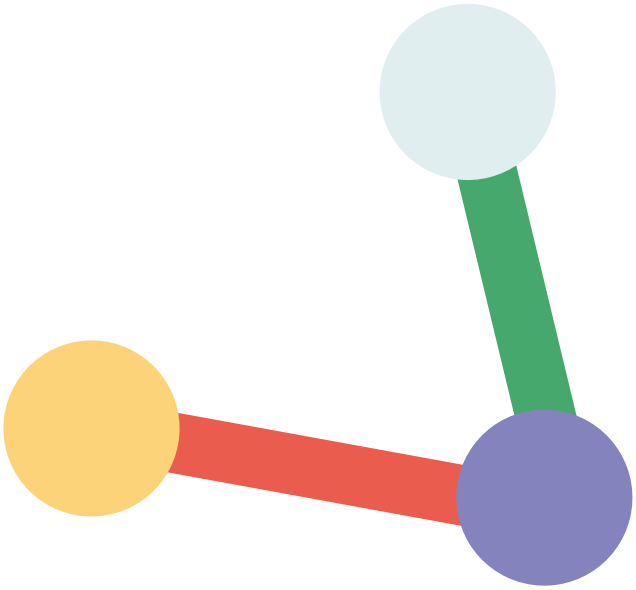
Finding COVID vaccines for everyone

CRN GM's 'One Greater Manchester' COVID-19 vaccine research strategy will continue to deliver studies across the region as we seek to identify vaccines for everyone. Opportunities for vaccine trial participation will be extended, with up-coming trials focusing on children and pregnant women. Trials investigating booster vaccines and third doses are also currently in set-up stages, and will help us gain a better understanding of possible future COVID-19 vaccine schedules. Our Business Development team continue to promote Greater Manchester as a prime location to carry out future vaccine trials.

Enhancing our volunteer database

Research teams across Greater Manchester will have easy access to potential volunteers for COVID-19 and other disease studies. Our bespoke Research for the Future (RftF) service will launch a campaign to develop a database of volunteers who have given their consent to be approached about participating in upcoming COVID-19 trials. This will build on an existing database of over 6,500 local volunteers already registered with RftF across its four Help BEAT campaigns for diabetes, heart disease, kidney disease and respiratory disease - plus our brand new Help BEAT Coronavirus campaign.





Beyond traditional research delivery

CRN GM will continue its focus on transforming research delivery and be a supportive community that develops our practices to go beyond traditional research delivery. We will continue to seek ways to reach underserved communities and work with them to offer more inclusive research opportunities for everyone in Greater Manchester.

Here's to you

The CRN Greater Manchester delivery team

Thank you to the Greater Manchester research community

We would like to say 'thank you' to everyone who has been involved in research across Greater Manchester over the past year. As soon as the potential impact of the COVID-19 global public health emergency was realised, the NIHR acted quickly to help set up and carry out a range of urgent research studies into the disease.

Since then, our local NHS Trusts and other health and social care providers have been working hard to ensure as many of our region's patients as possible have had the opportunity to take part in the latest COVID-19 studies. At the same time, they have also been striving to restart as much non-COVID-19 research as possible in a safe manner.

A tremendous amount of progress has been made in the past 12 months, which owes a great deal to the dedication of countless NHS staff members and the thousands of participants who have volunteered for trials in our region. **Thank you.**

Martin Gibson, Clinical Director of NIHR CRN Greater Manchester

How we support studies and how you can get involved in research

BE PART OF RESEARCH

Setting up and delivering research in Greater Manchester

For all enquiries about how we can support you to set up and deliver research in NHS, Public Health and Social Care settings in Greater Manchester, email our single point of contact address: **researchsupport.crngm@nihr.ac.uk**

You can also find out more:

- Visit our **Industry Route Map** of the support available through our Study Support Service
- Read more on our website – **https://local.nihr.ac.uk/lcrn/greater-manchester/**
- Follow us on Twitter **@NIHRCRN_gman** and **LinkedIn**
- Keep up-to-date with our latest news and developments by **subscribing to our monthly bulletin**

Undertaking vaccine research in Greater Manchester

We have the experience, capacity and capability to carry out a range of vaccine trials and have supported some of the nation's most important recent vaccine discoveries. Our Business Development team **share an overview of our expertise in this field**.

Supporting researchers

The Clinical Research Network Greater Manchester **help researchers** find participants for a wide range of research involvement and engagement opportunities, including grant applications, clinical trials and other Patient and Public Involvement and Engagement (PPIE) opportunities.

Careers in research

Interested in a career in research? Our **Greater Manchester Research Workforce Hub** is an ideal way to register your interest in fulfilling a role in research on a short-term basis. It offers flexible, paid opportunities which give prospective research employees an insight into a career in research, allowing you to sample a role and understand what a permanent switch to research could entail.

Get involved in care home research

Any care home interested in supporting research can join the NIHR Enabling Research in Care Homes (ENRICH) Research Ready Care Home Network. Your care home can join the ENRICH network by **signing up today**.

Take part in health research in Greater Manchester

There are many ways in which you can take part in health research in Greater Manchester – regardless of your health. It could be anything from completing surveys and quizzes, to providing feedback and taking part in clinical trials. Just some of the opportunities to contribute to improving everyone's health include:

Register to hear about research opportunities
If you are aged 18+, regardless of your health background, you can now sign-up to our unique Greater Manchester service, **Research for the Future**. Registering means we will inform you about research opportunities you may wish to take part in. We offer opportunities to get involved in research across all health conditions as well for as healthy volunteers

Volunteer for "Help BEAT…" campaigns in diabetes, heart disease, kidney disease, respiratory disease and coronavirus
Research for the Future also has five areas of particular interest, our **'Help BEAT' campaigns**. Our current campaigns are Help BEAT Diabetes, Help BEAT Heart Disease, Help BEAT Kidney Disease and Help BEAT Respiratory Disease and Coronavirus. We are especially keen to hear from people living with these health conditions as we regularly have research opportunities in these areas

Be Part of Research
Be Part of Research is a website run by the NIHR and is designed to help people find and contact research studies taking place near them, including studies happening in Greater Manchester

Sign-up to Dementia Research
Join Dementia Research is an NIHR service that enables you to register your interest and be matched with suitable dementia research studies taking place near you. Our knowledge of dementia currently lags behind that of other major conditions, such as cancer or heart disease, and the number of patients is set to double over the next 30 years. The service is predominantly aimed at people with dementia and their carers, but anyone with and without dementia over the age of 18 can sign-up and you can register on behalf of someone else

Become a Research Champion
We coordinate a group of local **Research Champions** and are always looking for more people to join the group. Research Champions are patients, carers, and members of the public who have taken part in a research study before, as well as those who haven't. Something that they all have in common is that they are passionate about getting more people involved in research so that we can develop better care and treatment for everyone.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Sue Ward, Group Deputy Chief Nurse Barbara Mitchell, Assistant Chief Nurse, Safeguarding, Patient Experience & Quality Claire Horsefield, Head of Customer Services
Date of paper:	June 2021
Subject:	Annual Complaints Report 2020/21 for MFT
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Patient and Staff Experience
Recommendations:	The Board of Directors is asked to note the content of this report, the work undertaken during 2020/21 and, in line with statutory requirements, provide the approval for the report to be published on the Trust website.
Contact:	Name: Barbara Mitchell, Assistant Chief Nurse, Safeguarding, Quality & Patient Experience Tel: 0161 274 4981

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

1. Executive Summary

1.1 The Trust adheres to the Statutory Instruments No. 309, which requires NHS bodies to provide an annual report on the Trust's complaints handling, which must be made available to the public under the NHS Complaint Regulations (2009)[1]. This annual report reflects 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.

1.2 This report celebrates achievements and improvements, whilst acknowledging continuous improvement is always fundamental in an ongoing effort to improve processes and services across the Trust. The impact of the Covid-19 pandemic on complaints and PALS activity is highlighted along with new ways of working adopted in order to maintain a responsive PALS complaints and service.

1.3 Throughout the report the term **Complaints** is used to describe complaints requiring a response from the Chief Executive and the term **Concerns** is used to describe informal contacts with the Patient Advice and Liaison Service (PALS), which require a speedier resolution to issues that may be resolved in real time.

1.4 The report refers to all Hospitals/Managed Clinical Services (MCS) and Local Care Organisations (LCO) across the MFT Group. These are Manchester Royal Infirmary (MRI), Manchester Royal Eye Hospital (MREH), Saint Mary's Hospital MCS (SMH), Royal Manchester Children's Hospital MSC (RMCH), University Dental Hospital of Manchester (UDHM), Clinical Scientific Services MCS (CSS), Manchester and Trafford LCOs, and Wythenshawe Hospital, Trafford General Hospital, Withington Hospital and Altrincham Hospital (WTWA).

2. Summary of Activity

2.1 As in 2019/20, the quality of complaints' data reporting continued to improve during 2020/21, as did the overall year performance for the timeliness of closing complaints.

2.2 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.

2.3 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.

2.4 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.

[1] The Local Authority Social Services and National Health Service Complaints (England) Regulations (2009). Available from: http://www.legislation.gov.uk/uksi/2009/309/pdfs/uksi_20090309_en.pdf

2.5 In response to the Covid-19 pandemic NHS England and NHS Improvement provided guidance in March 2020 in relation to complaint handling, which resulted in a system-wide pause in the NHS complaints process. The purpose of the pause was to release the time of clinical staff to deliver direct clinical care as well as enabling managers and administrative staff to focus on supporting the pandemic response. During this time MFT continued to acknowledge and act on immediate concerns and after careful consideration, the Trust complaints pause was lifted in a staged approached during May and June 2020.

2.6 Due to the nature of complaints' processes and management, the data fluctuates from day to day as complaints progress through the process and this can influence the numbers reported within anyone reporting period. Small variances within monthly, quarterly, and annual reporting are therefore expected and accepted.

2.7 As a measure of performance, the number of complaints should be considered in the context of organisational activity. **Table 1** below shows the number of complaints in the context of Inpatients, Outpatients and Emergency Department attendances for 2020/21 compared to 2019/20. These data show a reduction in number of complaints in all three areas associated with the reduced patient episodes, however, the rate per 1,000 FCEs remained similar to 2019/20 in inpatient and outpatient areas and a positive reduction was seen in emergency departments.

Table 1: Complaints received in context of activity

		2019/20	**2020/21**
Inpatient	Complaints Received	523	419
	Finished Consultant Episodes (FCE)	431,667	337,049
	Rate of complaints per 1000 FCEs	1.21	1.24
Outpatient	Complaints Received	711	380
	Number of Appointments	2,541,377	1,293,384
	Rate of complaints per 1000 Appointments	0.28	0.29
A&E	Complaints Received	191	105
	Number of Attendances	413,741	267,867
	Rate of complaints per 1000 attendances	0.46	0.39

2.8 The Trust has an internal target of no more than 20% of unresolved cases being over 41 days old at any one time. This allows the Trust to investigate complex complaints, which may involve multiple organisations as well as allowing sufficient time to undertake High Level Investigations (HLI) where appropriate.

2.9 At the end of March 2021, **19.3%** of cases were over 41 days, compared to **22.9%** at the end of March 2020. This represents a **3.6%** decrease in unresolved cases over 41 days old. All cases over 41 working days old continue to be escalated within the relevant Hospital/MCS/LCO and assurance is provided via the monthly Accountability Oversight Framework (AOF).

2.10 The average response rate for patients and carers raising a concern through PALS was **4.3** days during 2020/21, compared with **4.5** days during 2019/20.

2.11 The national statutory requirement for the acknowledgement of complaints, according to the NHS Complaints Regulations (2009) is to acknowledge 100% of all complaints no later than 3 working days after the complaints are received. Throughout 2020/21, **100%** was achieved.

2.12 The Parliamentary and Health Service Ombudsman (PHSO) represents the final stage of the NHS complaints process and the Trust works together with the PHSO to ensure that all feedback and lessons learnt from complaints contribute to service improvement throughout the year.

2.13 The PHSO closed **2** cases pertaining to the Trust between 1st April 2020 and 31st March 2021; of these; **1** complaint was partly upheld and **1** was not upheld. The details of the **2** PHSO cases are set out in this report (Section 12). This position compares to **17** cases closed in 2019/20 when **1** complaint was upheld, **7** cases were partly upheld, and **9** cases were not upheld. It should be noted that at the time of the evolving Covid-19 pandemic, the PHSO advised that it was taking them longer than usual to investigate health complaints. MFT had **9** cases under investigation by the PHSO at the end of March 2021, compared to **7** at the end of March 2020.

2.14 WTWA is the Hospital/MCS with the highest level of activity within the MFT Group and received the highest number of complaints in 2020/21, with **317** (**29.9%**) out of a total of **1,059**. This represents a decrease of **198** complaints received when compared to **515** in 2019/20.

2.15 MRI received the highest number of PALS concerns with **1,458** (**29.7%**) out of a total of **4,900**. This compares to **1,531** (**25.9%**) PALS concerns received in 2019/20, which is a decrease of **73** cases.

2.16 The oldest complaint case recorded as closed during 2020/21 was received by Corporate Services. The case was opened on 15th July 2019 and the case was **208** days old when it was closed on 12th June 2020. The complaint involved a staff member who was absent from work long term resulting in a delay in the complaints investigation process. The complainant was kept updated and fully supported throughout the process.

2.17 A significant focus and work to deliver improvements in 2020/21, has specifically demonstrated:

- The average response rate of complaints responded to within the agreed timescale has **improved** from **86.6%** in March 2020 compared to **88.1%** in March 2021.

- The number of re-opened complaints during 2020/21 was **248** (**19.0%**), representing an improvement when compared to **331** (**16.9%**) re-opened in 2019/20.

3. Complaints Review Scrutiny Group

3.1 The Complaints Review Scrutiny Group demonstrates Board level engagement and assurance regarding complaints handling through the Non-Executive Director Chair. This role is complimented by other core group members, which include a Trust Governor, an Associate Medical Director, the Head of Nursing (Patient Experience) and the Trust's Head of Customer Services. The group met three times in total during 2020/21 and reviewed **8** cases involving **6** Hospitals/MCS/LCOs across MFT.

For each participating Hospital/MCS/LCO and presented case, an evaluation of the effectiveness of actions taken and a progress review of any actions from the previous occasion was undertaken.

4. Complaints Improvement Programme

4.1 The Trust is committed to the delivery of continuous improvement in all aspects of the complaints process and to this end an annual improvement plan is developed and implemented. The Head of Nursing (Patient Experience) has continued to work with the Head of Customer Services, the PALS and Complaints Teams and the Hospital/MCS/LCO Teams to continue to identify and deliver improvements to the management of PALS and Complaints within the Trust.

4.2 Significant improvements delivered in 2020/21 include:

- 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

5. Learning

5.2 This 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 Board of Directors Quarterly Complaints Report.

6. People

6.1 The Trust is grateful to those patients and families who have taken the time to raise concerns and acknowledges their contribution to improving services, patient experience and patient safety.

6.2 The Trust would like to apologise to all those people who have had cause to raise concerns. We are committed to continually improving our services and acknowledge that whilst we do not always get it right, we believe that this report demonstrates the learning and changes we make as a direct result.

6.3 The Trust is committed to being open and honest and thank our staff for their openness and candour when undertaking investigations.

7. Recommendation

7.1 The Board of Directors is asked to note the content of this report and in line with statutory requirements provide approval for it to be published on the Trust's website.

Contents

1. Statement

1.1 The Trust adheres to the Statutory Instruments No. 309 which requires NHS bodies to provide an annual report on its complaints handling, which must be made available to the public under the NHS Complaints Regulations (2009)[1]. This annual report reflects all complaints and concerns made by (or on behalf of) patients of the Trust, received between 1st April 2020 and 31st March 2021.

2. Introduction

2.1 This report sets out achievements and improvements, whilst acknowledging that there are further improvements required in the context of continuous improvement.

2.2 Throughout this report the term **Complaints** is used to describe formal complaints requiring a response from the Chief Executives/Group Chief Executive and the term **Concerns** is used to describe informal contact with PALS requiring a speedier resolution to issues that may be resolved in real time.

2.3 The quality of complaints data reporting has continued to improve throughout 2020/21 and comparative data is provided within the report.

2.4 Due to the nature of the complaints' processes and management, the data fluctuates from day to day as complaints progress through the process; this can influence the accuracy of the numbers reported within anyone reporting period. For example, once a complaint has been received and registered, it may be withdrawn, de-escalated, identified as being out of time, or consent may not be received. Small variances within monthly, quarterly, and annual reporting are therefore expected and accepted.

2.5 It should be noted that NHS England and NHS Improvement provided guidance in March 2020 in relation to complaint handling, which resulted in a system-wide pause in the NHS complaints process. The purpose of the pause was to release the time of clinical staff to deliver direct clinical care as well as enabling managers and administrative staff to focus on supporting the pandemic response. During this time MFT continued to acknowledge complaints and act on immediate concerns and after careful consideration, the Trust complaints pause was lifted in a staged approached during May and June 2020.

3. Overview of Activity

3.1 The number of PALS concerns received for 2020/21 was **4,900**, which is **997** less than the number received in 2019/20 (**5,897**). This demonstrates a 16.9% decrease in the number of PALS concerns received during the last year. It is important to note however, that this significant reduction coincides with the Covid-19 pandemic and the reduced clinical activity across all Trust.

3.2 The number of PALS concerns in January, February and March 2021, has demonstrated a gradual increase; it is likely that this increase can be attributed to the increase in clinical activity across the Trust as part of the recovery following the initial pandemic response.

3.3 **Graph 1** provides the number of PALS concerns received by month for the financial year 2020/21.

Graph 1: Number of PALS contacts (by month) for 2020/21, MFT

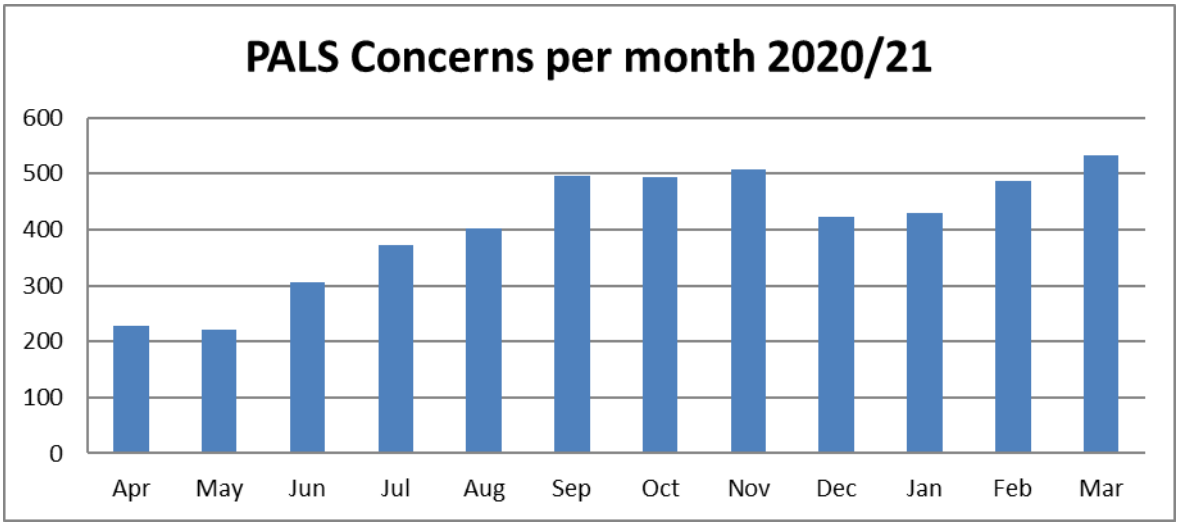


Table 2: Number of PALS contacts by Hospital/ MCS/ LCO

Hospital / MCS / LCO	2019/20	2020/21
Clinical Scientific Services (CSS)	335	303
Corporate Services	298	211
Manchester & Trafford Local Care Organisation (LCO)	52	82
Manchester Royal Infirmary (MRI)	1,531	1,458
Research & Innovation (R&I)	15	6
Royal Manchester Children's Hospital (RMCH)	621	432
Saint Mary's Hospital (SMH)	526	673
University Dental Hospital of Manchester (UDHM) / Manchester Royal Eye Hospital (MREH)	447	384
Wythenshawe, Trafford, Withington, and Altrincham (WTWA)	1,920	1,351
Not Stated / General Enquiry / Non-MFT	19	0
MFT Total	**5,897**	**4,900**

3.4 **Table 2** above demonstrates that the MRI received the highest number of PALS concerns, **1,458** out of a total of **4,900** (29.7%). This is a decrease of **73** cases from same reporting period in 2019/20 data when **1,531** (25.9%) were received by MRI.

3.5 WTWA received the second largest number of PALS concerns with 1**,351** out of a total of **4,900** (**27.6%**). This is a decrease of **569** cases from the same reporting period in 2019/20 when **1,920** (**32.5%**) were received.

3.6 As WTWA and MRI are the largest services in the Trust, it is expected that these two areas would receive the greatest proportion of PALS concerns.

3.7 All PALS concerns are RAG rated upon receipt based on the severity of the initial details of the concerns raised. **Table 3** below indicates the number of MFT contacts by risk rating grade. Analysis shows that 2020/21 has seen a significant decrease in the number of PALS concerns rated in all 3 categories. Of the **5** PALS concerns rated as amber:

1 = a breach patient confidentiality
1 = treatment/procedure
1 = an appointment delay (outpatient)
1 = delay/failure to recognise complication
1 = information request.

This position compares to **68** PALS concerns rated as amber in 2019/20.

Table 3: 2020/21 PALS contacts by risk grading, MFT

Category	2019/20	2020/21
Green	4,420	4,202
Yellow	933	532
Amber	68	5
Red	2	0
Not graded, escalated or enquiry	474	161
MFT Total	**5,897**	**4,900**

3.8 In this report year, the total number of PALS concerns includes those cases that were escalated for formal investigation (these are reported in Section 4 of this report), were withdrawn by the complainant or were considered to be out of time according to the NHS Complaints Regulation (2009)[1] timescales.

3.9 **Tables 4 to 7** are presented in **Appendix 1**. These tables indicate how people access the PALS and provide information about their demographics.

3.10 **Table 4** shows that the number of concerns raised face to face has decreased from **472** in 2019/20 to **97** in 2020/21: this is a decrease of 79.4%. This significant reduction coincides with the Trust's response to the pandemic and the necessary restrictions on normal visiting arrangements. The number of concerns raised by email and telephone continues to be the most favoured route of contact.

3.11 **Table 5** in **Appendix 1** details the number of contacts by age: the age range relates to the people who were the focus of the PALS concern as opposed to the person raising the concern.

3.12 **Table 6** in **Appendix 1** details the number of contacts by gender; again, the gender relates to the people who were the focus of the PALS concern. **Table 7** in **Appendix 1** describes the ethnicity of the patients who were the focus of the PALS enquiry.

3.13 The demographic data for PALS concerns presented within **Appendix 1** supports the findings[2] that younger people (or their parents) are more likely to express dissatisfaction with services than older people and that women more likely to express dissatisfaction with services than other sexes.

3.14 The percentage of people who did not state their ethnicity for PALS concerns has continued to increase from 48.0% in 2019/20 to 53.1% in 2020/21. Work has continued throughout this annual report year to improve the quality of this data to enable continued development of a responsive service: further information is detailed in Section 15 of this report.

[2] DeCourcy, West and Barron (2012) The National Adult Inpatient Survey conducted in the English National Health Service from 2002 to 2009: how have the data been used and what do we know as a result? BMC Health Services Research series: Open, Inclusive and Trusted 2012 12:71

3.15 **Graph 2** and **Table 8** provide a more detailed analysis of the main PALS themes and indicates that the greatest proportion of PALS concerns relate to treatment and procedure, communication and appointment delays/cancellations.

Graph 2: Top 5 PALS Themes 2020/21, MFT

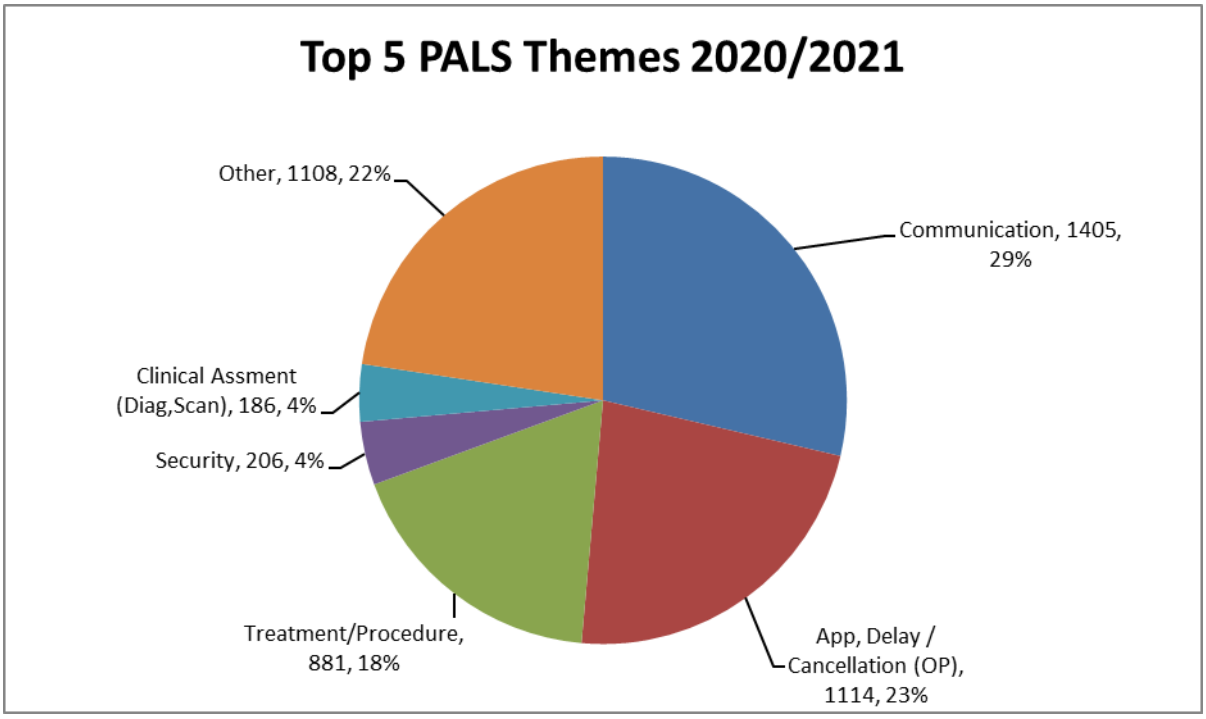


Table 8: Comparison of Top 5 PALS Themes**,** MFT

	2019/20	2020/21
1.	Communication	Communication
2.	Appointment Delay / Cancellation	Appointment Delay / Cancellation
3.	Treatment / Procedure	Treatment / Procedure
4.	Clinical Assessment (Diagnosis, Scan)	Security
5.	Attitude of Staff	Clinical Assessment (Diagnosis, Scan)

3.16 The average response rate for patients and carers raising a concern through PALS at MFT was **4.3** days during 2020/21, compared with **4.5** days during 2019/20.

4 Complaints Activity

4.1 The number of complaints has decreased in 2020/21 compared to the 2019/20 data. This year there were a total of **1,059** complaints received, compared to **1,628** in 2019/20, this is a decrease of 34.9%.

4.2 In response to Covid-19 and after careful consideration, the Trust's short 'pause' in complaints management was lifted in a staged approached during May and June 2020.

4.3 During 2020/21 the pandemic affected the type and number of complaints received by the Trust, with an unsurprising rise in concerns and complaints relating to Covid-19 in outpatient services.

Table 9: Number of Complaints, MFT

Year	2019/20	2020/21
Complaints Received	1,628	1,059

4.4 WTWA received the most complaints **317:** this represents a decrease of **38.4%** compared to the **515** received in 2019/20. The themes identified for WTWA were 'Treatment and Procedure, 'Communication' and 'Clinical Assessment'.

4.5 UDHM/MREH received **39** complaints this annual report year: this represents a reduction of **59.4%** compared to the **96** received in 2019/20. Worthy of note, however, is that where services are dealing with a smaller number of complaints this can appear to have a larger impact when these figures are presented as percentages.

4.6 **Table 10** below details the 2-year trend for complaints at Hospital/MCS and LCO level

Table 10: Number of complaints by Hospital/ MCS and LCO

Hospital / MCS / LCO	2019/20	2020/21
Clinical Scientific Services (CSS)	103	67
Corporate Services	68	44
Manchester & Trafford Local Care Organisation (LCO)	44	38
Manchester Royal Infirmary (MRI)	419	283
Research & Innovation (R&I)	0	0
Royal Manchester Children's Hospital (RMCH)	189	111
Saint Mary's Hospital (SMH)	194	160
University Dental Hospital of Manchester (UDHM)/ Manchester Royal Eye Hospital (MREH)	96	39
Wythenshawe, Trafford, Withington and Altrincham (WTWA)	515	317
Not Stated / General Enquiry / Non-MFT	0	0
MFT Total	**1,628**	**1,059**

4.7 Complaints are risk rated using a matrix aligned to that used to assess the severity of incidents within the Trust. This matrix assigns a level of Red, Amber, Yellow or Green dependent upon the risk score.

4.8 When compared to 2019/20, the numbers of Red, Amber and Green complaint cases received in 2020/21 have decreased. Yellow cases decreased by **28%** from **903** in 2019/20 to **650** in 2020/21. Of the **4** rated as Red in 2020/21:

- **2** relate to treatment/procedure
- 1 relates to appointment delay/cancellation (outpatient)
- 1 relates to communication.

4.9 **Table 11**, presented in **Appendix 2**, provides the breakdown of the risk rating of complaints for 2020/21 compared to 2019/20.

4.10 Equality monitoring data is collected in relationship to complainants' protected characteristics. Complainants are requested to provide information regarding their protected characteristics when they receive a written acknowledgement in response to a complaint; this information is presented within **Tables 12** to **14** in **Appendix 2**.

4.11 The age and gender of the patients involved in complaints during 2019/20 and 2020/21 are highlighted in **Tables 12** and **13** in **Appendix 2**. **Table 14** describes the ethnicity of the patients represented in complaints for the past 2 fiscal years.

As described above, work continued throughout 2020/21 to improve the quality of this data and further information is detailed in Section 15 of this report.

4.12 The demographic data for complaints presented within **Appendix 2**, supports the findings[2] that younger people (or their parents) are more likely to express dissatisfaction with services, and women are more likely to express dissatisfaction with services than other sexes.

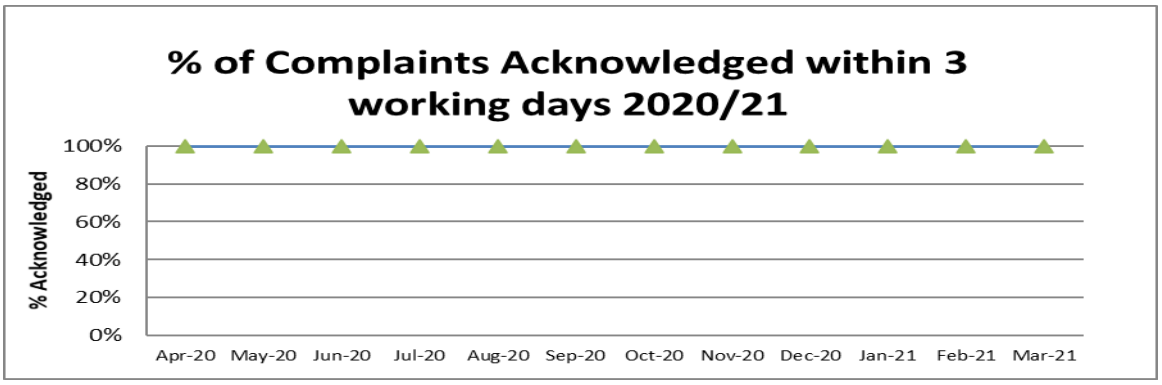
4.13 In respect of complaints, the percentage of people who did not declare their ethnicity has continued to improve, reducing from **21.3%** in 2019/20 to **18.4%** in 2020/21.

5 Acknowledging Complaints

5.1 The NHS Complaints Regulations (2009)[1] place a statutory duty upon the Trust to acknowledge 100% of complaints within 3 working days (**Graph 3**).

5.2 Complaints requiring acknowledgement include those which are withdrawn, those where consent or required information is not received, and those that are de-escalated or are deemed 'out of time' under the 2009 NHS Complaints Regulations.[1] Throughout 2020/2021, as in 2019/20, **100%** performance was achieved in all 12 months of the fiscal year.

Graph 3: Percentage of complaints acknowledged ≤ 3 working days during 2020/21, MFT



6 Response Times

6.1 The Trust target of resolving **80%** of complaints within 25 working days continues to be monitored closely. Based on the complexity of complaints and the Trust's Complaints Triage Process, all 'High and Medium' category complaints are allocated 40 or 60 working day timeframes. **Table 15** and **Graph 4** provide a breakdown of performance in 2020/21.

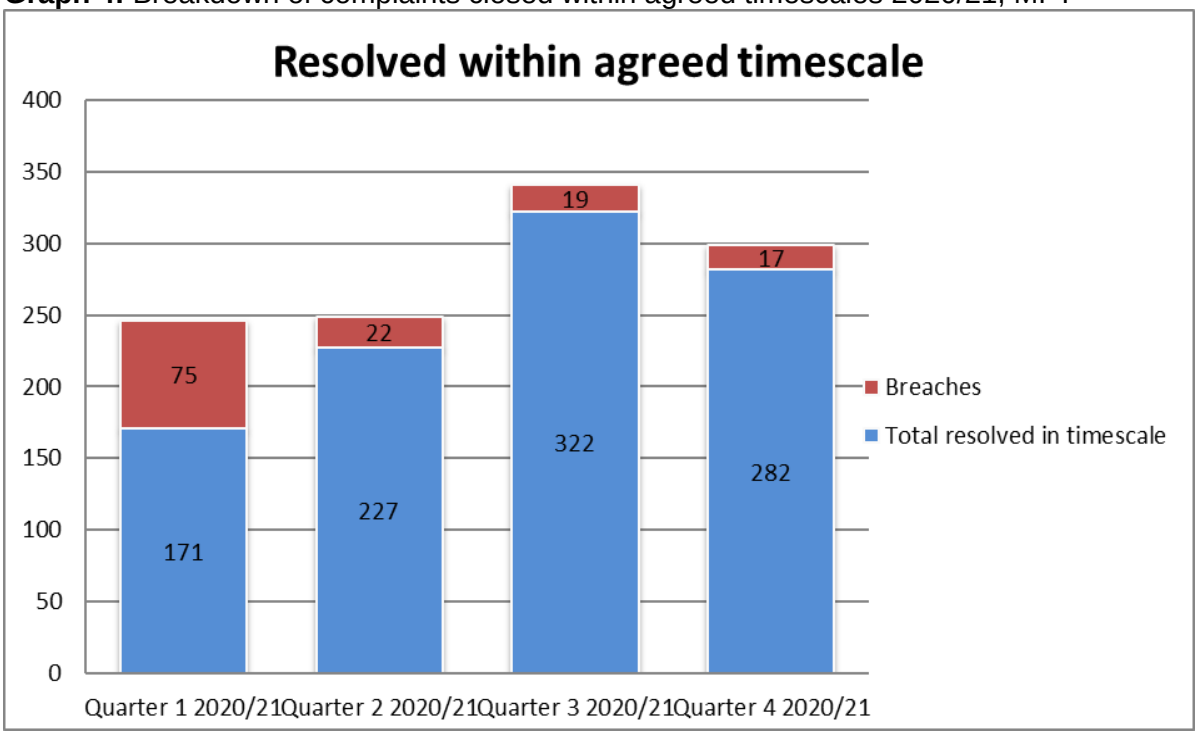
6.2 The Trust's performance in response times (**Table 15**) has been variable throughout the year with **810** (**71.36%**) complaints responded to in 0-25 working days, **108** (**9.52%**) being resolved in 26-40 days and **217** (**19.12%)** responded to in 41+ days. **26** complaints exceeded 100 days due to their complexity.

6.3 As in 2019/20, focus throughout 2020/21 has been to continuously deliver improvements in response times. In March 2021, **282** (**94.3%**) of complaints were responded to within the agreed timescale, compared to **171** (**69.5%)** in April 2020 (**Graph 4**). The continued focus and work on improvements has resulted in a continuously improving trend, therefore the current strategy for improvement will continue into 2021/22.

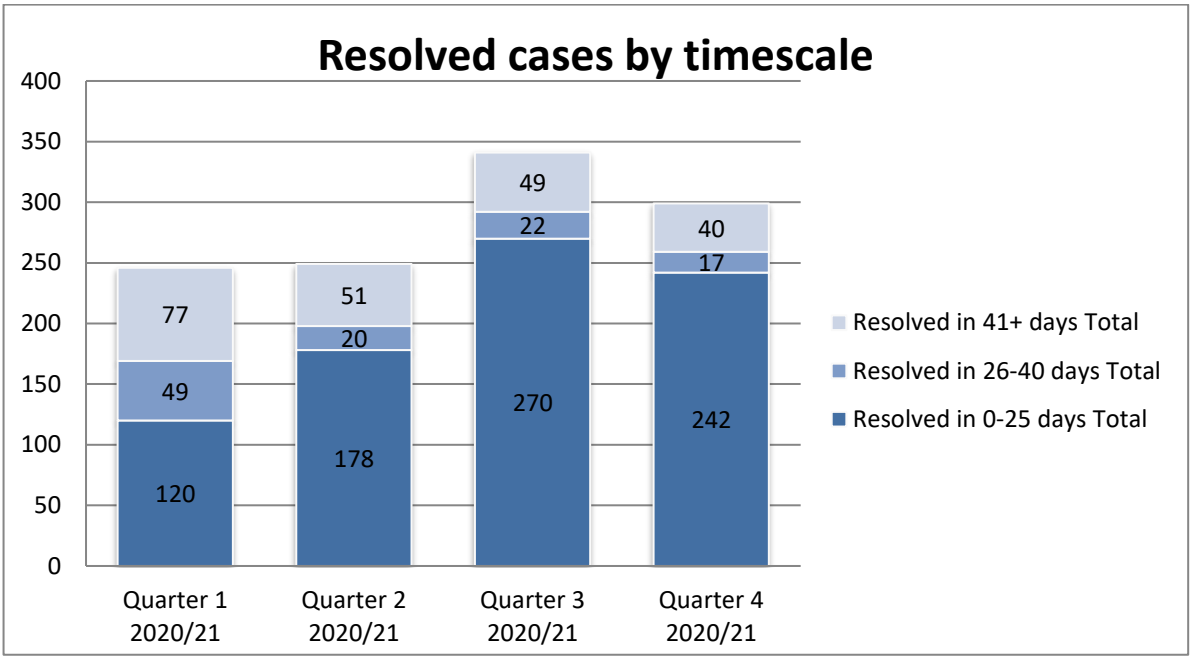
Table 15: Comparison of complaints resolved by timeframes, 2020/21, MFT

		2020/21
Complaints resolved	New Reopened **Total**	907 228 **1135**
Resolved in 0-25 days	New Reopened **Total**	650 160 **810**
Resolved in 26-40 days	New Reopened **Total**	91 17 **108**
Resolved in 41+ days	New Reopened **Total**	166 51 **217**
Total resolved in timescale		**1002**
Breaches		**133**
Total resolved		**1135**

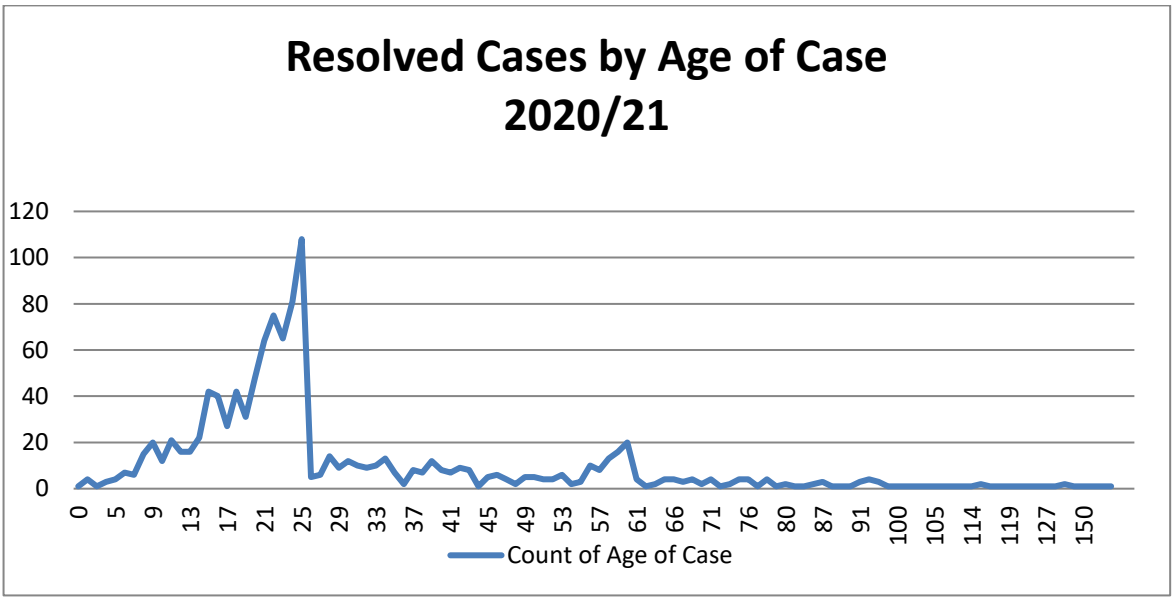
Graph 4: Breakdown of complaints closed within agreed timescales 2020/21, MFT



6.4 **Graph 5** shows the overall performance in relation to response times for complaints closed during 2020/21.



6.5 **Graph 6** then presents a granular level breakdown of the data shown in Graph 5.

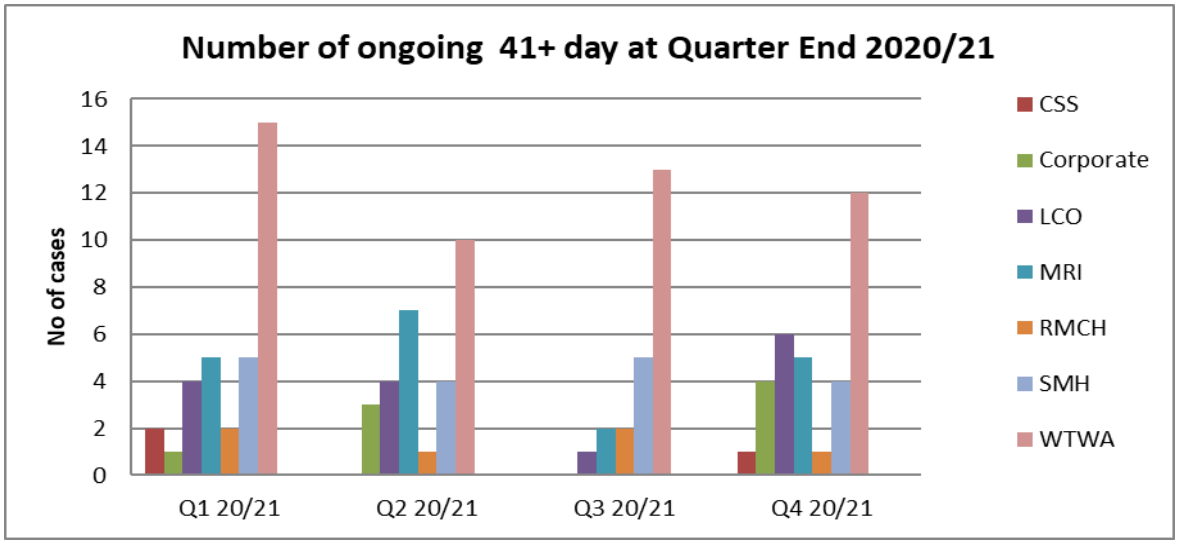


On-going Complaints

6.6 As in 2019/20 there has been a continued focus throughout 2020/21 on managing the number of open complaints that were over 41 working days old. At the beginning of April 2020, **55** (**23%**) of the total number of open cases (**240**) Trust-wide that were unresolved over 41 days. However, this figure did reduce throughout the year, ranging from **34** open cases at the end of June 2020, **29** at the end of September 2020, and **33** (**19.3%**) of open cases (**171**) at the end of March 2021.

6.7 **Graph 7** shows the number of open complaints, by Hospital/MCS/LCO unresolved after 41 days at the end of each quarter of 2020/21 and demonstrates a continued decrease in Q1, Q2 and Q3, and a slight increase in Q4, 2020/21.

Graph 7: Open complaints by Hospital/MCS and LCO unresolved after 41 days at the end of each quarter 2020/21.



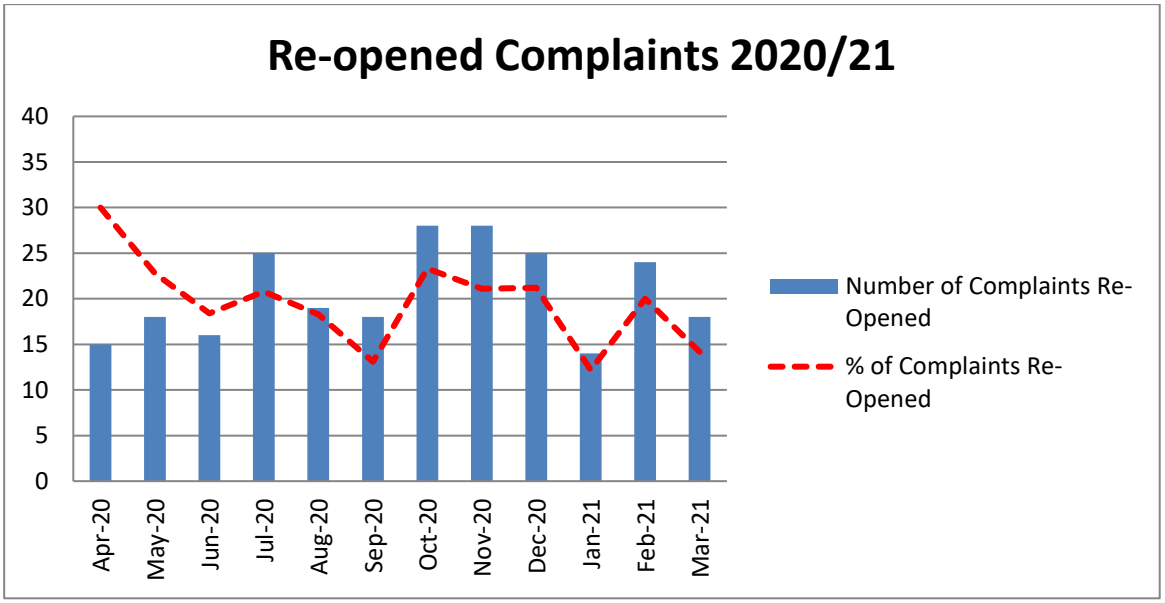
	Number of ongoing 41+ day cases at Quarter end 2020/21			
	Q1 20/21	**Q2 20/21**	**Q3 20/21**	**Q4 20/21**
Corporate	1	3	0	4
CSS	2	0	0	1
UDHM / MREH	0	0	0	0
MRI	5	7	2	5
RMCH	2	1	2	1
SMH	5	4	5	4
WTWA	15	10	13	12
LCO	4	4	1	6
MFT Total	**34**	**29**	**23**	**33**

6.8 All cases over 41 working days are monitored at Group level via the AOF, which informs the decision-making rights of Hospital/MCS and LCO Chief Executives and their teams.

6.9 The oldest case closed during 2020/21 was received by Corporate Services. The case was opened in July 2019 and the case was 208 days old when it was closed in June 2020. The complaint involved a Level 3 High Level Investigation within Corporate Services and MRI. Delays relating to staff availability due to absence impacted the response time. The complainant was kept updated and fully supported throughout the process.

6.10 Further contact from complainants after receipt of the Trust's written response is recorded as being re-opened and provides an indication of the quality and completeness of the response. A total of **248** (**19%**) cases were re-opened during 2020/21. This compares to **331** (**16.9%**) re-opened in 2019/20.

6.11 **Graph 8** details the number of re-opened complaints by month during 2020/21, MFT

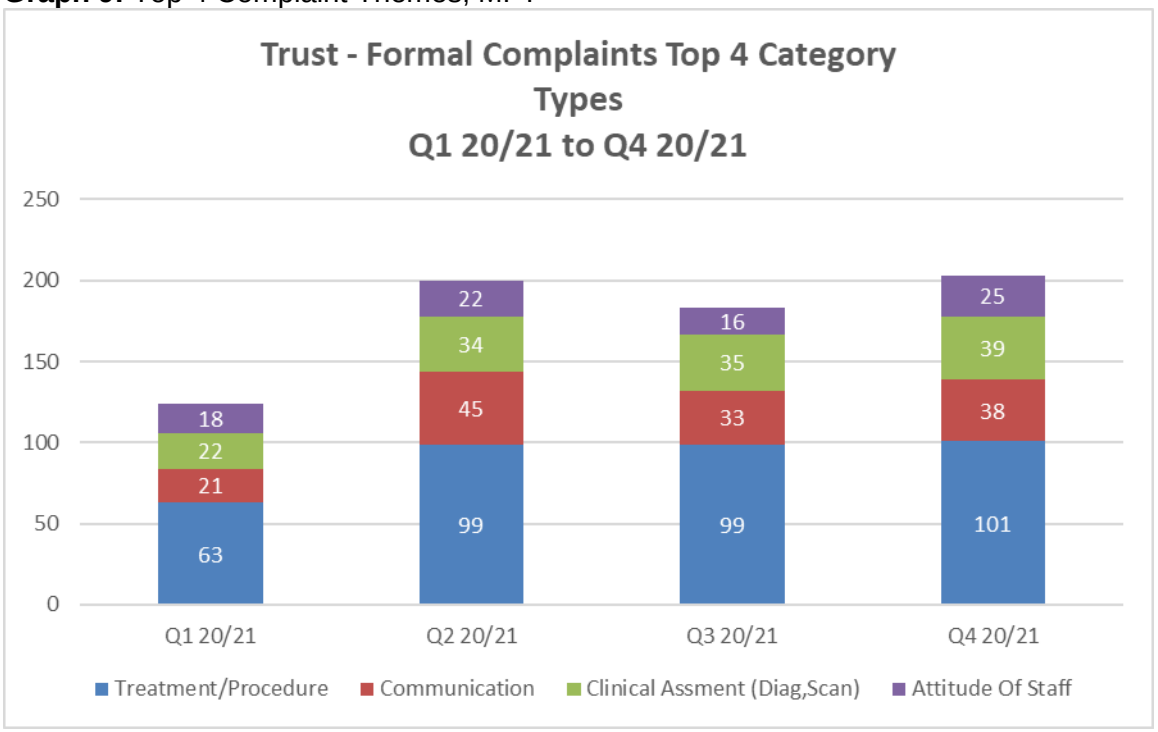


7 Themes

7.1 The themes and trends from complaints are reviewed at several levels across MFT. Each Hospital/MCS and LCO consider local complaints on a regular basis as part of their weekly complaints review meetings and the monthly Quality and Clinical Effectiveness Forums. Further analysis of complaint themes and trends is provided in the quarterly complaints reports to the Board of Directors.

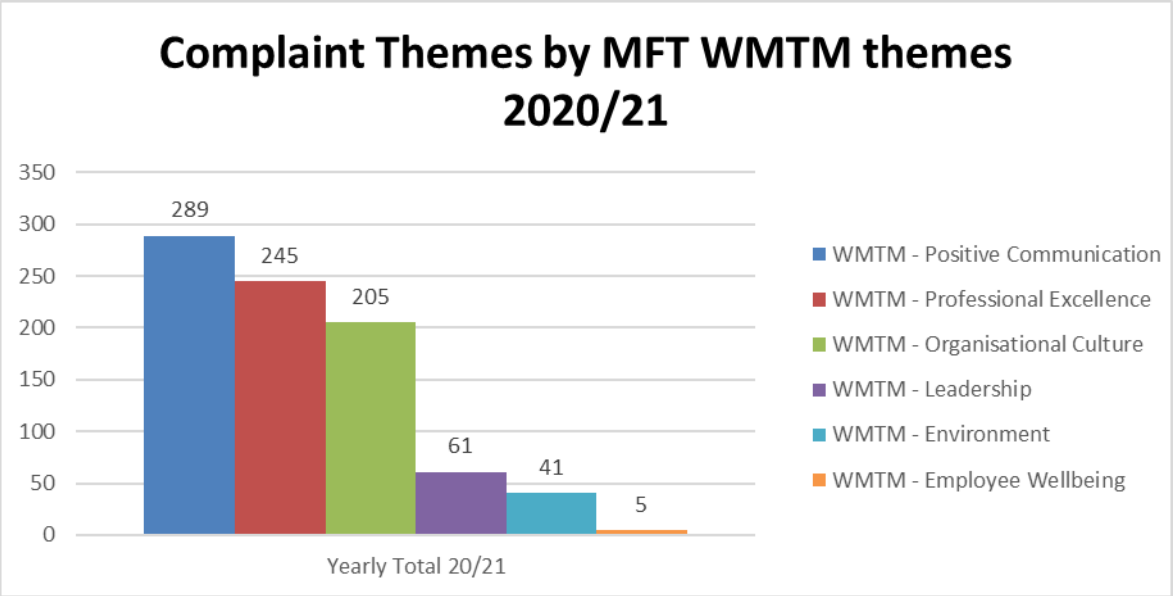
7.2 **Graph 9** below demonstrates the 4 most prevalent categories of issues raised in 2020/21.

Graph 9: Top 4 Complaint Themes, MFT



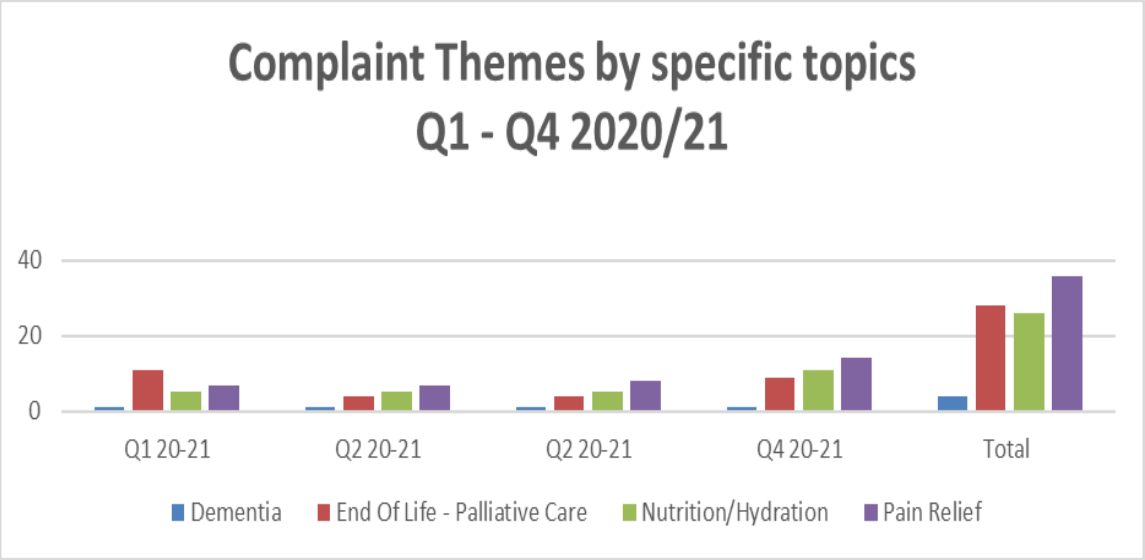
7.3 Theming of complaints to the Trust's "*What Matters to Me*" patient experience themes: **Positive Communication, Environment, Organisational Culture, Professional Excellence, Leader, Employee Wellbeing** continued during 2020/21 and these are shown in **Graph 10** below. Following an audit of closed cases, during 2020/21 the Corporate Complaints team re-evaluated how the WMTM categories were mapped on the Trust's Customer Services module. This has resulted in the enhancement of data collection within the existing process showing significant improvement in the collection of the Trust-wide themes that relate to the MFT WMTM categories being drawn from complaints with a total of **846** WMTM themes identified during 2020/21 compared to **209** in 2019/20. These data provide a focus for improvement activity.

Graph 10: Complaints – Theming of complaints to MFT WMTM themes, 2020/21



7.4 The mapping and tracking of complaints to specific aspects of care has also continued during 2020/21. **Graph 11** below provides a more detailed analysis of the number of MFT complaints relating to dementia, pain relief, end of life care and nutrition and hydration, and demonstrates an increase in complaints relating to pain relief and nutrition and hydration. In 2021/22, processes will be established to strengthen use of this analysis to inform improvement activity.

Graph 11: Complaints themes by specific topics



	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21
Dementia	1	1	1	1
End of Life – Palliative Care	11	4	4	9
Nutrition & Hydration	5	5	5	11
Pain Relief	7	7	8	14
MFT Total	**24**	**17**	**18**	**35**

7.5 In addition to the continuing capture of complaints relating to dementia, pain relief, end of life care and nutrition and hydration, during 2021/22, learning disability, cancer care and treatment, outpatient appointment intended but not booked, hospital acquired Covid-19 infection, transfer and safe and effective discharge will also to be captured and used for monitoring and to target improvement activity. This data will be reported in Q1, 2021/22.

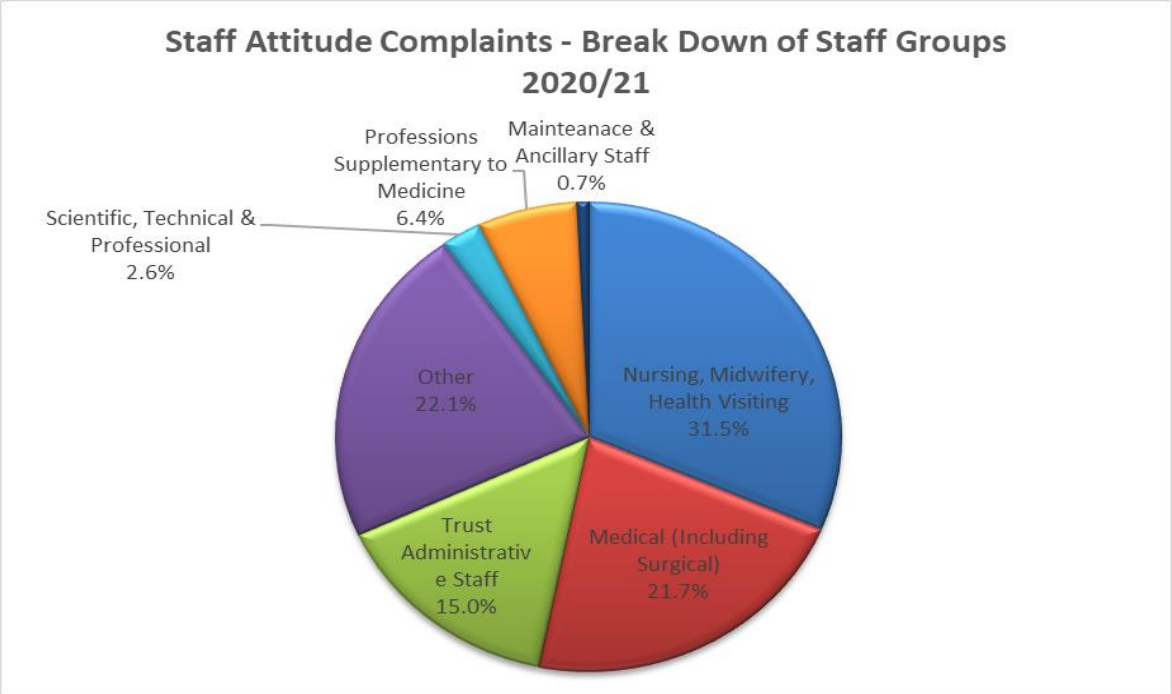
8 Our People

8.1 **Table 16** below provides the number of complaints and PALS concerns that refer to 'staff attitude' whilst **Graph 12**, also below, breaks these down into the staff groups involved.

Table 16: Number of complaints and concerns that refer to staff attitude

Attitude of Staff	2019/20	2020/21
PALS Concerns	247	186
Complaints	121	81
Total	**368**	**267**

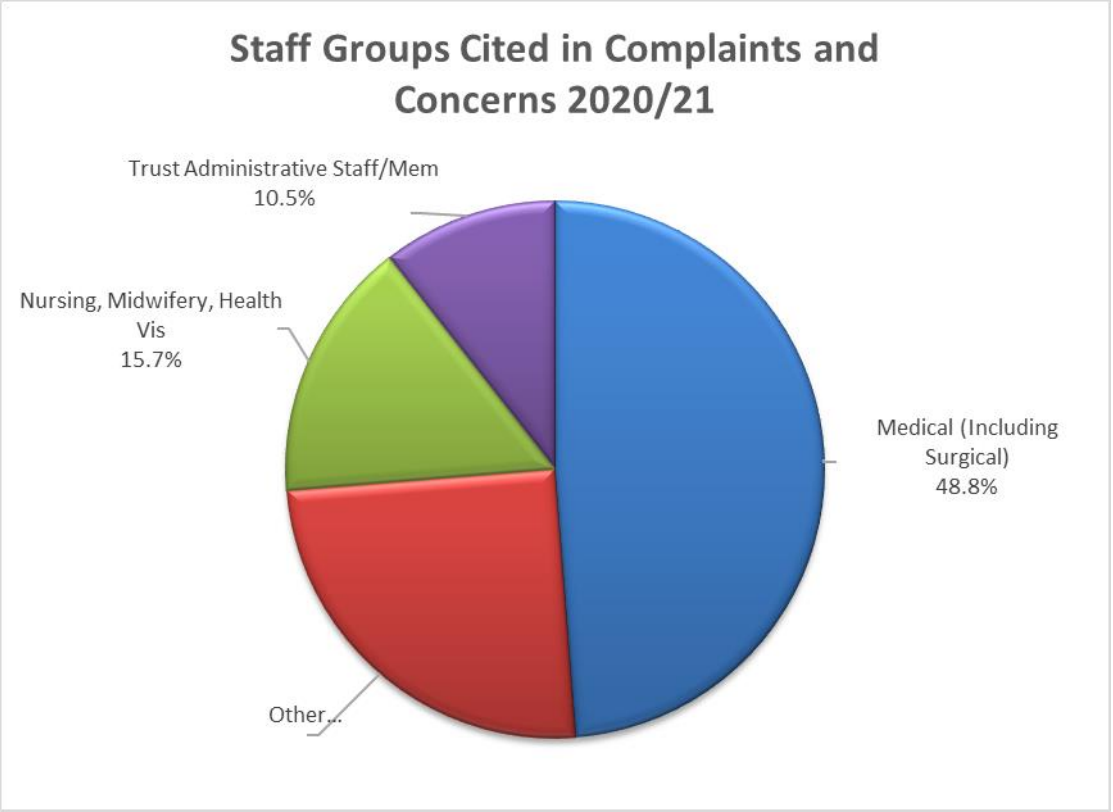
Graph 12: Percentage of complaints and PALS concerns relating to staff attitude by staff group, MFT



8.2 During 2020/21, the number of complaints and PALS concerns received (**5,959**) which cited staff attitude decreased in number to **267** (**4.48%**) compared to **368** (**4.89%)** during 2019/20, it is, however, important to note that this reduction coincides with the Covid-19 pandemic and a reduced level of clinical activity Trust wide. The Trust's Values and Behaviours, "What Matters to Me" Patient Experience framework and Improving Quality Programme (IQP) play a vital role in continuing to reduce concerns relating to attitude, and work will continue throughout 21/22 to map and track this data. The attitude of the nursing, midwifery, health visiting staffing groups was cited in more complaints (**31.5%)** than any other staffing group; notably this is the Trust's largest staff group. In 2020/21 there was an **11.7%** reduction in the number of complaints received citing the attitude of the medical staffing group (**21.7%).** This is a significant reduction when compared to **33.4%** in 2019/20, however as noted above, this reduction can also be attributed to the reduced clinical activity Trust wide.

8.3 **Graph 13** below highlights the top 3 professions referenced in complaints and PALS concerns for any reason. Medical Staff are the highest group referenced with a total of **2,570** complaints, followed by nursing, midwifery, health visiting staff who are referenced in **829** complaints. Whilst recording limitations prevent further analysis of this data to determine whether these references relate to specific grades of medical staff or certain nursing, midwifery or health visiting staff, it is recognised that medical staff are usually the lead practitioner for episodes of care, and nursing, midwifery and health visiting staff are often the first point of contact for patients. It is not, therefore unusual, or unexpected for these staff groups to be cited by patients who wish to make a complaint.

Graph 13 Top 3 most referred to professions in Complaints and PALS concerns, MFT



9 Overview and Scrutiny

9.1 The Trust's Complaints Review Scrutiny Committee is chaired by a Non-Executive Director and is a sub-group of the Group Quality and Safety Committee. Meetings are held every two months.

9.2 The main purpose of the Committee is to review the Trust's complaints processes in a systematic and detailed way through the analysis of actual cases, to ascertain learning that can be applied in order to continuously improve the overall quality of complaints management; with the ultimate aim of improving patient experience.

9.3 In response to Covid-19, the Complaints Review Scrutiny Committee was stepped down during Quarter 1, 2020/21, however during the remainder of 2020/21 the committee met three times in total reviewing eight presented cases involving six Hospitals/MCS/LCOs across MFT.

9.4 The actions agreed at each of the Complaints Review Scrutiny Committee meetings, are recorded and provided to the respective Hospital/MCS/LCO following the meeting in the form of an Action Log, with progress being monitored at subsequent meetings.

9.5 Examples of the learning identified from the cases presented and actions discussed and agreed at the meetings in 2020/21 are outlined in **Table 17** below. All Hospitals/MCS/LCO teams are asked to identify and share transferable learning from the scrutiny process within and across their services.

Table 17: Actions identified at the Complaints Scrutiny Committee during 2020/21

	Hospital/ MCS/LCO	Learning	Actions
Quarter 2	**MRI**	Failure to meet patient's hygiene needs.	Patient Hygiene Quality Improvement Project initiated.
		Live donors feel their care was not as good as it should have been.	Explore gaining and sharing patient feedback via virtual platforms. Post Covid-19 pandemic response: 1.Recommencement of the Improving Quality Programme project once transplant programme restarted. 2.Review introduction/how to improve the Enhanced Recovery Programme. 3.Focus on the need for clear communication with patients (donor + recipient). - Introduce communication pathways with recipient via iPads and co-ordinators.
Quarter 2	**LCO**	Lack of staff knowledge around Ascot House admission criteria.	Continue to work with the Hospitals/MCS to provide a consistent understanding of the admission criteria to Ascot House. Review and consideration to be given to improving the 'pre-screening' documentation. Review and improve the communication process between ward staff &=and the assessor. Review 'Trusted Assessors' training.
		Failure to provide patient with alternative rehabilitation options.	Promote services and create a service profile clearly detailing referral criteria. Establish pathways with nursing teams and discharge co-ordinators.
		Ensure staff can	Routinely review complaints and

		reflect on complaints and support offered to staff who are the subject of complaints.	share learning at team meetings. LCO Head of Governance to provide staff with support through the complaints process as detailed in complaints management policy.
		Ensure lessons are learnt in relation to patient experience by sharing the patient's story.	Patient's poor experience shared individually with identified clinical staff. The patient's story to be filmed and shared with the relevant teams.
Quarter 2	**SMH**	Inadequate escalation of patient's condition and concerns.	Maternity Bleep Holder Guideline introduced at Wythenshawe Hospital ensuring a 'helicopter' view of activity and escalation of women requiring senior reviews. Four hourly ward rounds with senior midwife and multi-disciplinary team (MDT) oversight to be implemented. Pain management review undertaken. Obstetric Triage process (BSOTS) introduced to support escalation of women that require senior review.
		Poor understanding of maternal viewpoint and needs. Communicate WMTM with women.	WMTM principles introduced into day to day practice. Raise staff awareness of complaints and PALS concerns and provide support to manage and de-escalate situations. Increase Local Resolution/Tell us Today events. Link activity with Commitment 4 of the Patient Engagement and Involvement Strategy.
Quarter 2	**RMCH**	Junior Nursing Staff are exposed to challenging conversations.	Provide education and training in relation to dealing with conflict.

		Communication is a recurring theme within the Paediatric Haematology/Oncology Service.	Establish the vision and develop the implementation of the **'Always Event' Programme.**
Quarter 3	**WTWA**	Communication breakdown with the family whilst the patient was on the ward.	Embed virtual visiting. Develop/enhance process the of offering/providing families time to meet with the clinical team caring for the patient should they have any concerns they wish to discuss in person.
		Poor quality and minimal information provided within the patient's electronic discharge.	Discuss at Directorate meetings – Explore pursuing electronic discharges via voice recorder. Undertake an audit to define the best standards and criteria.
		The consultant's offer to meet with the family not shared within the two written complaint responses.	All staff involved/providing comment/s to the complaint investigation to review the written response prior to final Divisional quality assurance.
		MDT input not sought as part of the complaint investigation. - Ineffective scoping of complaint upon receipt in the Division.	Lead Investigator for each complaint to have delegated authority to take ownership and responsibility for the complaint, including establishing and confirming the relevant staff/teams required to comment.
		Brusque words used in final paragraph of the written complaint responses.	Ensure wording is softened when appropriate. With the support of the Corporate Complaints team undertake audits using the Complaint Quality Standards Checklist.
Quarter 3	**CSS**	Poor communication in relation to: - Patient's feelings not listened to. - MDT discharge plans and Discharge to Assess referral.	Staff member to undertake Communication Training. Discuss complaint anonymously at the local team meeting. Discuss with the Therapy team the importance of verbal and written

			discharge communication. Therapy Discharge/Flow Champions identified to link in with the LCO therapist to work on the Discharge Pathway. – Explore how this can be implemented for the whole of MFT.
		Tone and content in a written complaint response fell short of expected standard.	Share written response and audit outcome with the Allied Healthcare Professionals team and discuss the expected standards. With the support of the Corporate Complaints team embed and increase frequency of the undertaking of the Complaint Quality Standards Checklist audits. Staff to undertake Complaints Training. Improve cross reference of responses with the original complaint ensuring each question is responded to fully.
		Nursing input not sought as part of the complaint investigation. - Ineffective scoping of complaint upon receipt in the MCS/Division.	Lead Investigator for each complaint to have delegated authority to take ownership and responsibility for the complaint, including establishing and confirming the relevant staff/teams/departments required to comment.
Quarter 4	**WTWA (Medicine)**	Communication breakdown with the medical team when the patient was re-admitted.	Process of reviewing discharge checklist to be developed.
		Timely administration of time specific medications.	Undertake an audit of monitoring and education.
		Multiple ward moves impacted on patient's care.	Review to be undertaken to improve communication standards between the Bed Managers and clinicians.

		Patient re-admitted one week following discharge – failed discharge.	Staff to undertake pre-discharge blood glucose monitoring training. With the support of Clinical Governance explore patients bringing in their own blood glucose equipment to hospital.
		Junior staff in attendance at a complaint local resolution meeting (CLRM) - Unknown CLRM procedure/expectations . - Senior support not sought as part of CLRM.	Explore stress inoculation therapy (SIT) for staff attending CLRM's. Explore mediators chairing the CLRM's. Explore and develop Complaints Meeting Training - 'Effective Complaint Local Resolution Meetings – Expectations and best practice for staff'.
Quarter 4	**WTWA (Heart & Lung)**	Disjointed communications between the family, Hospital Complaints Investigating team and the MCS High Level Investigating (HLI) team.	Explore and develop process for undertaking combined complaint investigations and HLI's across multi Hospital/ MCS/ LCO boundaries. In-conjunction with developing triangulation process for complaint investigations and HLI's, review and develop clear processes for the role of the Family Liaison Officer (FLO) where there is multi Hospital/MCS/LCO involvement. Review how HLI findings are shared with families.

9.6 In addition to the scrutiny described above, complaints would normally also be reviewed within the accreditation process to assess if teams are aware of complaints specific to their area and to examine what actions have been taken and what changes have been embedded to improve services. In response to Covid-19, the Trust paused the accreditation process in 2020/21, however, this was replaced by an assurance process in which complaints activity continued to be scrutinised.

9.7 Complaints are also triangulated with feedback received through a number of different processes including the Friends and Family Test (FFT), National Survey data, the Care Opinion and NHS Websites and the Trust's real time "**What Matters to Me"** Patient Experience surveys in order to identify and act upon any trends.

10 Patient Experience Feedback

10.1 Care Opinion and NHS Website Feedback

Care Opinion is an independent healthcare feedback platform service whose objective is to promote honest conversations about patient experience between patients and health services. 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 that they have received. The Care Quality Commission[3] (CQC) utilises information from both websites to help monitor the quality of services provided by the Trust.

10.2 There has been a significant decrease from **201** postings in 2019/20 to **98** postings in 2020/21 (**51.2%).** The number of posts on these websites by category; positive, negative, and mixed negative comments, are detailed in **Table 18** below**.** These data demonstrate that most comments received in 2020/21 were again positive (**73.5%** 2020/19 compared to **64.7%** in 2019/20). **18.4%** of the comments related to a negative experience in respect of Trust services, however, this is a positive decrease of **7.0%** compared to 2019/20 when **25.4%** of comments were categorised as negative.

Table 18 Number of Care Opinion postings by Hospital/MCS and LCO 2020/21

Number of Patient Opinion Postings received by Hospital/MCS/LCO 2020/21			
Hospital/MCS/LCO	**Positive**	**Negative**	**Mixed**
Clinical Scientific Services (CSS)	1	0	0
Corporate Services	0	0	0
Manchester & Trafford Local Care Organisation (LCO)	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%)**

10.3 **Table 19** provides four examples of the feedback received and the subsequent responses posted on Care Opinion and NHS Website that were published in 2020/21

CSS, Wythenshawe Hospital
A patient gave the Intensive Care Unit (ICU) at Wythenshawe Hospital a rating of 5 stars. *After testing positive for Covid I recently returned home thanks to the absolutely wonderful care of the ICU and post ICU teams. Just to say 'thank you' does not seem anywhere near enough. All the staff that helped me on this sometimes-traumatic experience were just amazing, always positive, always caring, even given the fact the risk they were under for their own health. To be greeted on every occasion with smiling*

[3] https://www.cqc.org.uk/what-we-do/how-we-use-information/how-we-use-information

faces behind the masks lifted my spirits and strengthened my own fight to recovery. My family and I will be eternally grateful to them.

Response

Thank you for taking the time to share your feedback on the NHS website following treatment for Covid-19 at Wythenshawe Hospital Intensive Care Unit (ICU).

It was very kind of you to take the time to write and compliment the staff as it is good to receive positive feedback which reflects their hard work and dedication. We are pleased to read that you received wonderful care from the staff members who looked after you during this traumatic experience and that their positivity and smiling faces lifted your spirits and strengthened your resilience to recover and we wish you well for the future.

Manchester Royal Eye Hospital

Excellent

I was very fortunate to be seen shortly before National Covid lockdown, for a repair to a previous procedure at a different hospital some 15-18 months earlier. I was apprehensive as the first operation had been painful and resulted in extensive facial bruising and did not work. The experience at RMEH could not have been more different. I had a very lengthy wait, due to an emergency procedure for another patient, obviously unforeseen. Despite a long day, the staff, perhaps picking up on my anxiety, went ahead with my operation instead of rescheduling. That in it-self was much appreciated. The procedure, whilst not pleasant, was carried out with what seemed great skill and care. All staff could not have been more pleasant (barring one receptionist whose manner was `interesting' fortunately, she had no clinical role!), thoughtful and caring. The lovely female surgeon who carried out my procedure has done a superb job; far less bruising than before, and no sign of the condition returning. I would want to return here if I ever require ophthalmology services again, an excellent unit. So glad it was done before Covid.

Response

Thank you for your positive comments posted on the NHS website regarding your care at Manchester Royal Eye Hospital. It was very kind of you to take the time to write and compliment the staff as it is good to receive positive feedback which reflects the hard work and dedication of our staff. We were sorry to hear that your positive experience did not extend to the receptionist staff. Please be assured that we have passed your comments to the appropriate line manager.

If you would like to discuss your feedback in more detail, please contact our Patient Advice and Liaison Service on 0161 276 8686 or by e-mailing pals@mft.nhs.uk

Saint Mary's Hospital

"Excellent from start to finish"

I arrived at 7am to have my surgery and I was greeted by a lovely nurse and taken to a room. Here I met the surgeon and the anaesthetist who explained everything and put my mind at ease. I was put on a ward at 9.30 then was taken down to surgery at 10.30. All the staff I met were lovely and really helped put my mind at ease, as this was my first time being put to sleep. I went into theatre where they put me to sleep and the next thing, I knew I was waking up in the recovery room. The only thing I would like to suggest is that when a patient has just come round from surgery, the surgeon should tell the nurse or write down what they did as they told me when I woke up and I can't remember what they said due to just coming round. Overall service was outstanding and very professional. I would recommend this hospital/ward to everyone.

Response
Thank you for your positive comments posted on the NHS Website regarding your care in the Gynaecology Services at Saint Mary's Hospital. It was very kind of you to take the time to write and compliment the staff as it is good to receive positive feedback which reflects the hard work and dedication of our staff. The Trust has introduced a behavioural framework within which all members of the nursing and medical teams' practice, so it was reassuring to read that you found both medical, nursing and support staff caring, supportive and professional and that your experience has been a positive one. I can assure you that we have passed on your feedback to the Clinical Head of Division for Gynaecology and Head of Nursing who will be delighted to share your feedback with the staff involved. We would like to take this opportunity to wish you well for the future.
University Dental Hospital of Manchester
"Change of procedure" *Visited the hospital with my elderly mother. Staff/service excellent as always. I was informed at the hospital that I could not go in with her due to new procedure to allow patient only to enter regarding Covid rates increasing. Fully understand and accept this but disappointed not to be told of this earlier and to be told that hospital not putting this new restriction on letters/emails being sent to patients. Spent a cold hour outside waiting for her as nowhere to go for coffee etc.*
Response
We are very sorry to receive your comments and concerns via the NHS Website about your experiences in January 2021. Unfortunately, due to the Covid pandemic we have had to implement additional safety measures to keep both our patients and staff safe. The limited waiting space within the hospital and the requirement of social distancing measures, this has resulted in the Dental Hospital being unable to accommodate relatives/escorts accompanying patients to their appointments. We do have a Covid information leaflet for patients which is sent out with all appointment letters. However, we have been made aware that since we have transferred to a Central Trust printing resource, the information leaflet has not been sent out with the appointment letters. We would like to sincerely apologise for this and for the inconvenience this caused you when attending the hospital with your mother. We are in the process of getting this issue resolved to ensure that our patients are fully aware of the current restrictions we have in place. If you would like to discuss your experience with us in more detail, please do not hesitate to contact our Patient Advice and Liaison Service (PALS) on 0161 276 8686 or by e-mailing pals@mft.nhs.uk

11. Meetings with Complainants

11.1 A total of **43** Local Resolution Meetings (LRMs) are recorded as taking place during 2020/21 of which **17** related to MRI, **9** related to WTWA, **6** related to SMH with the remainder being spread evenly across RMCH, CSS, LCO, Corporate and UDHM/ MREH. This compares to **113** LRMs held in 2019/20 and represents a decrease of **61.9%.** This decrease can be attributed to the Trust's pausing of all face to face LRMs in response to the Covid-19 pandemic in the first wave. Of note, the Trust resumed all face to face complaint LRMs in Q4, 2020/21.

11.2 Meetings are arranged by the identified Complaints Case Manager and high-level summary letters are provided to the complainant with an audio recording of the discussion. This enables the complainant to listen to the recording outside the meeting so that they can review specific responses or consider any further questions they may wish to raise.

12. Parliamentary and Health Service Ombudsman (PHSO)

12.1 The PHSO is commissioned by Parliament to provide an independent complaint handling service for complaints that have not been resolved by the NHS England (NHSE) and UK government departments. The PHSO is not part of government, NHSE, or a regulator. The PHSO is accountable to Parliament and their work is scrutinised by the Public Administration and Constitutional Affairs Committee.

12.2 The PHSO make final decisions on complaints that have not been resolved by NHSE and UK government departments and other public organisations. The PHSO do this fairly and without taking sides. Their services are free. The PHSO considers and reviews complaints where someone believes there has been injustice or hardship because an organisation has not acted properly or fairly or has given a poor service and have not put things right.

12.3 In response to the Covid-19 pandemic national complaint handling guidance, the PHSO did not accept new health service complaints, nor did they progress existing cases that required contact with the NHS. Given the unprecedented situation, the PHSO went on to advise service users that they were likely to experience delays of several months and asked that the PHSO office did not receive complaints relating to: delays with complaint responses, matters which are likely to resolve themselves in the next few weeks/months, and delays in service delivery, which were non-critical and as a result of an organisation coping with the pandemic.

12.4 As a result of the PHSO position, the PHSO informed the Trust of only **2** complaint investigation outcomes during 2020/21. **Table 20** below shows the financial year in which the Trust initially received the complaints, which have since been closed in 2020/21 following PHSO investigation.

Table 20: Financial year in which the Trust, including legacy organisations, initially received the complaints closed in 2020/21 following PHSO investigation.

Year	Number Received
2018/19	2

12.5 **Table 21** shows the outcome of the PHSO investigation for complaints resolved in 2019/20 and 2020/21.

Table 21: Outcome of PHSO investigations 2019/20 and 2020/21, MFT

	2019/20	2020/21
Fully upheld	1 (5.89%)	0
Partially upheld	7 (41.17%)	1 (50%)
Not upheld or withdrawn	9 (52.94%)	1 (50%)

12.6 In summary, 1 case was not upheld, 1 case was partially upheld, and 0 cases were fully upheld. In neither of the cases were the Trust required to pay financial redress. This compares to the payment of **£1,950** to **3** complainants in 2019/20 and **£3000** to complainants in 2018/19. The Trust had **9** cases under review by the PHSO at the end of Quarter 4 in 2020/21.

12.7 **Table 22**, presented in **Appendix 3** provides details of the PHSO cases that were resolved in 2020/21 and shows the distribution of PHSO cases across the Hospitals/MCS/LCOs.

13. Complaint Data Analysis and Implementing Learning to Improve Services

13.1 All Hospitals/MCS/LCOs receive their complaint data via automated reports produced by the Ulysses Customer Services Module. Hospitals/MCS/LCOs also review the outcomes of complaint investigations at their Quality or Clinical Effectiveness Committees. The following tables show the complaint data for each of the Hospitals/MCS/LCOs mapped against a number of key performance indicators. A selection of complaints is provided to demonstrate how learning from complaints has been applied in practice to contribute to continuous service improvement during 2020/21. All of these examples have been published in the quarterly Board of Directors Complaints Reports during 2020/21.

13.2 Manchester Royal Infirmary

Manchester Royal Infirmary (MRI)	**2019/20**	**2020/21**
Number of Complaints	419	283
Number of PALS Concerns	1531	1458
Number of Re-Opened	99	78
Number Closed in 25 days	261	216
Number Closed Over 41 Days	103	68
Number of Meetings Held	31	17
Top 3 Themes		
Treatment/Procedure		
Communications		
Clinical Assessment (Diag.Scan)		

Hospital/ MCS/LCO	**Complaint and Lessons Learnt**
Head & Neck Q1	Patient Experience: A complaint was received in relation to the patient's 'reasonable adjustments' not being shared with the extended hospital teams who were due to be involved in the patient's care on the day of his procedure. This ultimately resulted in the patient declining to have the proposed surgery. As a result of the complaint the following actions were taken: ▪ All teams involved in the patient's care were made aware of the patient's 'reasonable adjustments' that were required to be in place on the day of the procedure. ▪ Assurances provided to the patient. ▪ The patient attended for investigations and has agreed to have the proposed surgery.

Urology, Renal & Transplantation Q2	Ineffective communication and poor nursing care in relation to hygiene needs: A complaint was received from a patient raising concerns in relation to poor communication with the live donor, and his hygiene needs not having been met. As a result of the complaint the following actions were agreed: ▪ Patient Hygiene Quality Improvement Project initiated. ▪ Implementation of 'Patient Status at a Glance Boards' (PSAG) outside each patient bay. ▪ Patient feedback to be gained and shared via virtual platforms. ▪ Post Covid-19 pandemic response: - Recommencement of Improving Quality Programme (IQP) project once Transplant programme restarted. - Explore re introducing and consider how the Enhanced Recovery Programme can be improved. - Focus on the need for clear communication with patients (donor + recipient). - Develop recipient communication pathways via iPads and co-ordinators.
Theatres & Elective In-Reach **Outpatient Clinical Services** **Head & Neck Specialties Q3**	Patient Experience: During this quarter a rise in coronavirus-related complaints were received across the Trust. A patient's surgery was cancelled due to a delay in the patient's Covid-19 swab test being reported by the laboratory. Actions: ▪ A revised process was implemented enabling patients to attend for Covid-19 swab testing 48 hours prior to surgery. ▪ Introduction of daily inspection of specimens. A further patient raised concern as to why they had been challenged on their refusal to wear a face mask on entering the centre. Actions: ▪ The importance of documenting a patient's exemption from wearing a face mask in their medical records discussed with all staff. ▪ Additional signage displayed in the centre detailing 'No admission to the centre without a face covering or a valid exemption'. An additional patient raised concern regarding her Micro Ear Suctioning Clinic appointment being cancelled because of Covid-19. Actions taken: ▪ Meeting the requirements of Covid-19 a revised Nurse-Led Micro Ear Suctioning Clinic implemented at Trafford and Altrincham Hospitals. ▪ The patient's appointment was rescheduled.

13.3 Royal Manchester Children's Hospital

Royal Manchester Children's Hospital (RMCH)	2019/20	2020/21
Number of Complaints	189	111
Number of PALS Concerns	621	432
Number of Re-Opened	22	25
Number Closed in 25 days	81	94
Number Closed Over 41 Days	56	37
Number of Meetings Held	10	2
Top 3 Themes		
Treatment/Procedure		
Communication		
Clinical Assessment (Diag.Scan)		

Hospital/ MCS/LCO	Complaint and Lessons Learnt
RMCH Q3	Clinical Assessment/Facilities: A complaint was received from a patient's mother raising concerns that the refining of the clinic space, in line with Covid-19 pandemic restrictions, had caused an impact to her daughter's psychology assessment. As a result of the complaint the following actions were taken: ▪ An urgent review of seating arrangements was undertaken and ensuring the requirements of Covid-19 Social Distancing measures, chairs removed, and alternative chairs made available. ▪ Additional adjustable assessment tables were made available in the assessment rooms.
RMCH Q4	Treatment/Procedure: A complaint was received from a patient's mother raising concerns as to whether surgery was necessary and could it have been avoided. As a result of the complaint investigation, the following actions were agreed: ▪ Complaint to be shared and discussed with consultant colleagues. ▪ Changes in practice to ensure all patients are reviewed prior to listing for surgery by an ophthalmologist and physiotherapist.

13.4 Wythenshawe, Trafford, Withington and Altrincham (WTWA)

Wythenshawe, Trafford, Withington and Altrincham (WTWA)	2019/2020	2020/2021
Number of Complaints	515	317
Number of PALS Concerns	1920	1351
Number of Re-Opened	104	72
Number Closed in 25 days	377	256
Number Closed Over 41 Days	94	92
Number of Meetings Held	33	9
Top 3 Themes		
Treatment/Procedure		
Clinical Assessment (Diag.Scan)		
Communication		

Hospital/ MCS/LCO	Complaint and Lessons Learnt
WTWA Q1	Patient Experience: A complaint was received in relation to a patient's needs not being considered or effectively communicated during the response to the Covid-19 pandemic when the patient attended hospital for review and a blood test. As a result of the complaint the following actions were taken: ▪ The patient's concerns were shared at the Units team meeting. ▪ An incident report was submitted on the Trust's Incident Reporting System. ▪ To enable the family to attend and stay with the patient at their next appointment an individual consultation room was made available.
WTWA Q2	Patient Experience, Communication: A patient complained that as an 'expert patient' she had been 'disempowered' upon her admission to hospital. As a result of the complaint the following actions were agreed: ▪ Nursing staff to undertake self-administration of medication and diabetes management training. ▪ Provision of additional one to one clinical educator provision to support communication, managing changing priorities and other identified competencies. ▪ All Nursing staff to undertake training in the Management of Sliding Scales and Management of Diabetes.

13.5 Saint Mary's Hospital (SMH)

Saint Mary's Hospital (SMH)	2019/2020	2020/2021
Number of Complaints	194	160
Number of PALS Concerns	526	673
Number of Re-Opened	49	19
Number Closed in 25 days	149	114
Number Closed Over 41 Days	35	48
Number of Meetings Held	10	6
Top 3 Themes		
Treatment/Procedure		
Clinical Assessment (Diag.Scan)		
Attitude of Staff		

Hospital/ MCS/LCO	Complaint and Lessons Learnt
SMH Q2 & Q3 (Gynae)	Access, Communication: A range of complaints received during these quarters demonstrated the impact on communication and access to gynaecology services during the Covid-19 pandemic. A patient raised concern regarding poor communication, cancelled outpatient appointments and a delay in surgery. A further patient reported difficulty accessing the emergency gynaecological services and the lengthy waiting times for surgery. As a result of the complaints the following actions were taken: ▪ Recovery Plan implemented with all patients prioritised in line with the Royal College guidelines. ▪ Action Plan implemented to address shortfalls in administrative team. ▪ A revised service provision model was developed enabling Gynaecology Services to meet the requirements of the NHS third phase response to Covid-19. This allowed the commencing in the reduction of the backlog of patients requiring elective treatment.

13.6 Clinical & Scientific Services (CSS)

Clinical & Scientific Services (CSS)	2019/2020	2020/2021
Number of Complaints	103	67
Number of PALS Concerns	335	303
Number of Re-Opened	22	21
Number Closed in 25 days	79	59
Number Closed Over 41 Days	18	12
Number of Meetings Held	6	3
Top 3 Themes		

Treatment/Procedure
Clinical Assessment (Diag.Scan)
Attitude of Staff

Hospital/ MCS/LCO	Complaint and Lessons Learnt
CSS (Critical Care) Q3	Patient Experience: A complaint was received from a patient raising concerns that his wellbeing had been affected during an inpatient admission due to the noise levels on the ward. As a result of the complaint the following actions were agreed: ▪ Patients' headphone requirements were discussed with the nursing team and importance of patients being offered/provided with headphones at the beginning of all shifts reiterated to staff. ▪ The anonymised complaint was shared at the Trust's Quality and Patient Experience Forum in November 2020. ▪ Headphones sock in Critical Care reviewed and increased to mitigate any supply challenges. ▪ The nurse caring for the patient supported in reflecting on events leading to the complaint.

13.7 University Dental Hospital of Manchester (UDHM) and Manchester Royal Eye Hospital (MREH)

University Dental Hospital of Manchester (UDHM) and Manchester Royal Eye Hospital (MREH)	2019/2020	2020/2021
Number of Complaints	96	39
Number of PALS Concerns	581	384
Number of Re-Opened	13	10
Number Closed in 25 days	78	36
Number Closed Over 41 Days	6	7
Number of Meetings Held	5	1
Top 3 Themes		
Treatment/Procedure		
Appointment/Delay/Cancellation (outpatient)		
Communication		

Hospital/ MCS/LCO	Complaint and Lessons Learnt
MREH Q2	Access: A complaint was received from a patient raising concerns that due to visiting restrictions, (due to the pandemic), she had not been able to bring her daughter to her clinic appointment. This resulted in the patient not fully understanding the planned treatment of care. As a result of the complaint the following actions were taken: ▪ All staff were reminded of the importance of making reasonable adjustments for patients when necessary. ▪ The complaint was shared with the nursing team, and to support the patient and relieve their anxieties, staff were reminded of the importance of listening to, and facilitating requests from patients and their families and carers where possible. ▪ The nurse caring for the patient supported in reflecting on events leading to the complaint.
UDHM Q3	Patient Experience, Communication: A patient complained that because of the consultant being called to theatre at the last minute, his outpatient appointment was cancelled whilst he sat in the clinic waiting room. As a result of the complaint the following actions were agreed: ▪ A review of the Oral and Maxillo-facial Surgeons Appointment Scheduling was undertaken. ▪ A review of the standards of communication between clinicians at different NHS Trust was undertaken.

13.8 Research & Innovation (R&I)

Research & Innovation (R&I)	2019/2020	2020/2021
Number of Complaints	0	0
Number of PALS Concerns	15	6
Number of Re-Opened	0	0
Number Closed in 25 days	0	0
Number Closed Over 41 Days	0	0
Number of Meetings Held	0	0
Top 3 Themes		
Appointment/Delay/Cancellation (outpatient)		
Communication		
Documentation		

13.9 Corporate Services

Corporate Services	2019/2020	2020/2021
Number of Complaints	68	44
Number of PALS Concerns	298	211
Number of Re-Opened	13	11
Number Closed in 25 days	25	23
Number Closed Over 41 Days	23	29
Number of Meetings Held	2	2
Top 3 Themes		
Attitude of Staff		
Infrastructure (Staffing, Environment)		
Communication		

Hospital/ MCS/LCO	Complaint and Lessons Learnt
Corporate	A staff member from a partner organisation, based on an MFT site, was frequently mimicked and treated disrespectfully by a particular member of the security team despite him explaining he had a neurological disorder and requesting that the security officer stopped behaving inappropriately towards him. As a direct result of the complaint, the following actions were taken: ▪ The security officer was immediately excluded from the Trust premises. ▪ A decision was made to replace the agency security company.

13.10 Manchester and Trafford Local Care Organisation (LCO)

LCO	2019/2020	2020/2021
Number of Complaints	44	38
Number of PALS Concerns	52	82
Number of Re-Opened	9	12
Number Closed in 25 days	15	13
Number Closed Over 41 Days	14	31
Number of Meetings Held	3	3
Top 3 Themes		
Treatment/Procedure		
Access		
Communication		

Hospital/ MCS/LCO	Complaint and Lessons Learnt
LCO Q2	Communication, Staff Attitude: A patient raised concerns about the poor communication experienced by her and her carer when attending clinic; The patient was also concerned regarding the staff member's attitude and the interactions with the carer's assistance dog. As a direct result of the complaint, the following actions were taken: ▪ Standards of communication and patient experience discussed with all clinic staff. ▪ Guidance obtained from the Assistance Dogs website and circulated to all staff to raise awareness in the appropriate interaction of assistance dogs. Information also shared through the Quality and Safety Committee.

13.11 Non-MFT

Non-MFT	2019/2020	2020/2021
Number of Complaints	0	0
Number of PALS Concerns	18	0
Number of Re-Opened	0	0
Number Closed in 25 days	0	0
Number Closed Over 41 Days	0	0
Number of Meetings Held	N/A	0

14. Complaint Satisfaction Survey

14.1 The Complaint Satisfaction Survey was developed by the Picker Institute and is based on the PHSO, the Local Government Ombudsman (LGO) and Healthwatch England's user-led 'vision' of the complaints system; **'My Expectations for Raising Concerns and Complaints'**[4]. The survey was sent to **1,099** MFT complainants following closure of their complaints during 2020/21, with an increased response rate of **31.6%** compared to **11.1%** in 2019/20.

14.2 Whilst **88.1%** of the complainant survey respondents indicated that they received the outcome of their complaint within the given timescales, only **35.4%** of complainants felt that the response they received addressed all of the points they raised in their complaint, with a further **26.7%** reporting that the response did not address any of the points. **33.5%** of complainants felt they received an explanation of how their complaint would be used to improve services, with a further **25.7%** of complainants wanting an explanation, but reporting that they had not received one.

[4] PHSO, the Local Government Ombudsman (LGO) and Healthwatch (2014) My Expectations for Raising Concerns and Complaints. Available from: https;//www.ombudsman.org.uk/publications/my-expectations-raising- concerns-and-complaints

14.3 These results indicate the need for continuous improvements to the quality of complaint investigations and written responses. It is anticipated that the Complaints Letter Writing Training Educational Sessions (further detail of which is in Section 15 of this report) will bring improvements to this process incrementally over time.

Comments received from complainant include the following:

- *"I felt like I was not going to be cared for as well after making the complaint".*
- *"Failings were identified, agreed upon, action taken".*
- *"The doctor looking after me at my next appointment properly explained things instead of brushing things and rushing the appointment".*
- *"They appear to work completely separately".*
- *"Well-structured process".*
- *"I am not confident that the supposed improvements will actually be addressed, and the process is purely an academic exercise".*
- *"I was treated more like a person and not a bed number".*
- *"It is my opinion that the NHS in respect of my complaint colluded together".*
- *"I received a prompt response and was assured my case would be dealt with appropriately by the first point of contact".*
- *"Staff on the call tried to reassure me why they follow policies".*
- *"All correspondence, from the initial telephone call was very respectful, sympathetic, empathetic and detailed. The communication between myself and the hospital was timely and regular".*
- *"I did not feel the complaint was handled professionally because there seems to be no depth of investigation into the initial diagnosis".*

15. Work Programme 2020/21 - Update

15.1 In 2020/21 the Patient Services Team committed to several work-streams; a progress update for each is detailed below:

- **In-house Complaints Letter Writing Training Package/Education Sessions**

15.2 The training package, which was developed in 2019/20 and tailored to support and develop skills in staff who investigate and respond to complaints was due to be launched at Wythenshawe Hospital in Q2, 2020/21; however, as a result of the pandemic and in order to reduce transmission of coronavirus a decision to pause the delivery of all face to face training and educational sessions was made. In view of this, and to make at the minimum, a certain proportion of complaint training accessible and deliverable, the Trust's Head of Customer Services organised for the In-house Complaints Letter Writing Training to be delivered virtually. During Q3, 2020/21 the Corporate Complaints team delivered its first remote training session of the In-house Complaints Letter Writing Training for staff via the Trust's 'Big Blue Button' virtual meeting space on the Trust's Learning Hub.

In light of the on-going Covid-19 outbreak the training sessions continue to be delivered virtually across the Trust's Hospitals/MCS/ LCOs providing staff with the correct tools needed to investigate and respond to complaints.
The process for delivering face to face educational sessions will be reviewed in line with government guidelines during 2021/22.

- **In-house Customer Service e-learning package**

15.3 The e-learning Customer Service package tailored specifically to meet the needs of the Trust was completed in Q4 of 2020/21. It was anticipated for this to happen in Q2, 2020/21, however given the unprecedented situation of the pandemic, this was delayed. Launch of the first module of the e-learning education package on the Trust's Learning Hub will be completed in Q1 of 2021/22. Through this e-learning package Trust staff will be given the opportunity to:

- To identify MFT customers and know what they require.
- Understand why customer service is important to the Trust and the NHS.
- Be aware of how to provide great customer service in healthcare.
- Know how patient experience is affected by their actions, approach, and communication.
- Understand the importance of feedback to improving services.
- Know how to deal with concerns and complaints.

15.4 During 2021/22 work will commence on the development of a Module 2 e-learning Customer Service package, with the module reflecting on complaints handling in line with The Local Authority Social Services and NHS Complaints (England) Regulations 2009.

- **Family Liaison and Virtual Visiting Service**

15.5 During 2020/21 a Family Liaison Team (FLT) was temporarily established to support patients, families and staff following the implementation of the Trust's Interim Covid-19 Visiting Policy.

15.6 The FLT was made up of staff redeployed from their usual roles due to the suspension of elective work and the national 'pause' in the complaints process during the pandemic response. The team members consisted of a Corporate Lead Nurse, a Matron, Dental Nurses and several PALS and Corporate Complaints staff.

15.7 Throughout the first wave of the pandemic, in order to reduce the footfall in clinical areas and maintain safety the FLT provided a valuable service to patients, families, and carers. Following the first wave of the pandemic many of these staff returned to their substantive roles and in the latter part of 2020/21 'Virtual Visiting' was temporarily established to support patients to keep in touch with their loved ones using video calls.

Overall, virtual visiting had a positive impact on the patient experience.

15.8 For further support for patients to stay in touch with their families over the festive period, a Christmas Virtual Visiting Service was developed in Q3, 2020/21 for a period of 12 days by the Corporate PALS and Complaints and Patient Experience teams.

15.9 Feedback from patients, families and volunteers about the Virtual Visiting Service included the following:

"As a volunteer this is a brilliant service and being able to support patients by simply talking to them and introducing them to a virtual video call makes such a difference. Some of the patients, particularly the older ones, have never had the opportunity to have interactions in this manner before and it helps reassure their families too. What I particularly enjoy is seeing the patient's recovery and progress in between the different visits and this is what has made such a difference to my experience as a Volunteer".

"The virtual visiting service has been very good and very helpful especially with the pandemic going on. Patients have been able to have video calls with their loved ones and at least when relatives that have not seen their loved ones for a while it has given them some reassurance".

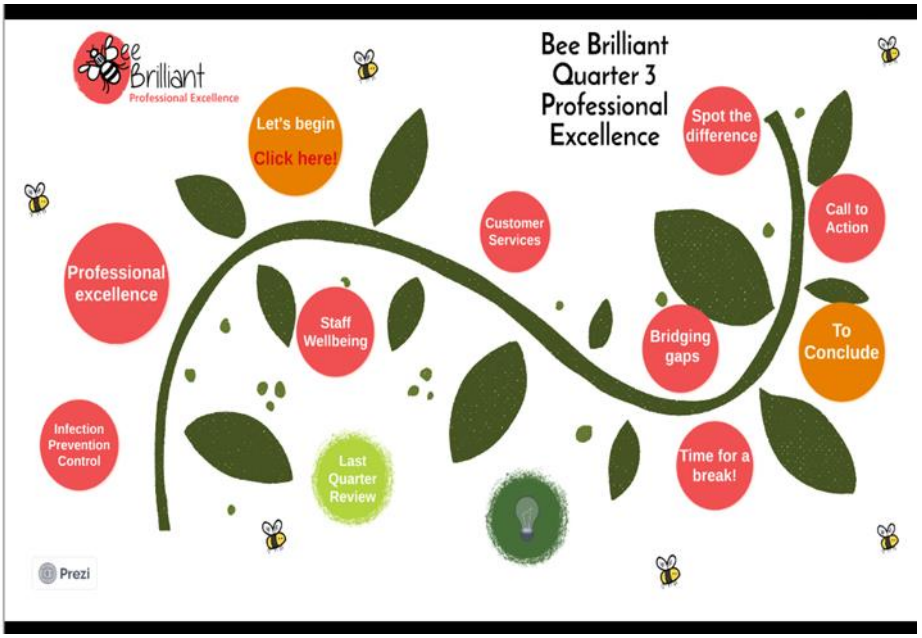
"Just being able to see my mum in real time makes such a difference to me and provides me with reassurance that she is recovering. Thank you for providing this service for both us."

"I am so appreciative of the Volunteers; this is a fantastic service".

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

15.10 Bee Brilliant is a core element of the Trust's Improving Quality Programme. During 2020/21 the Trust's 'Professional Excellence' Bee Brilliant presentation focused on Customer Services, with themes and changes in practice from complaints being showcased to provide staff with the understanding that:

- Complaints are a learning opportunity to support the Hospitals /MCSs/ LCO to improve patient experience.
- By applying categorisation and theming to a complaint, the Trust can improve the quality of care where themes emerge, and practice is identified as requiring improvement.



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

15.11 To provide assurance that the Trust's policies and processes for responding to patient complaints are appropriately designed an internal audit was undertaken during 2020/21. This audit included assessment of the design of the local complaints process within each Hospitals/MCS/LCOs, including how these align to the overall Trust Complaints' Policy.

15.12 The audit reviewed a sample of 25 patient complaints received by the Trust between 1st October 2019 and 30th September 2020. 5 complaints were audited from MRI and 5 were audited from WTWA to reflect the higher volume of patients and complaints received by these areas. The remaining 15 complaints were split evenly between the remaining Hospitals/MCS/LCOs. Overall the audit found the Trust to have:

- Appropriate design controls in place in relation to complaints handling for the areas tested, which ensures complaints are acknowledged and responded to in a timely manner.
- Hospital/MCS/LCO written complaint responses are of a high quality and written in an appropriate tone.
- Lessons learned from complaints are sufficiently circulated.
- Complaints processes and controls operate effectively with some minor exceptions. The exceptions predominantly related to:
    - Responses to complaints not being sent within the timesframes agreed in the Trust's Complaints Policy
    - Complainants not being made fully aware of the support available to them
    - Complaint Satisfaction Surveys are not being sent out to complainants once the case is closed.
- **8** low priority (good practice that would achieve better outcomes) recommendations.
- Positive Assurance rating of "**Significant assurance** with minor improvement opportunities" was provided to the Trust.

The audit found that the Trust's policies and processes for responding to patient complaints are generally well designed with minor improvements to be made. A Complaints Audit Action Plan was developed and implemented to address the recommendations in Quarter 4.

- **Equality and Diversity Monitoring Information**

15.13 In light of the continued challenges in the collection of the equality and diversity data during 2020/21 an audit to evaluate the collection of this data was undertaken. The audit findings identified good compliance with regard to 'gender' and 'ethnicity' data, however, identified the need to improve data collection in relation to 'religion' and 'disability' status. In order to ensure complainants are informed of their right to support with their 'religion' and/or 'disability' status and in addition to provide staff with a valuable tool in obtaining this important information, a departmental Equality and Diversity Checklist was developed and introduced during the latter part of 2020/21.

- **Standard Operating Procedures**

15.14 To ensure the Trust maintains compliant with the NHS Complaints Regulations (2009), a review of the PALS and Complaints Standard Operating Procedures (SOPs) continued throughout 2020/21. SOPs which have been updated/approved this year include:

- Process for requesting extension to response timescale

Additionally, in response to the pandemic the following SOPs were developed this year:

- Process for virtual local resolution meetings (VLRM's)
- Process for virtual visiting

15.15 In response to a formal restructure of the Trust's Corporate PALS and Complaints Service, which is due to be implemented in Q1 of 2021/22, a full review of all SOPs and standard letter templates commenced in Q4, 2020/21. It is anticipated that this review will be completed early 2021/22.

16. Work Programme 2021/22

16.1 The PALS and Complaints key priorities for 2020/21 include:

- **Implementation of the Trust's new Corporate Complaints and PALS Structure:**
  Deliver an enhanced, responsive, and compliant PALS and Complaints Service across the Trust.

- **Delivery of a North Manchester General Hospital Corporate PALS and Complaints Service:**
  Completion of the Single Hospital Service for the City of Manchester and Trafford sees NMGH come into MFT on 1st April 2021. Following the transaction, the delivery of a Corporate PALS and Complaints integration plan will commence with the reopening of the PALS Office at NMGH.

- **Complaints Process:**
  Continue to work with the Hospitals/MCS and LCO teams to improve responsiveness to complaints and the processes by which they are managed, making the necessary changes, in line with national recommendations.

- **Complaints Training:**
  Continue to offer training to staff and implement a programme of training sessions on complaints management when safe to do so. This will include the development of Module 2 Customer Service e-learning package.

- **Complaints Feedback:**
  As described in MFT's Experience and Involvement Strategy 2020-23, MFT is committed to listening to, acting on and learning from feedback from all service users and staff. To achieve this commitment work is planned to commence exploring how complaint feedback is collected and used.

- **Complaint Learning in practice:**
  Continue to utilise complaints data and analysis to inform improvement activity and demonstrate learning in practice.

- **Supporting Staff**
  Continue to support PALS and Complaints Team Leaders through the development and implementation of bespoke supervisory sessions.

- **Communication enhancement**
  Continue to improve and enhance the Trust's PALS and Complaints information available on the Trust's external and internal websites.

17. Conclusion and Recommendation

17.1 During this annual report year a significant amount of work has continued to take place to improve the timeliness of complaint responses, to reduce the number of re-opened complaints and to manage the number of open complaints over 41 working days old. As a result, there has been an overall improvement, however, there remains opportunity for further improvement. Close monitoring and always seeking positive performance and improvement, will continue with, performance being monitored at a Group level via the Accountability Oversight Framework (AOF).

17.2 The three primary themes of dissatisfaction remain largely the same as 2019/20, with the most common being Treatment/Procedure, Communication, and Clinical Assessment. The actions outlined in this report demonstrate that complaints received by the Trust are acted upon and are used to inform work aimed at improving the patient's experience. Analysis of the complaint themes and trends will continue to be closely monitored at Group level and via local governance forums.

17.3 In order to ensure that the Trust delivers an enhanced, responsive, and compliant Corporate Complaints and PALS service across MFT, the Trust's Complaints Policy will be reviewed and updated in 2020/21. Additionally, Complaints and PALS processes will continue to be reviewed and developed throughout the year. The In-house Complaints Letter Writing Training and e-learning Package will be utilised to support the delivery of education and training to enhance the Trust's customer service offer and to support continual improvement in the quality of complaint responses during 2020/21. Bespoke complaints and PALS training will continue to be delivered across the Trust to improve outcomes and understanding.

17.4 The Trust is grateful to those patients and families who have taken the time to raise their concerns and complaints and acknowledges their contribution to improving services, patient experience and patient safety.

17.5 The Board of Directors is asked to note the content of this report, the work undertaken by the Corporate and Hospitals /MCS and LCO teams to improve the patient's experience of raising complaints and concerns and, in line with statutory requirements, provide approval for the report to be published on the Trust's website.

Appendix 1

Tables 4 to 7 provide information regarding how people access the PALS service and provides their demographical breakdown.

Table 4: Source of PALS Concerns by enquirer

Source	2019/20	2020/21
Email	2462	2276
Face to Face	472	97
Complaints	0	2
Family Support	0	0
PALS	1	0
Letter	55	43
MP	0	5
Other	9	33
Telephone	2892	2424
Tell us Today	6	3
Totals	**5,897**	**4,900**

Table 5 details the number of contacts by age; the age range relates to the people who were the focus of the PALS concern as opposed to the person raising the concern

Age Range	2019/20	2020/21
0 – 18	1092	650
19 – 29	578	506
30 - 39	767	745
40 - 49	640	544
50 – 59	826	576
60 – 69	753	598
70 – 79	737	661
80 – 89	413	472
90 – 99	87	144
100+	4	4
Totals	**5,897**	**4,900**

Table 6 details the number of contacts by sex; the sex relates to the people who were the focus of the PALS concern.

	2019/20		2020/21	
Sex	Number of Concerns	Percentage of Concerns	Number of Concerns	Percentage of Concerns
Female	3309	56.1%	2878	58.7%
Male	2546	43.1%	1998	40.8%
Not Specified	3	0.05%	1	0.0%
Other	39	0.67%	23	0.5%
Total	**5,897**		**4,900**	

Table 7 describes the ethnicity of the patients who were the focus of the PALS enquiry.

Category	2019/20	2020/21
Any Other Ethnic Group	58	64
Asian or Asian British - Bangladeshi	9	6
Asian or Asian British - Indian	44	47
Asian or Asian British - Other Asian	34	23
Asian or Asian British - Pakistani	106	112
Black or Black British - African	62	47
Black or Black British - Caribbean	46	41
Black or Black British - Other Black	22	14
Chinese Or Other Ethnic Group - Chinese	12	8
Mixed - Other Mixed	15	22
Mixed - White & Asian	15	10
Mixed - White & Black African	11	4
Mixed - White & Black Caribbean	56	22
White - British	2053	1751
White - Irish	64	51
White - Other White	86	72
Do Not Wish to Answer	376	4
Not Stated	2828	2602
Totals	**5,897**	**4,900**

Appendix 2

Tables 11 to 14 provide information regarding the risk rating of complaints and the demographic details of the person affected because of the complaint

Table 11: Complaint Risk Rating

Category	2019/20	2020/21
Not Stated / Other	0	0
White	0	0
Green	49	28
Yellow	903	650
Amber	670	377
Red	6	4
Totals	**1,628**	**1,059**

Table 12: Age range of person who was the subject of the complaint

Age Range	2019/20	2020/21
0 - 18	384	218
19 - 29	159	88
30 - 39	222	143
40 - 49	172	99
50 - 59	186	142
60 - 69	184	122
70 - 79	178	135
80 - 89	109	85
90 - 99	34	27
100+	0	0
Totals	**1,628**	**1,059**

Table 13: Sex of person who was the subject of the complaint

	2019/20		2020/21	
Sex	Number of Concerns	Percentage of Concerns	Number of Concerns	Percentage of Concerns
Female	907	55.7%	605	57.1%
Male	706	43.4%	436	
Not Specified	13	0.8%	17	
Other	2	0.1%	1	
Total	**1,628**		**1,059**	

Table 14: Ethnicity of the person who was the subject of the complaint

Category	2019/20	2020/21
Any Other Ethnic Group	13	9
Asian or Asian British - Bangladeshi	8	2
Asian or Asian British - Indian	16	14
Asian or Asian British - Other Asian	15	5
Asian or Asian British - Pakistani	38	33
Black or Black British - African	31	18
Black or Black British - Caribbean	14	12
Black or Black British - Other Black	8	3
Chinese Or Other Ethnic Group - Chinese	4	2
Mixed - Other Mixed	1	7
Mixed - White & Asian	9	5
Mixed - White & Black African	5	2
Mixed - White & Black Caribbean	14	7
White - British	712	434
White - Irish	25	17
White - Other White	42	24
Do Not Wish to Answer	327	270
Not Stated	346	195
Totals	**1,628**	**1,059**

Appendix 3

Table 22: Complaints closed between 1st April 2020 and 31st March 2021 following PHSO investigation

Hospitals/ MCS/LCO	Outcome	Date complaint initially received by the Trust	PHSO Rationale/Decision	Recommendations
Quarter 2				
MRI (GI Medicine & Surgical Specialties	Partly upheld	July 2018	Failure to provide appropriate care needs. Failure in communication in respect of DNAR Poor documentation in respect of communication with family members	Provide a full acknowledgement of failings and apology for impact, uncertainty and distress caused. Explain what actions have been taken to address failings and identify specific reasons for failings and outline learning taken from specific issues.
WTWA (Heart & Lung)	Not upheld	November 2018	No failings found	None

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Julie Cawthorne, Assistant Chief Nurse/Clinical Director of Infection Prevention and Control
Date of paper:	July 2021
Subject:	Annual Infection Prevention and Control Report 2020/21
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Staff and Patient Experience Staff and Patient Safety
Recommendations:	The Board of Directors are asked to receive the Annual Report for April 2020 to March 2021 and approve for publication
Contact:	Name: Julie Cawthorne, Assistant Chief Nurse / Clinical Director of Infection Prevention Control Tel: 0161 276 4042

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST
BOARD OF DIRECTORS

Infection Prevention and Control (IPC) Annual Report 2020/2021

1. Executive Summary

1.1 The Trust has a statutory responsibility to be compliant with the Health and Social Care Act 2008 (Department of Health, 2010). A requirement of this Act is for the Board of Directors to receive an annual report from the Director of Infection Prevention and Control (IPC). This report details Infection Prevention and Control activity from April 2020 to March 2021 outlining key achievements in this extraordinary year.

1.2 On 31st December 2019, the World Health Organisation (WHO) was alerted to 27 cases of pneumonia of unknown aetiology in Wuhan, China. As the outbreak emerged, the cause was identified as a novel coronavirus, designated as severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), and the associated clinical syndrome was termed COVID-19[1]. Spread of the virus outside China was first identified on 13th January 2020 in Thailand, and to Europe (France) on 25th January 2020. The first two cases in the United Kingdom were confirmed on 31st January 2020. The first UK death was reported on 5th March 2020. On 11th March, the WHO declared COVID-19 a global pandemic of international concern.

1.3 This year has been one of unprecedented and exceptional challenges both nationally and locally due to the COVID-19 pandemic. The Trust-wide response from all staff coming together to provide the best possible standards of safe care for all our patients is to be commended. Staff have supported visitors and each other to implement policies and procedures to reduce the risk of transmission of COVID-19.

2. Key Achievements and Challenges

2.1 Dr Rajesh Rajendran was welcomed to the Trust in October 2020 as Associate Medical Director in Clinical and Scientific Services (CSS) for IPC. Rajesh came to the Trust from his role at Mid Cheshire NHS Foundation Trust where he was the Associate Medical Director for Infection Control, Patient Safety and Quality.

2.2 From the 1st August 2020 the IPC Nursing Services Team at North Manchester General Hospital (NMGH) were welcomed to the IPC/Tissue Viability (TV) Team at Manchester Foundation Trust (MFT).

2.3 As a temporary measure during the first wave of the COVID-19 Pandemic (March – May 2020) the team provided additional on-site support for IPC over 7 days to the clinical teams. There were significant benefits to services and patient care because of the onsite presence and positive feedback from the Hospitals/MCS and Local are Organisation (LCO). Following a review, the service was extended to provide a permanent onsite weekend/bank holiday support from March 2021.

2.4 The Trust Infection Prevention and Control/Tissue Viability (IPC/TV Team) were asked to renew the provision of IPC advice and guidance to St Ann's Hospice across the three North West

[1] Zhou F, Yu T, Du R, Fan G, Liu Y, Liu Z, et al. Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study. Lancet. 2020;395(10229):1054-62.

Hospice sites: the Neil Cliffe Centre (based at Wythenshawe Hospital); Heald Green, and Little Hulton through a Service Level Agreement (SLA).

2.5 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 throughout the year.

2.6 The emergency (EPPR) response to the pandemic was led by the Chief Operating Officer supported by the Chief Nurse/DIPC. Strategic meetings were held daily and later reduced to three days a week with the ability to flex back up in the event of a significant surge in cases.

2.7 The Trust responded to changing national guidance as knowledge of the virus developed. The Chief Nurse/DIPC chaired a High-Level Expert IPC Group as part of the response to support the rapid interpretation and implementation of IPC guidance. This group worked with the clinical subgroup chaired by a joint medical director and reported into the Strategic Group and the Group Infection Control Committee.

2.8 The Trust completed the IPC Board Assurance Framework (IPC BAF) developed by NHS England/Improvement (NHSE/I) first published in June 2020. The IPC BAF was continually updated and has been reviewed at the meetings of the Board of Directors and sub-committees.

2.9 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. The document outlined how staff were expected to work in the context of the COVID-19 pandemic in a way that is consistent with the Trust's Vision, Values and Behaviours and ensured that as a Trust, we were doing all we could to protect patients and each other.

2.10 Clinical service areas were designated according to COVID-19 protected areas (green); COVID-19 Indeterminate areas (amber) and COVID-19 positive areas (blue) wherever possible. IPC precautions were implemented across all clinical areas. A risk assessment was undertaken to determine social distancing of 2metres. In some areas where there was a higher risk of transmission of infection (amber care pathways) the Trust implemented the use of Clinell Redirooms to provide additional isolation capacity.

2.11 In line with national guidance an enhanced programme of cleaning frequencies was agreed with the PFI partnership 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.

2.12 Testing for COVID-19 was a high priority, the IPC Team worked with the clinical teams to develop an overarching COVID-19 Staff and Patient Screening Strategy to provide a framework for operational screening policies. The Strategy was updated throughout the year in accordance with changes in national guidance.

2.13 The 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.

2.14 There was continuous surveillance of all COVID-19 positive cases undertaken by the IPC surveillance team. The daily COVID-19 data was circulated at all levels across the Group.

2.15 Each case was reviewed by the IPC nursing team to ensure that all aspects of Infection Prevention Control standards were being followed and any further actions required put in place.

2.16 The national definition of a Hospital Onset COVID-19 Infection (HOCI) was an infection occurring on or after day eight of admission. All incidents of HOCI were investigated and reported to NHSE/I.

2.17 If a case formed part of an outbreak[2], an outbreak was declared, and control measures implemented. Daily updates on outbreaks were circulated across the Trust. Each outbreak was reported to NHSE/I and monitored daily for 28 days.

2.18 There were 115 COVID-19 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.

2.19 An in-depth review of outbreaks was taken across two hospital sites between November 2020 and January 2021.The findings indicated that there were good areas of practice as well as lessons to be learned. The findings were shared across the Group and local action plans developed and monitored through the Hospital/MCS IPC framework.

2.20 The joint medical directors worked with the medical director at NHSE/I and contributed to the development of a structured judgement review tool for each patient who died having acquired Covid-19 whilst in the trust. This work is ongoing.

2.21 The Senior Responsible Officer for the vaccination programme at MFT was the Chief Nurse/DIPC. The programme was led by the Corporate Director of Nursing, and the Chief Pharmacist with strong links to the regional and national teams. The Trust had vaccination clinics at MRI, Wythenshawe Hospital and NMGH.

2.22 The vaccination was offered to the Trust's front healthcare workers and affiliates, patients aged over 80 and care home workers. MFT was also asked to undertake vaccinations for several other providers including: Greater Manchester Mental Health (GMMH), Greater Manchester Health and Social Care Partnership (GMHSCP), the Christie NHS Trust and NWAS. MFT worked with these organisations to ensure staff had access to vaccines through a managed process. MFT continued to offer the vaccine in partnership with MHCC to support the local population immunisation programme. On the 31st March 2021 100% staff had been offered the COVID-19 vaccine, 83.4% had taken up the first vaccine and 73% had either had or booked their second vaccine.

2.23 During the first wave of the of the pandemic there were national supply issues regarding the provision of Personal Protective Equipment (PPE). Deliveries were intermittent with variable levels of stock. The Trust worked with local external companies to source alternative consumables that were not consistently available through NHS Procurement this included alcohol hand rub, FFP3 respirators, face visors and disposable/re-useable gowns.

2.24 There was a national shortage of CE marked single use face visors/protective eyewear. The Trust worked with colleagues at the University of Manchester to design a face visor. A risk assessment

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

was undertaken on the use of Non-CE marked visors and a recommendation that the use of the visors produced via University of Manchester be implemented as required when supplies of CE marked visors were not available in order to reduce the risk of infection and protect staff.

2.25 The inconsistency in supply of disposable FFP3 respirators led to staff having to be intermittently re-fit tested for a mask from an alternative supplier. This was led by the Assistant Chief Nurse and procurement lead. All Hospitals/MCS teams were tasked with keeping an up to-date local register of staff who had been fit tested including the date and make(s) of FFP3 respirator for which they had been successfully fit tested.

2.26 A task and finish group was established to develop, review, and standardise a range of information leaflets for patients, visitors, and staff. The group was led by the IPC Team supported by the quality Improvement Team and a range of key stakeholders from across the clinical sites.

2.27 In March 2020, a strategic decision was made to restrict visiting across the Trust in line with national guidance, to protect patients and staff by reducing footfall to minimize the transmission of COVID-19. An interim visiting policy was developed by the Deputy Chief Nurse within the context of the national guidance in place at the time. The policy has been revised and updated five times between March 2020 and April 2021 to take account of the changing national and local position.

2.28 During the first wave of the pandemic, MFT participated in a national pilot to investigate the prevalence of asymptomatic COVID-19 infection in hospital staff and patients. The study demonstrated that there was a small but significant cohort of asymptomatic staff and patients within the hospital. This data, along with similar results from other participating sites, was critical in forming policies around asymptomatic screening.

2.29 The Trust participated in the evaluation and validation of several Point of Care (POC) devices for the detection of COVID-19 in patients including the DNA Nudge and Abbott ID now. Following successful validation, the ID now has been used in the Emergency Departments at the Manchester Royal Infirmary (MRI) and Wythenshawe hospitals to facilitate rapid identification of positive patients.

2.30 The collection of COVID-19 test samples within the Trust. This new medium contains chemicals which have been demonstrated by PHE to inactive SARS-CoV-2, rendering it non-infectious within 10 minutes. MFT was the first Trust in the UK to implement this novel transport medium, significantly reducing the time taken for samples to be tested in the laboratory by eliminating the 'make safe' step required to inactivate samples prior to testing[3]

[3] Genomic and healthcare dynamics of nosocomial SARS-CoV-2 transmission (Elife, 2021)

Ellingford JM, George R, McDermott JH, Ahmad S, Edgerley JJ, Gokhale D, Newman WG,Ball S, Machin N, Black GC. Genomic and healthcare dynamics of nosocomial SARS-CoV-2 transmission. Elife. 2021 Mar 17;10:e65453. doi: 10.7554/eLife.65453. PMID: 33729154;PMCID: PMC8009659.

Geographical and temporal distribution of SARS-CoV-2 clades in the WHO European Region, January to June 2020. (Euro Surveillance, 2020)
Alm E, Broberg EK, Connor T, Hodcroft EB, Komissarov AB, Maurer-Stroh S, Melidou A, Neher RA, O'Toole Á, Pereyaslov D; WHO European Region sequencing laboratories and GISAID EpiCoV group; WHO European Region sequencing laboratories and GISAID EpiCoV group. Geographical and temporal distribution of SARS-CoV-2 clades in the WHO European Region, January to June 2020. Euro Surveill. 2020 Aug;25(32):2001410. doi: 10.2807/1560-7917.ES.2020.25.32.2001410. Erratum in: Euro Surveill. 2020 Aug;25(33):PMID: 32794443; PMCID: PMC7427299.

Evaluating the Effects of SARS-CoV-2 Spike Mutation D614G on Transmissibility and Pathogenicity (Cell, 2021)

Volz E, Hill V, McCrone JT, Price A, Jorgensen D, O'Toole Á, Southgate J, Johnson R, Jackson B, Nascimento FF, Rey SM, Nicholls SM, Colquhoun RM, da Silva Filipe A, Shepherd J, Pascall DJ, Shah R, Jesudason N, Li K, Jarrett R, Pacchiarini N, Bull M, Geidelberg L, Siveroni I; COG-UK Consortium, Goodfellow I, Loman NJ, Pybus OG, Robertson DL, Thomson EC, Rambaut A, Connor TR. Evaluating the Effects of SARS-CoV 2 Spike Mutation D614G on Transmissibility and Pathogenicity. Cell. 2021 Jan 7;184(1):64-75.e11. doi: 10.1016/j.cell.2020.11.020. Epub 2020 Nov 19. PMID: 33275900; PMCID: PMC7674007.

SECTION 3: INFECTION PREVENTION and CONTROL ARRANGEMENTS

3.1 The Director of Infection Prevention and Control (DIPC)

Professor Cheryl Lenney, was appointed as the Chief Nurse and designated DIPC for the Trust from September 2017. Cheryl started working at Central Manchester Foundation Trust (CMFT) in 2002 and was appointed as Chief Nurse/DIPC for MFT and its predecessor organisation from 2015.

3.2 The Infection Prevention and Control Team (IPCT)

There have been several changes in the IPC leadership team throughout the year:

Dr Rajesh Rajendran was welcomed to the Trust in October 2020 as Associate Medical Director in Clinical and Scientific Services for IPC. Rajesh previous role was at Mid Cheshire NHS Foundation Trust where he was the Associate Medical Director for Infection Prevention and Control, Patient Safety and Quality. Dr Rajendran replaced Dr Andrew Dodgson as the Trust IPC Doctor.

Mrs Julie Cawthorne continued to provide the senior nursing and strategic leadership as Assistant Chief Nurse IPC/Tissue Viability/Clinical DIPC**.**

Mrs Michelle Worsley has recently been appointed to the role of Head of Nursing for IPC. Michelle has worked at the Trust for 31 years in a variety of settings including adults and neonates. Michelle was appointed as an IPC Specialist Nurse in 2007 and moved to the MRI and later the Manchester Royal Eye Hospital to develop her clinical leadership experience. Michelle returned to IPC in August 2020 as Lead Nurse and was recently successful in obtaining the position of Head of Nursing for IPC and Tissue Viability services.

The IPC team were delighted to welcome Consultant Virologists **Dr Nicholas Makin** and **Dr Shazaad Ahmad** into their roles as Infection Control Doctors. Both consultants have supported the IPC Team and Clinical Colleagues across the Trust during the Pandemic and bring with them a wealth of knowledge and experience.

Dr Andrew Dodgson, Consultant Microbiologist and Trust Infection Prevention and Control Doctor (ICD) stepped down as ICD in 2020 to take up the role of Head of Service for Microbiology & Virology for the Trust/PHE Department (the Manchester Medical Microbiology Partnership).

Thank you and farewell to **Dr Kirsty Dodgson** who was a key member of the IPC team as the Deputy IPC Doctor for seven years and supported the Trust for 14 years in surveillance.

Thanks also to **Dr Moira Taylor** who retired at the end of March 2021 from her role as Consultant Microbiologist and ICD for Wythenshawe, Trafford, Withington, and Altrincham (WTWA).
Moira provided constant professional support to the IPC team at WTWA and has had a long career in the NHS supporting staff and patients in IPC.

3.3 Antimicrobial Stewardship Pharmacists

Fran Garraghan was the Lead Antimicrobial Stewardship Pharmacist for the Trust, supported by two specialist antimicrobial pharmacists at the ORC Campus and one at Wythenshawe Hospital. Together the Team supported interventions to optimise antimicrobial use, reduce inappropriate antimicrobial consumption, to minimise patient harm and the development of antimicrobial resistance.

3.4 Microbiology and Virology Laboratory Services

Microbiology and Virology Laboratory services were provided on-site at the ORC by the Manchester Medical Microbiology Partnership. Virology services were provided across the region as well to the Trust.

3.5 The Infection Prevention and Control (IPC)/Tissue Viability (TV) Nursing Team

In total there were 56 members of the IPC/TV Nursing Team including specialist nurses, surveillance and administrative staff who provided a service to all Hospital/MCS/Local Care Organisations. A chart demonstrating an overview of the structure can be found in Appendix 1.

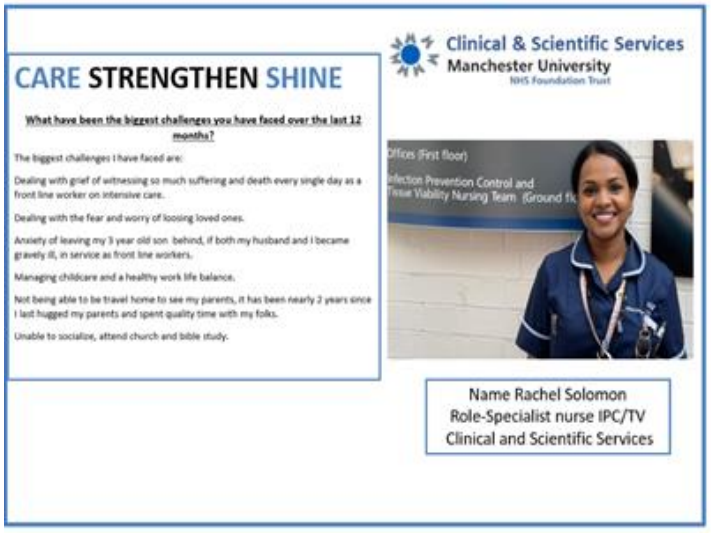
From the 1st August 2020 the IPC Nursing Services Team at North Manchester General Hospital were welcomed to the IPC/TV Team at MFT.

3.6 Changes to the Weekend and Bank Holiday Service Delivery of IPC Nursing Service

As temporary measure during the first wave of the COVID-19 Pandemic (March to May2020) the IPC Team provided additional on-site support for IPC at weekends (7day service) to the clinical teams. There were significant benefits to services and patient care because of the onsite presence and positive feedback from the Hospitals/MCS and LCO. This precipitated a service review and the recruitment of three additional Band 6 nurses to support the expansion of the service to provide onsite weekend/bank holiday support from March 2021.

3.7 Care, Strengthen, Shine

In 2021 the IPC /TV Nursing Team participated in the CSS ‘Care, Strengthen, Shine’ event. This was an opportunity to pause and reflect during the anniversary of the first COVID- 19 lockdown. A summary of the feedback from the team can be found below:

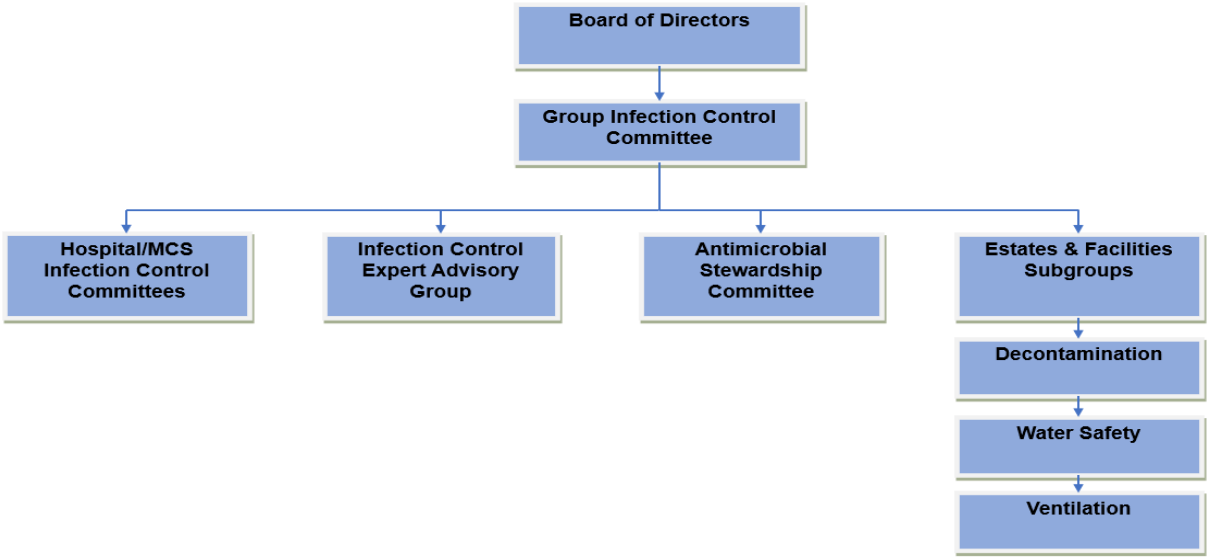


3.8 The Group Infection Control Committee (GICC)

The Group Infection Control Committee had corporate responsibility for overseeing the implementation of Infection Prevention and Control activities. The GICC met virtually three times during the year and was chaired by the Chief Nurse/DIPC. The Group Infection Control Committee reported to the Group Management Board. The GICC
Terms of Reference (TOR) can be found in Appendix 2.

3.9 Framework for IPC

The IPC governance framework can be seen below.



3.10 Infection Prevention and Control Structure within the Hospitals/Managed Clinical Services (MCS)/Local Care Organisation (LCO)

There is an Infection Control Committee within each Hospital/MCS and LCO. The day to day management for IPC was delegated to the Directors of Nursing by the Chief Nurse/DIPC. Each Hospital/MCS/LCOs appointed a Clinical Lead to support IPC policy and practice across professional groups and represent their Hospitals/MCS/LCO at the GICC.

Each hospital/MCS/LCO present their minutes from the ICC and escalate any issues or concerns. Attendance at the hospital/MCS/LCO meetings includes designated IPC nurses and ICDs.

The Chief Nurse/DIPC commissioned an end of year review for each hospital/MCS that was presented at hospital/MCS/LCO virtual meetings chaired by the DIPC. The reviews were well received by all key stakeholders and are summarised as end of year reports in Appendix 3.

The review meetings were held individually with the Directors of Nursing (lead directors for IPC in the hospitals/MCS/LCOs), supported by their Senior Team, local Infection Control Doctor and IPCN(s). The review panel was led by the Chief Nurse/DIPC supported by the Associate Medical Director for IPC and the Assistant Chief Nurse for IPC/Tissue Viability/Clinical DIPC. The sessions were an opportunity to reflect on the previous year, focus on activity and performance, celebrate achievement, and understand what we had learnt; feedback was very positive from all those involved.

Work has begun on producing an IPC dashboard with the trust informatics team.

3.11 Service Level Agreement (SLA) with St Ann's Hospice

The Trust IPC/TV Team were asked to renew the provision of IPC advice and guidance to St Ann's Hospice across the three North West Hospice sites: the Neil Cliffe Centre (based at Wythenshawe Hospital); Heald Green, and Little Hulton through a Service Level Agreement (SLA).

3.12 Nightingale Hospital North West (NNW)

The IPC/TV Team provided support to the Nightingale Hospital North West including advice on planning and training on the principles of IPC, based on the Trust existing policies and procedures. The team continued to maintain a service since the facility was opened until the service closed in March 2021.

SECTION 4: MANAGEMENT of the COVID-19 PANDEMIC APRIL 2020-MARCH 2021

4.1 Background

The world was first alerted to the existence of a potential outbreak of a novel respiratory virus on the 31st December 2019. On the 9th January 2020, it was confirmed that a novel coronavirus had been detected in patients associated with the outbreak. The novel virus was subsequently named SARS-CoV-2 (with the disease being called COVID-19) and on the 30thJanuary 2020 the World Health Organisation declare a global health emergency amid fears that the virus had the potential to cause a global pandemic.

The first UK case of COVID-19 was identified on the 31st March 2020 in a traveller that had returned from Wuhan City. The first UK death was recorded on the 5th March 2020 and on the 11th March the World Health Organisation declared that COVID-19 had become a global pandemic.

4.2 Trust IPC Framework to Manage COVID-19

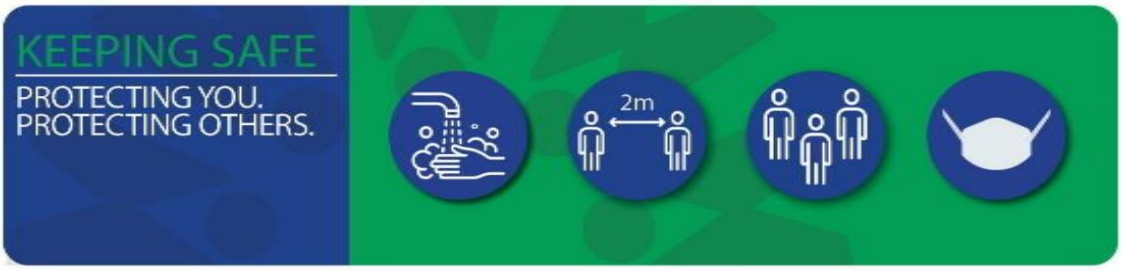
The emergency (EPPR) response to the pandemic was led by the Chief Operating Officer supported by the Chief Nurse/DIPC. Strategic meetings were held daily and later reduced to three days a week with the ability to flex back up in the event of a significant surge in cases.

The Trust responded to changing national guidance as knowledge of the virus increased. The Chief Nurse/DIPC chaired a high-level Expert IPC Group as part of the response to support the rapid interpretation and implementation of IPC guidance. This group reported into the Strategic Group and the Group Infection Control Committee.

The Trust completed the IPC Board Assurance Framework (BAF) developed by NHS England/Improvement (NHSE/I), first published in June 2020. 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 served as an improvement tool to optimise actions and interventions. The IPC BAF was continually updated and has been reviewed at the meetings of the Board of Directors and sub-committees.

The Trust has followed the national guidance from NHS England and Improvement and Public Health England (PHE) throughout the pandemic alongside the Trust IPC policies.

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. The document outlined how staff were expected to work in the context of the COVID-19 pandemic, in a way that is consistent with the Trust’s Vision, Values and Behaviours and ensured that as a Trust, we were doing all we could to protect patients and each other.



4.3 The Clinical Sub-Group (CSG)

The Clinical Sub-Group was a sub-group of the Strategic Group. It was chaired by the Medical Director and included Clinical Directors, Virology Consultants, IPC specialists, The Deputy Chief Nurse, Risk Governance leads and Infectious Diseases Consultants from North and South Manchester.

The CSG was a forum to discuss and advise the Strategic Group on treatment s for COVID-19, and Clinical pathways for patients with COVID-19. Initially the CSG held virtual meetings three times a week and were stepped down following the second wave, to be re-convened as appropriate.

4.4 The Role of the IPC Expert Advisory Group

The Trust IPC Expert Group was a subgroup of the GICC. The Trust Expert Group reported to the GICC and advised the Trust COVID-19 Strategic Group and Clinical Sub-group. In the extra ordinary circumstances created by the pandemic the Group meetings were re-convened to meet fortnightly and were chaired by the Chief Nurse/Director IPC. Representation on the group included Senior IPC experts, the Group Medical Director, the Deputy Chief Nurse, and the Corporate Director of Nursing.

4.5 Key Activities during the Pandemic

The Key activities of the Trust IPC Expert Group focused on:

Interpretation of national guidance and implementation into Trust policy for changes to Patient/Staff Screening and Personal Protective equipment (PPE) and other practices to reduce and control the spread of COVID-19 infection

Review and recommendations following guidance from professional Colleges

Management of changes to testing including laboratory and point of care testing.

Advice on vaccination programme

Management of patients with COVID-19 infection including outbreak management

Patient and staff information including posters and leaflets, as seen below

Review and dissemination of lessons learned from local outbreaks

Advice on the management of patient pathways

Preparation of surveillance data for internal and external dissemination

Contribution to specialist local guidance with clinical colleagues

Updating the Group on the research activity undertaken by the IPC Team during the pandemic

Staff Training and education on COVID-19 precautions including Team meeting sessions to provide an informal forum for updates and frequently asked questions

Overseeing the management of change process to implement 7 day working of the IPC nursing team

4.6 Patient Pathways

The IPC team worked with the clinical teams to identify and manage elective and non-elective patients who are at high/medium/low risk of COVID-19. The IPC team worked in tandem with each Hospital/Managed Clinical Service (MCS) to implement the pathways at an operational level to support patient flow using a risk assessment process to prioritise isolation facilities and safe working practice.

Entrances and exits for staff and visitors to the Hospital/Care Facility were clearly identified and where possible separated out to reduce the footfall. All entrances and exits were clearly sign posted with relevant and up to date guidance on precautions required by both staff and visitors to reduce the risk of COVID-19 infection.

4.7 Patient Care Zones

Clinical service areas were designated according to COVID-19 protected areas (green), COVID-19 Indeterminate areas (amber) and COVID-19 positive areas (blue) wherever possible. IPC precautions were implemented across all clinical areas. A risk assessment was undertaken to determine social distancing of 2metres. In some areas where there was a higher risk of transmission of infection (amber care pathways) the Trust implemented the use of Clinell Redirooms to provide additional isolation capacity.

Where it was not possible to dedicate clinical services e.g. Radiology, Emergency Departments a risk assessment was undertaken to reduce the risk of cross transmission of COVID-19.

This included

- Streaming of patients at front facing areas
- Providing dedicated appointment time slots
- Avoid clustering of patients in communal waiting areas
- Reviewing the environment to reduce clutter and facilitate social distancing

In non-clinical communal areas including corridors/break room facilities for staff social distancing and the wearing of appropriate Personal Protective Equipment (PPE) were put in place.

4.8 Enhanced Cleaning

In line with national guidance an enhanced programme of cleaning frequencies was agreed with PFI partners 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:

- NMGH
- MRI
- Wythenshawe
- Trafford

Within the above hospitals the priority areas to receive enhanced cleaning were identified as the Emergency Departments and Assessment units (AMU/SAU) where there was a high turnover of patients and, it was difficult to maintain social distancing. In total additional cleaning was agreed for 11 areas across the Trust. Following a review in February 2021 the period for enhanced cleaning was extended.

4.9 Patient and Staff Testing

Testing for COVID-19 was a high a high priority, the IPC Team worked with the clinical teams to develop an overarching COVID-19 Staff and Patient Screening Strategy to provide a framework for operational screening policies. The Strategy was updated throughout the year in accordance with changes in national guidance.

The 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.

Summary of Patient Testing Until December 2020

COVID- 19 Protected Pathways –Green Designated Area	
Elective admissions	• Patient advised to self-isolate for 14 days prior to admission, (later reduced to 72 hours unless patient immune-suppressed) • Household contacts to also self-isolate • COVID19 test within 72 hours prior to admission • If test negative - admit to Green Zone • If test positive – reschedule procedure (if urgent transfer to COVID-19 pathway) • Screen for symptoms on arrival if symptomatic reschedule the appointment
Day case admissions	• Patient advised to self-isolate for 14 days prior to admission, (later reduced to 72 hours unless patient immune-suppressed) • Household contacts to also self-isolate • COVID19 test within 72 hours prior to admission • If test negative - admit to Green Zone • If test positive – reschedule procedure (if urgent transfer to COVID-19 pathway) • Screen for symptoms on arrival, if symptomatic reschedule the appointment
COVID-19 Indeterminate Care Pathway – Yellow Designated Area	
Emergency department	• Stream patients on arrival into COVID-19 low risk/high risk • Screen for symptoms on arrival • Allocate to cohort area to await results of test • Document decisions in clinical notes • Protect patients in shielded category
Emergency admissions	• COVID-19 test taken at decision to admit • Admit to appropriate clinical area

4.10 Patient Testing from December 2020

In December 2020 NHSE/I published Key Actions: Infection Prevention and Control testing as a result the following changes were made to patient/staff testing:

- All emergency patients were tested at admission, whether or not they had symptoms
- Those who went on to develop symptoms of COVID-19 after admission were retested at the point of onset of symptoms
- Those who tested negative on admission were retested on day 3 of admission, and again between 5-7 days post admission, (the Trust policy included screening every 7 days thereafter).

4.11 Staff Testing

Staff were tested weekly using PCR on wards were there were outbreaks of COVID-19. In addition, staff working on wards where there were extremely vulnerable patients (e.g. Haematology/Oncology) were tested weekly to protect the patient group. Twice weekly lateral flow antigen testing for patient facing staff was introduced in December 2020 supported by regular communication to encourage staff to participate and register results in the interests of patient/staff safety.

4.12 MFT Newly Confirmed COVID-19 Cases

Chart 1 below demonstrates the number of newly confirmed COVID-19 in-patient cases from March 2020 (declaration of the pandemic) to April 2021

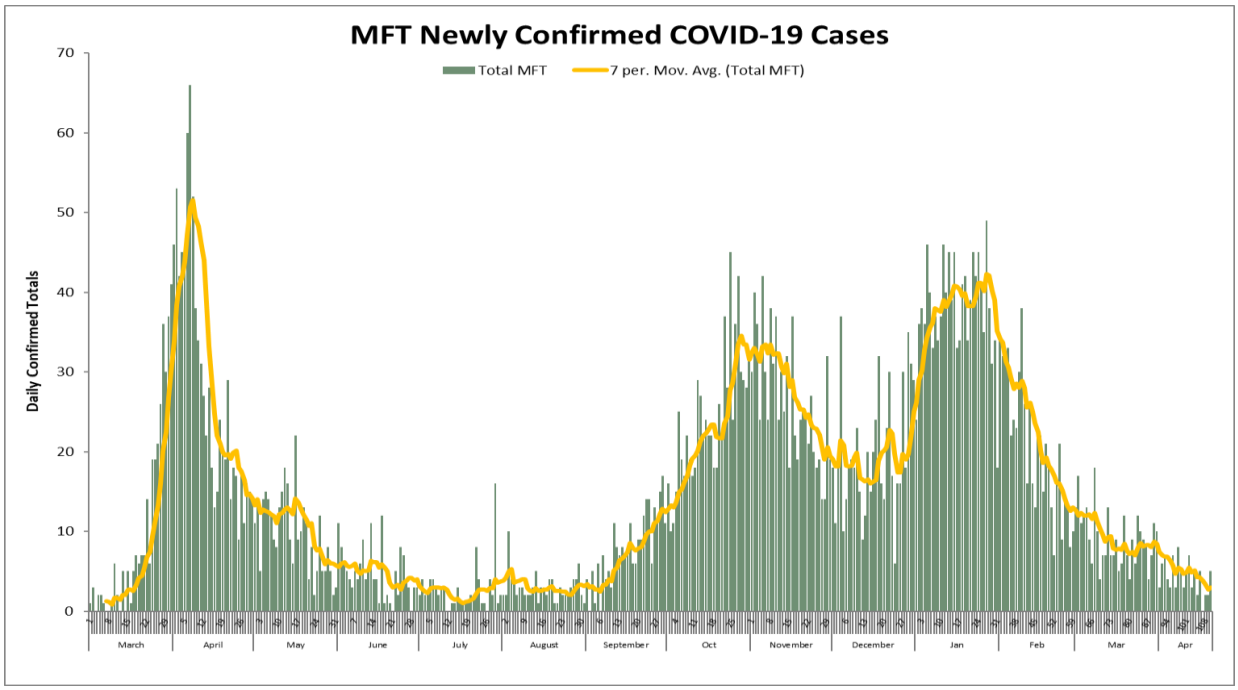


Chart 1 newly confirmed Covid-19 in-patient cases March 2020 to April 2021

Chart 2 below demonstrates the HOCI rate per 100,000 occupied overnight beds

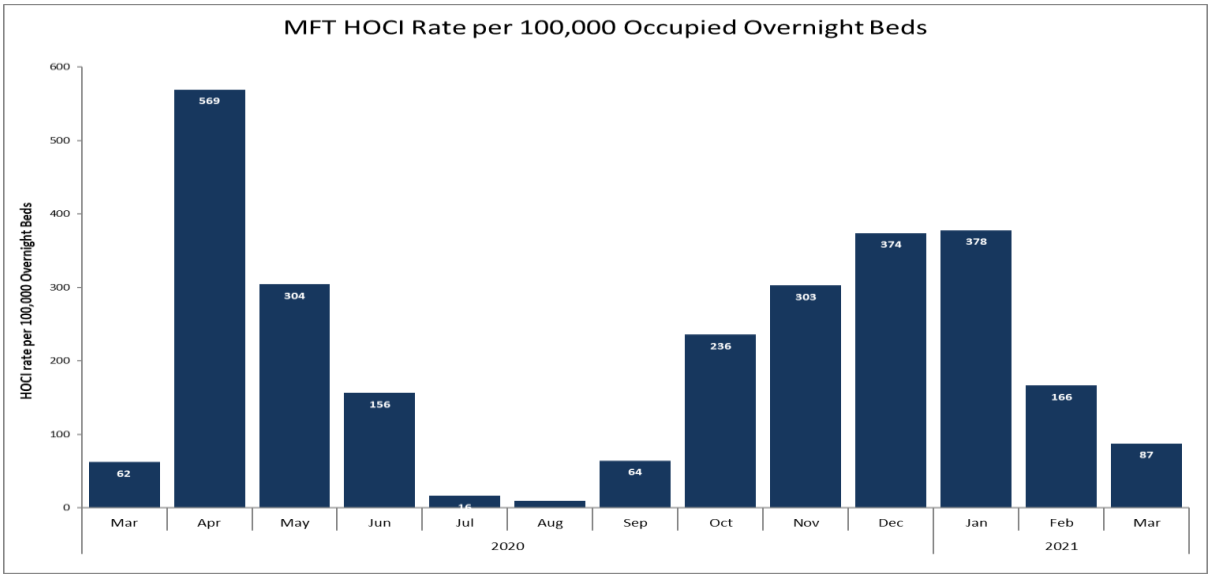


Chart 2 – MFT HOCI rate per 100,000 overnight beds

Chart 3 shows the total number of COVID-19 cases by Greater Manchester Trusts by setting of acquisition from March 2020 – March 2021 (data from North West IPC Monthly Report).

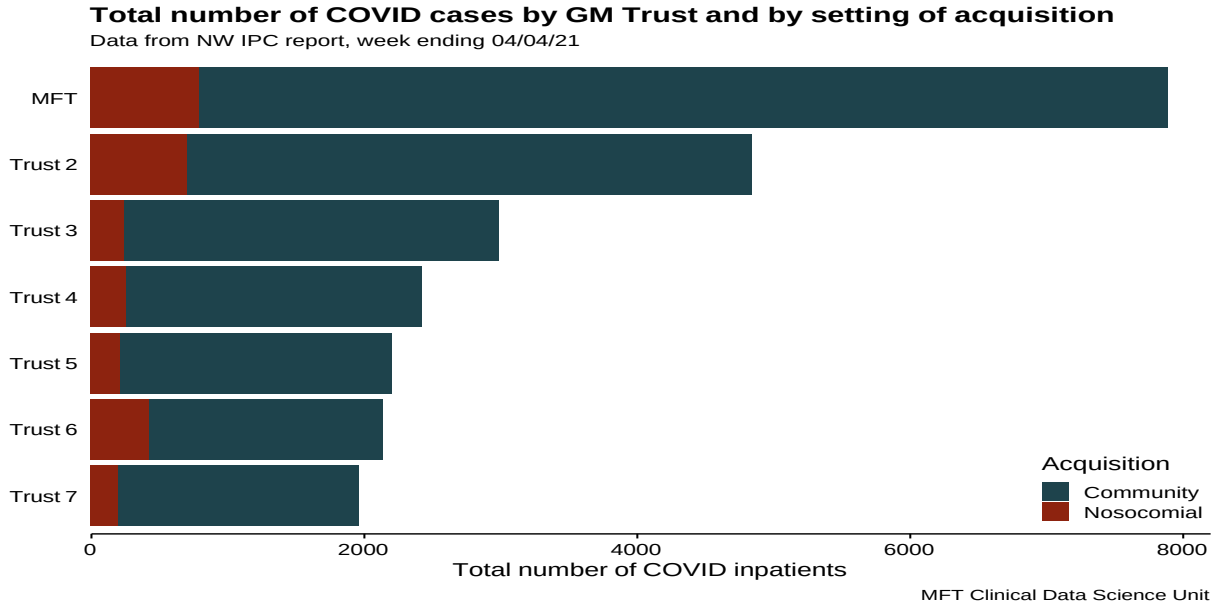


Chart 3 – COVID-19 cases from North West IPC Monthly report

4.13 MFT Hospital Onset COVID-19 Infections (HOCI)

The national definition of a HOCI was an infection occurring on or after day eight of admission. All incidents of HOCI were investigated and reported to NHS E/I.

4.14 Outbreaks of Hospital Onset COVID-19 (HOCI) Outbreaks

There was continuous surveillance of all COVID-19 positive cases undertaken by the IPC surveillance team. The daily COVID-19 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 actions required put in place.

If a case formed part of an outbreak[4], an outbreak was declared, and control measures implemented. Daily updates on outbreaks were circulated across the Trust. Each outbreak was reported to NHSE/I and monitored daily for 28 days.

Table 1 below shows the number of COVID-19 outbreaks across ORC, Wythenshawe, Trafford and North Manchester General Hospitals and the Local Care Organisations from 1st June 2020– 31st March 2021. The escalation in numbers between October 2020 and January 2021 can be attributed in part to the rising local community prevalence rate.

MFT COVID-19 Outbreaks	
June 2020	4
July 2020	0
August 2020	1
Septmenber 2020	7
October 2020	21
Novemeber 2020	22
December 2020	17
January 2021	25
February 2021	12
March 2021	6

Table 1 – MFT COVID-19 Outbreaks June 2020 – March 2021

4.15 In-Depth Review of Outbreaks

An in-depth review of outbreaks in one hospital during October and November 2020 was undertaken. The outbreaks occurred predominantly on wards where non-elective patients (NEL) were cared except for one surgical ward. Indication from 160 cases sent for Whole Genome Sequencing (WGS) demonstrated a link between 13 cases indicating some cross transmission of COVID-19 infection amongst patients.

A similar review was undertaken at another hospital in January 2021. Findings from both reviews reflected similar themes.

4.16 Findings:

- There was evidence of a good level of compliance with IPC standards identified from a review of audits of Hand Hygiene and Environmental cleaning
- There was some variability in screening dates identified
- It was identified that there was a need to reduce patient moves across the hospital

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

- There was a need to focus on sample turnaround times and coordinate new testing platforms with laboratory medicine
- There was a need for more timely declaration of outbreaks with IPC team
- That staff and patient testing key to prevention and management

4.17 Actions:

- The findings were shared across the Group Communication channels to remind staff to undertake twice weekly using lateral flow testing, and to record the result. PCR testing during outbreaks continued
- Patient testing protocols put in place for pre-admission and non-elective admissions
- All subsequent outbreaks subject to the same review to ensure continuous learning, accountability, and oversight
- Regular audits of compliance with patient screening protocols implemented at local level
- Outbreaks meetings reviewed and moved to set times three times a week to enable consistent management and sharing of good practices and local issues
- The Trust COVID-19 outbreak checklist was developed and used as a framework to ensure compliance with the Trust outbreak Policy
- The movement of patients reduced and where safe and appropriate patients with COVID-19 remained on the COVID-19 ward until discharge.
- The IPC Team provided further education and training for staff
- The use of Hydrogen Peroxide Vapour (HPV) to decontaminate the environment was focussed on areas of high risk
- The Senior IPC team provided additional advice and support to the site management teams during out of hours periods, for issues related to the management of patients with COVID-19 and patient flow

4.18 MFT COVID-19 Vaccination Programme

The vaccination programme for COVID-19 was managed at a national level under the leadership of the Department of Health and Social Care (DHSC). NHS England and NHS Improvement (NHSEI) Regions were given operational responsibility for ensuring delivery of the vaccination programme (Public Health Functions agreement for 20/21). This was delegated to Greater Manchester Health and Social Care Partnership (GMHSCP) through the Section 7A agreement.

The Senior Responsible Officer for the vaccination programme at MFT was the Chief Nurse/DIPC. The programme was led by the Corporate Director of Nursing, and the Chief Pharmacist with strong links to the regional and national teams. The Trust had vaccination clinics at MRI, Wythenshawe Hospital and NMGH.

The vaccination was offered to the Trust's front healthcare workers and affiliates, patients aged over 80 and care home workers. MFT was also asked to undertake vaccinations for several other providers including: Greater Manchester Mental Health (GMMH), Greater Manchester Health and Social Care Partnership (GMHSCP), the Christie NHS Trust and NWAS. MFT worked with these organisations to ensure staff had access to vaccines through a managed process.

MFT continued to offer the vaccine in partnership with MHCC to support the local population immunisation programme. On the 31st March 2021 100% staff had been offered the COVID-19

vaccine, 83.4% had taken up the first vaccine and 73% had either had or booked their second vaccine.

4.19 Policies, procedures, and guidelines for vaccination

- A series of clinical standard operating policies were developed from National guidance, that supported safe receipt, storage, preparation, and administration of the vaccine
- An extraordinary Medicines Optimisation Board ratified the Medication Standard Operating Procedure's which were then submitted to the Regional Chief Pharmacist in support of final sign-off and approval

4.20 Vaccination workforce

- A dedicated senior pharmacist and dedicated senior vaccination nurse provided oversight of preparation and administration of the vaccine in all clinic settings
- Identified vaccinators undertook training in line with Health Education England e-learning programmes, alongside the Trust's training
- Essential infrastructure teams supported the clinics in their set up and smooth running. This included Information and Technology teams, Procurement teams and Employee Health and Wellbeing teams
- Essential support teams, including estates, administration, security, portering and domestic staff were operational within the clinic settings

4.21 Information and technology

- The Simply Book booking system was in place for patients and care home workers
- The Employee Health and Wellbeing (EHWB) Empactis system was in place for clinical extremely vulnerable staff to book into clinics based on an assessment of their risk
- The National Immunisation System (NIMS) was the agreed platform to capture vaccination data
- Situation reports (Sitreps) were submitted nationally and regionally each day providing a range of information

4.22 Communications and Engagement

- A Trust Communications and Engagement Plan ensuring alignment with Greater Manchester Health & Social Care Partnership, was implemented to encourage uptake and evidence the safety and efficacy of the vaccine/s
- The communication plan was reviewed every day by the Director leading the vaccination programme to ensure it remained reactive and contemporaneous
- Staff Side supported the development of a series of Frequently Asked Questions which were updated on a regular basis

4.23 Personal Protective Equipment (PPE)

During the first wave of the of the pandemic there were national supply issues regarding the provision of PPE. Deliveries were intermittent with variation in levels of stock. The Trust worked with local external companies to source alternative consumables that were not consistently available through NHS Procurement this included alcohol hand rub, FFP3 respirators, face visors and disposable/re-useable gowns.

4.24 FFP3 Respirators

A Trust-wide risk assessment was undertaken, and the following control measures implemented to mitigate the risk of low levels of FFP3 Respirators:

- The Trust escalated supply issues to the incident Coordination Centre (North West), NHS E/I
- The Trust worked with suppliers to obtain and secure further stocks of disposable respirators
- Stock levels of the most widely used disposable respirators were prioritised to areas where staff were already fit-tested to these masks
- In accordance with revised national PPE Guidance (PHE, 02.04.20), The Trust:
    - Sourced FFP2 respirators as a possible alternative to FFP3 respirators
    - Extended the use of disposable respirators to sessional use in accordance with national guidance
- Additional Portacount quantitative fit testing machines were purchased to support increased fit testing and alternative suppliers for qualitative fit testing kit consumables were sourced
- The Trust purchased re-useable FFP3 respirators that were dedicated to Critical Care areas and scoped access to alternative industrial suppliers for additional stock

4.25 Face Visors

CE Marking and Standards state that all PPE should be marked with a 'CE' symbol. This demonstrates that it meets the minimum legal standards. There was a national shortage of CE marked single use face visors/protective eyewear. The Trust worked with colleagues at the University of Manchester to design a face visor. A risk assessment was undertaken on the use of Non-CE marked visors and a recommendation that the use of the visors produced via University of Manchester be implemented as required when supplies of CE marked visors were not available in order to reduce the risk of infection and protect staff.

Following advice from Dr Susan Hopkins Healthcare Epidemiologist Consultant in Infectious Diseases and Microbiology at PHE, (02/04/20), decontamination of single use items such as face visor/protective eye wear was authorised following a local risk assessment. The IPC team developed a Standard Operating Procedure (SOP) for decontamination of single use visors which was disseminated across the Trust.

4.26 '**Be Aware and Let's Prepare' Campaign**

Following the first wave of the pandemic there was an opportunity during summer to proactively prepare for the winter season for COVID-19 and the added risk of a potential increase in admissions associated with influenza.

It was essential to ensure that all staff across the organisation were prepared to manage the potential challenges ahead. Previously the Trust has launched a campaign to refresh ad re-invigorate the key principles of Infection Prevention and Control, usually in August to coincide with the changeover of junior medical staff and in preparation of the programme to immunize frontline healthcare workers against influenza.

This year the Campaign was launched in August 2020 across all Hospitals/MCS under the banner of 'Be Aware and Let's Prepare' led by the Directors of Nursing and focused on the following themes.

4.27 Hand Hygiene and Aseptic Non-Touch Technique (ANTT)

Hand hygiene is the single most important method of preventing cross infection. There are three essential components, technique, opportunities to perform hand hygiene and appropriate facilities**.** There was a national focus on the importance of hand hygiene during the pandemic and a need to maintain good levels of compliance. Each Hospital/MCS was encouraged to develop local fun and innovative ways to support hand hygiene practice and encouraged to share what has worked well across the wider organisation.

There was also a call to action, to ensure that all staff who undertook ANTT procedures were competency assessed as compliance with the Trust standard for, assessment had declined during the first wave of the pandemic.

4.28 Fit testing for an FFP3 Respirator and Personal Protective Equipment (PPE)

Feedback suggests a major cause of anxiety amongst staff during the first wave of the pandemic was the knowledge to select appropriate PPE, the length of time to wear PPE and donning and doffing. The situation was exacerbated by the frequent changes to national guidance.

The inconsistency in supply of disposable FFP3 respirators led to staff having to be intermittently re-fit tested for a mask from an alternative supplier. All Hospitals/MCS teams were tasked with keeping an up to-date local register of staff who had been fit tested including the date and make(s) of FFP3 respirator for which they had been successfully fit tested.

4.29 Monitoring of Compliance with Practice

Monitoring hand hygiene compliance and use of PPE was essential to provide assurance. The IPC team piloted an audit tool during the campaign and received feedback from clinical teams which were included in the final version. The tool became available electronically by September 2020. The frequency of local audit was set at least monthly and increased in areas where there is a high incidence of infection. Audit results were feedback to the Directors of Nursing for further action as required.

4.30 Social Distancing

The three key elements to preventing the spread of COVID-19 were hand hygiene, use of PPE and social distancing. Staff, patients, and visitors were constantly made aware through communications and posters of the need to 'make space' between themselves and others for example, encouraging patients not to go off the ward unless wearing a face mask and to stay by their bedside. Staff were advised to take staggered breaks and visitors should be discouraged from standing in clusters in the hospital grounds.

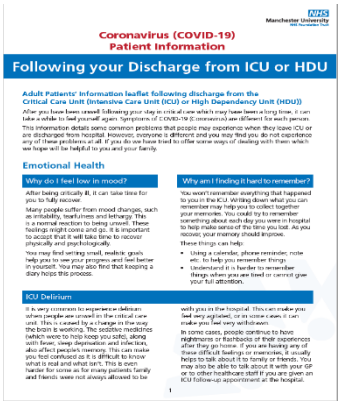
4.31 The Environment

A clutter free environment provides assurance and promotes confidence in staff, patients, and visitors that the Trust is maintaining a clean safe environment for care, reducing fomite surfaces reduces the risk of cross infection. In addition, it makes it easier to decontaminate the environment. All wards and departments were encouraged to remove and dispose of damaged or broken equipment as part of the campaign.

4.32 Information

A task and finish group was established to develop, review, and standardise a range of information leaflets for patients, visitors, and staff. The group was led by the IPC Team supported by the quality Improvement Team and a range of key stakeholders from across the clinical sites.

Some examples of the leaflets can be seen below;


Coronavirus (COVID-19)
Patient Information

Following your Discharge from ICU or HDU

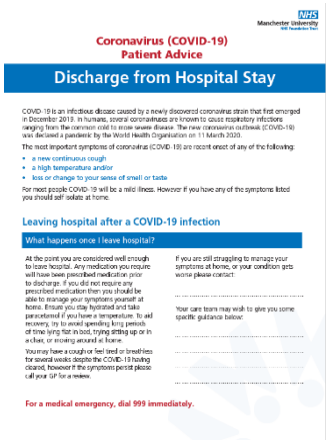
Adult Patients' Information leaflet following discharge from the Critical Care Unit (Intensive Care Unit (ICU) or High Dependency Unit (HDU))

Emotional Health

Why do I feel low in mood?

Why am I finding it hard to remember?

ICU Delirium

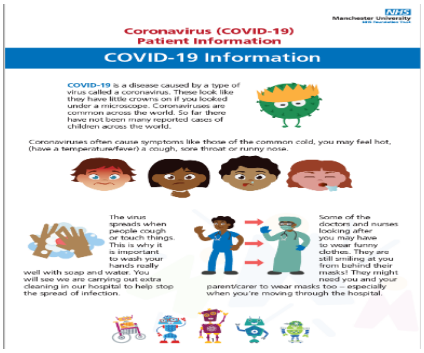

Coronavirus (COVID-19)
Patient Advice

Discharge from Hospital Stay

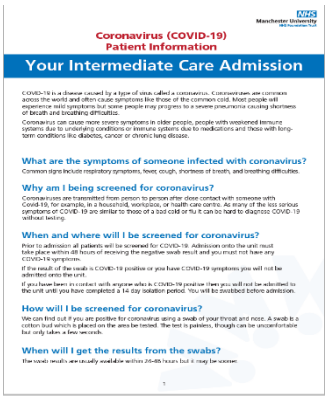
Leaving hospital after a COVID-19 infection

What happens once I leave hospital?

For a medical emergency, dial 999 immediately.


Coronavirus (COVID-19)
Patient Information

COVID-19 Information


Coronavirus (COVID-19)
Patient Information

Your Intermediate Care Admission

What are the symptoms of someone infected with coronavirus?

Why am I being screened for coronavirus?

When and where will I be screened for coronavirus?

How will I be screened for coronavirus?

When will I get the results from the swabs?

4.33 MFT COVID-19 Interim Visiting Policy

In March 2020, a strategic decision was made to restrict visiting across the Trust aligned to the national guidance produced by NHSE/I to protect patients and staff by reducing footfall to minimise the transmission of COVID-19. An interim visiting policy was developed by the Deputy Chief Nurse within the context of the national guidance in place at the time, namely: *COVID-19 Guidance for infection prevention and control in healthcare settings* and *NHS Visitor Guidance.* The policy has been revised and updated five times between March 2020 and April 2021 to take account of the changing national and local position.

All versions of the policy have supported a compassionate approach by facilitating visiting in specific circumstances, such as at the end of life or for patients living with a learning disability, whilst ensuring that any agreed visitors comply with safety measures, including face masks, PPE, social distancing, and handwashing.

4.34 Serious Judgement Review on Harm and Mortality potentially associated with HOCI

New Guidance was issued in March 2021 from NHSE/I following a growing focus on the undertaking of Serious Case reviews (SJR's) for COVID-19 cases and concern that the current structure of the SJR template was not capable of capturing the elements of care delivery, practice and environmental factors that may be important in identifying:

- Contributory factors in the acquisition
- Opportunities for learning
- Evaluation of whether the death was avoidable

The Trust's SJR review group was led by the Medical Director and supported by the Director of Clinical Governance. To support the review:

- A 'Rapid Decision Group' was established, with senior members of Informatics, IPC, Patient Safety/Clinical Governance team and the Medical Examiner's office, and a final data set agreed. The group met regularly and has driven the development of the data set, the mortality review and the duty of candour processes.
- A process for the reporting, investigation and undertaking of duty of candour on HOCI was agreed and is underway at the time of writing this report.
- All HOCI were reported as an individual incident with one StEIS report submitted to cover all individual cases.
- The duty of candour process was supported with template letters for personalisation and completion within Hospitals/MCS.
- The Mortality Review Portal and Incident Reporting System has been updated with required key lines of enquiry in line with National guidance
- Mortality data was reviewed to ensure a more contemporaneous approach to understanding outcomes across the Group.

There are 129 HOCI requiring a mortality review. The four Hospital sites are undertaking their reviews. Lessons learned will be presented in a report to the Board of Directors and the Group Infection Control Committee in 21/22.

4.35 Diagnostic Services to Support the IPC Response

The Virology laboratory at MFT was the first regional Public Health Laboratory to begin testing for SARS-CoV-2 on the 11th February 2020 and by the time the UK national lockdown was declared on the 30th March 2020, the laboratory was performing around 2,000 SARS-CoV-2 tests per day to support the management of COVID-19 at MFT and the region. During the COVID-19 pandemic the Virology department at MFT has worked closely with the Infection Prevention Control Team and the wider Trust to provide diagnostic services to support the management of patients and Infection Control.

4.36 Introduction of Rapid testing

During the early phase of the pandemic it became clear that rapid testing was essential to the IPC management of suspected COVID-19 patients. NHS England published guidance stating that hospitals should implement segregation of COVID-19 positive patients from those that were negative and awaiting results. The Trust implemented a 'Blue, Amber' Green' pathway to facilitate this and rapid testing supported early isolation of positive cases by reducing the turnaround time for results. Rapid testing using the Cepheid Infinity

(Cepheid, USA) was introduced on the 17th April 2020 and the reduction in turnaround times is shown in figure 1

Standard Assays (8800 and Flow)	Collection to Receipt (hours)	Collection to Reporting (hours)
ORC	6.7	22.5
Wythenshawe Site	13.2	28.6

Cepheid Rapid Test	Collection to Receipt (hours)	Collection to Reporting (hours)
ORC	4.0	6.2
Wythenshawe Site	4.3	6.6

Figure 1 - Turnaround times for COVID-19 standard tests and rapid tests

4.37 Asymptomatic COVID-19 Infection Staff and Patient Pilot

During the first wave of the pandemic, MFT participated in a national pilot to investigate the prevalence of asymptomatic COVID-19 infection in hospital staff and patients. The study demonstrated that there was a small but significant cohort of asymptomatic staff and patients within the hospital (fig 2.) and this data, along with similar results from other participating sites, was critical in forming policies around asymptomatic screening.

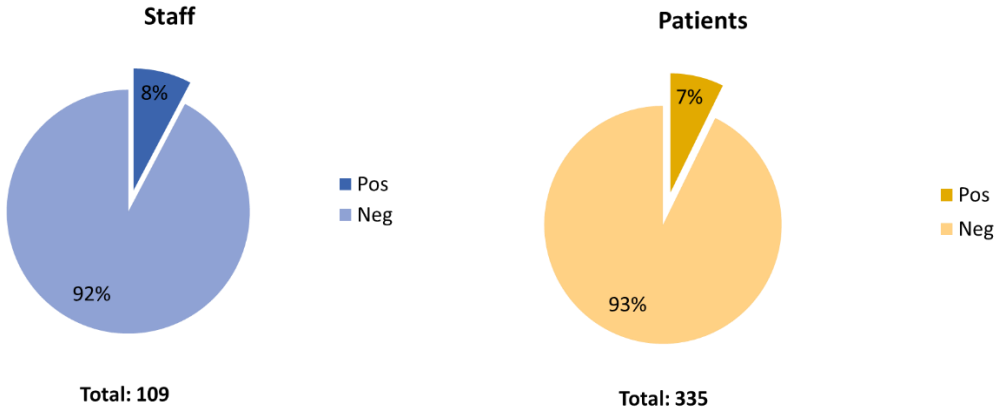


Figure 2 - Results from the asymptomatic COVID-19 infection pilot

4.38 Staff self-swabbing pilot

In June 2020, the Trust undertook a pilot study to evaluate the efficacy of self-taken samples for the detection of COVID-19 infection. Although no positive cases were detected in the self-taken sample group (due to low prevalence at the time of the study), the levels of human cellular control in self-taken samples supported the use of this collection method for asymptomatic screening. Self-taken samples have become routinely used for asymptomatic staff testing in green areas of the hospital and in response to outbreaks, reducing the resources required to undertake testing in these settings.

4.39 COVID-19 Point of Care Testing

The Trust participated in the evaluation and validation of several Point of Care (POC) devices for the detection of COVID-19 in patients including the DNA Nudge and Abbott ID now. Following successful validation, the ID now has been used in the Emergency Departments at the MRI and Wythenshawe hospitals to facilitate rapid identification of positive patients.

4.40 Introduction of PrimeStore Transport Medium

In order to alleviate some of the pressures placed on service delivery and to improve the turnaround time for COVID-19 results, the Virology department implemented the use of PrimeStore (Longhorn Vaccines and Diagnostics, USA) molecular transport medium in December 2020 for the collection of COVID-19 test samples within the Trust. This new medium contains chemicals which have been demonstrated by PHE to inactive SARS- CoV-2, rendering it non-infectious within 10 minutes. MFT was the first Trust in the UK to implement this novel transport medium, significantly reducing the time taken for samples to be tested in the laboratory by eliminating the 'make safe' step required to inactivate samples prior to testing.

Since the introduction of the new transport medium for all patient testing within the Trust, the compliance with the 24-hour turnaround time for testing has significantly increased for both ORC and Wythenshawe sites (chart 4)

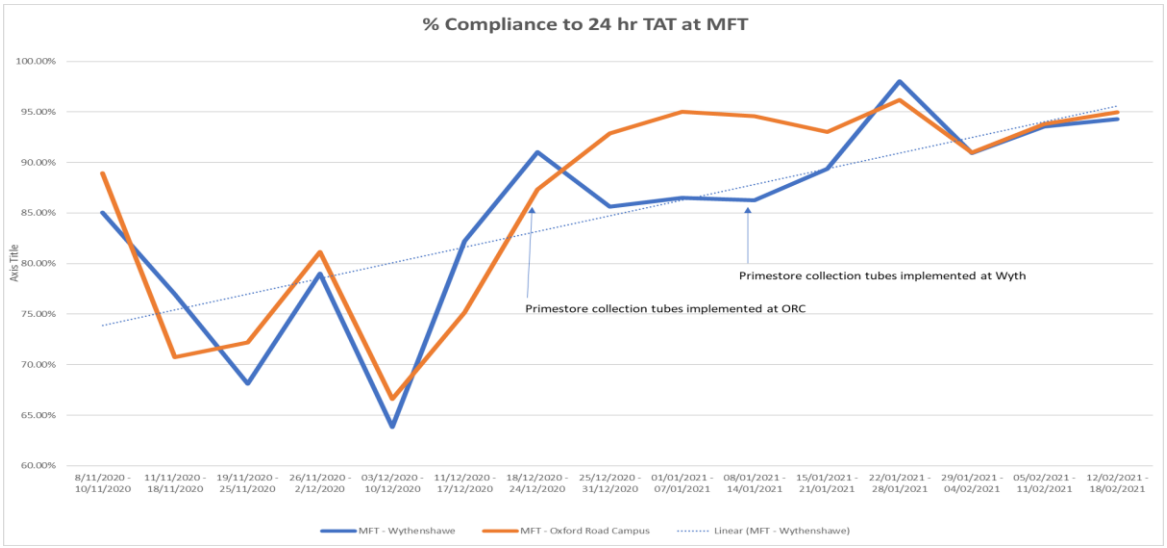


Chart 4 - Improvement in TAT for COVID-19 tests with introduction of PrimeStore transport medium

4.41 Whole Genome Sequencing of COVID-19 to Support IPC Management of Patients

The IPC team has worked closely with Virology and the Genetics Department at MFT on two key studies to investigate the utility of whole genome sequencing to support the investigation and management of hospital onset COVID-19 infection (HOCI) within the Trust.

During the first wave, 173 samples from patients and staff were analysed in collaboration with the Genetics Department at MFT to determine the whole genome sequence for SARS-CoV-2 strains detected in positive individuals. The results of this study (published in e Life: Genomic and healthcare dynamics of nosocomial SARS-CoV-2 transmission) demonstrated that clusters of infection could be identified in staff and patients, with significant associations

between place and time, providing evidence that transmission events have occurred between COVID-19 positive health care workers and patients during the first wave of the pandemic.

Following on from this study, MFT participated in the national COG-UK HOCI study, led by University College London, which aimed to investigate the impact of SARS-CoV-2 whole genome sequencing on the management of HOCIs within secondary care. The outline of the study is shown in figure 3.

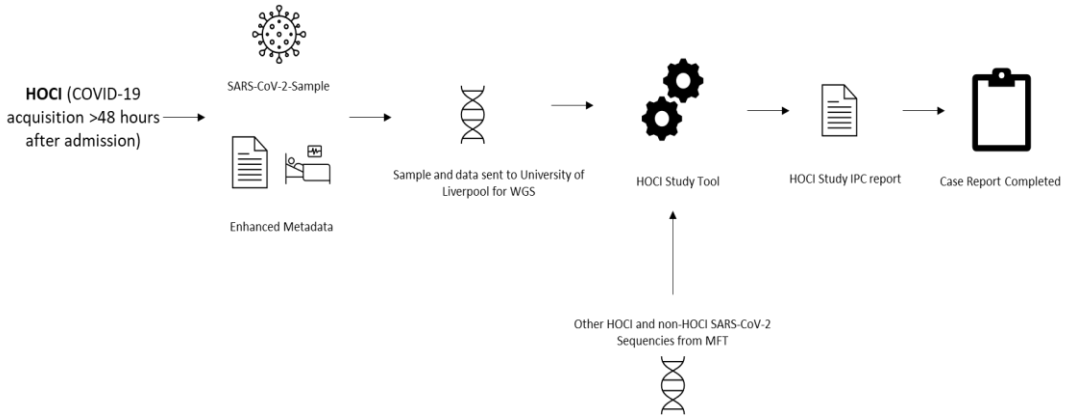


Figure 3 - COG-UK HOCI study outline

A total of 311 HOCI patients were enrolled in the study. Sequencing reports were generated for each case which identified any closely matching cases within the same unit or hospital which may have been involved in direct transmission. This enabled the IPC team to make informed decisions about the likely source of outbreaks and to implement additional IPC measures in response to the reports. The study is now in the analysis phase and publication of the results are expected in the summer of 2021.

4.42 Publications

The contribution of the Virology Team to developing the evidence base is reflected in their contributions to the following three publications

Genomic and healthcare dynamics of nosocomial SARS-CoV-2 transmission (Elife, 2021)

Ellingford JM, **George R**, McDermott JH, **Ahmad S,** Edgerley JJ, Gokhale D, Newman WG,Ball S, **Machin N,** Black GC. Genomic and healthcare dynamics of nosocomial SARS-CoV-2 transmission. Elife. 2021 Mar 17;10:e65453. doi: 10.7554/eLife.65453. PMID: 33729154;PMCID: PMC8009659.

Geographical and temporal distribution of SARS-CoV-2 clades in the WHO European Region, January to June 2020. (Euro Surveillance, 2020)

Alm E, Broberg EK, Connor T, Hodcroft EB, Komissarov AB, Maurer-Stroh S, Melidou A, Neher RA, O'Toole Á, Pereyaslov D; WHO European Region sequencing laboratories and GISAID EpiCoV group; WHO European Region sequencing laboratories and **GISAID EpiCoV group**. Geographical and temporal distribution of SARS-CoV-2 clades in the WHO European Region, January to June 2020. Euro Surveill. 2020 Aug;25(32):2001410. doi: 10.2807/1560-7917.ES.2020.25.32.2001410. Erratum in: Euro Surveill. 2020 Aug;25(33):PMID: 32794443; PMCID: PMC7427299.

Evaluating the Effects of SARS-CoV-2 Spike Mutation D614G on Transmissibility and Pathogenicity (Cell, 2021)

Volz E, Hill V, McCrone JT, Price A, Jorgensen D, O'Toole Á, Southgate J, Johnson R, Jackson B, Nascimento FF, Rey SM, Nicholls SM, Colquhoun RM, da Silva Filipe A, Shepherd J, Pascall DJ, Shah R, Jesudason N, Li K, Jarrett R, Pacchiarini N, Bull M, Geidelberg L, Siveroni I; **COG-UK Consortium,** Goodfellow I, Loman NJ, Pybus OG, Robertson DL, Thomson EC, Rambaut A, Connor TR. Evaluating the Effects of SARS-CoV 2 Spike Mutation D614G on Transmissibility and Pathogenicity. Cell. 2021 Jan 7;184(1):64-75.e11. doi: 10.1016/j.cell.2020.11.020. Epub 2020 Nov 19. PMID: 33275900; PMCID: PMC7674007.

SECTION 5: HEATLHCARE ASSOCIATED INFECTIONS (HCAI)

5.1 HCAI Performance Targets

The prevention and control of infection is a high priority for the Trust and there is a strong commitment to prevention of all HCAI Infections.

This section contains a summary of the data submitted through Public Health England's (PHE) mandatory surveillance system, and summaries of additional alert organisms/trends under local surveillance. Data is presented as number of cases unless otherwise stated. Surveillance data for COVID-19 is included in section four.

The national and local programme for surgical site infection surveillance was suspended from 1st April 2020 due to the pandemic.

5.2 Surveillance data for North Manchester General Hospital (NMGH)

Surveillance data for North Manchester General Hospital (NMGH) are not included within the main body of this section as they continued to be part of the Pennine Acute Hospitals Trust. [5] Please see below.

THE NORTH MANCHESTER CARE ORGANISATION														
	Target 2020 2021	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD Performance/ Target
MRSA BSI	0	0	0	0	0	0	0	0	0	0	1	0	0	1/0
MRSA Acquistion	35	0	1	0	0	0	0	1	0	1	1	1	0	5/35.
MSSA BSI	12	1	2	1	1	1	0	2	0	0	0	1	0	9/12.
E.coli BSI	24	0	2	3	3	0	3	2	3	1	1	1	2	21/24
CDI	35	1	0	3	2	2	1	2	6	1	1	2	1	22/35.
CPE Acquisition	6	0	0	0	0	0	0	0	0	0	0	0	0	0/6.
VRE BSI	12	0	0	1	0	0	0	0	0	0	0	0	1	2/12.
*Please note blood cultures may take up to 5 days to obtain a result														

There was one incident of attributable Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia, 22 attributable incidents of *Clostridium difficile* infection (CDI) and 36 incidents of Gram-Negative Bacteraemia (GNBSI). Formal integration of HCAI data will be complete by May 2021 at which point NMGH data will be presented as part of MFT. All incidents were investigated, supported by the MFT IPC Team from August 2020.

[5] These results are reported by PAHT

5.3 MFT Healthcare Associated Infections (HCAI)

The Trust's performance for key HCAI metrics are presentied below. Final overnight occupied bed data obtained from Informatics was used to determine HCAI rates for the previous and current reporting years to allow performance during the pandemic/reduced activity to be determined by comparing MFT's 2020/2021 position to that of 2019/2020:

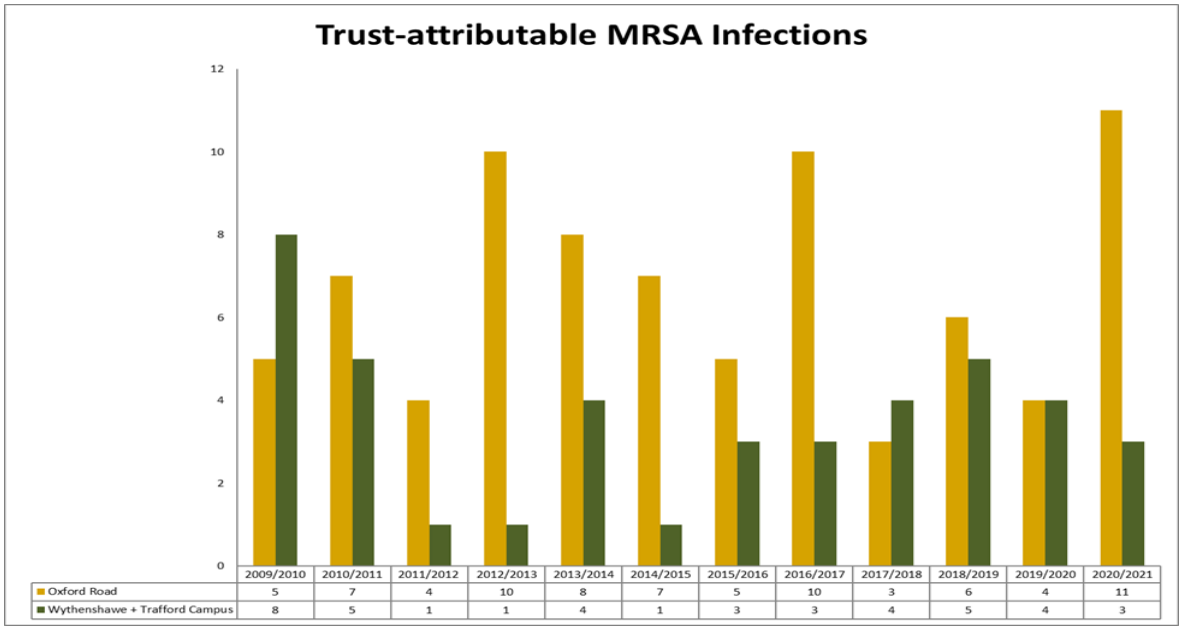
- *Clostridium-difficile* infections (CDI) rates have increased from **19** to **34** per 100,000 overnight beds
- Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia rates have increased from **1** to **3** cases per 100,000 overnight beds
- Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia rates increased from **10** to **19** cases per 100,000 overnight beds
- Gram-negative Bloodstream Infection (GNBSI) rates have increased from **35** to **55** cases per 100,000 overnight beds

5.4 Shelford Group Comparison

The Trust's performance compared to other members of the Shelford Group can not be established accurately due to the impact of the pandemic on activity and an absence of recent overnight bed data for Shelford Group colleagues (required by PHE to calculate rates).

5.5 Incidents of MRSA Bacteraemia and CDI

Performance for the last 12 months for incidents of MRSA bacteraemia and CDI, can be found in Charts 5 and 6 below:



	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021
Oxford Road	5	7	4	10	8	7	5	10	3	6	4	11
Wythenshawe + Trafford Campus	8	5	1	1	4	1	3	3	4	5	4	3

Chart 5: Trust – Attributable MRSA bacteraemia (2007/8 – 2020/21)

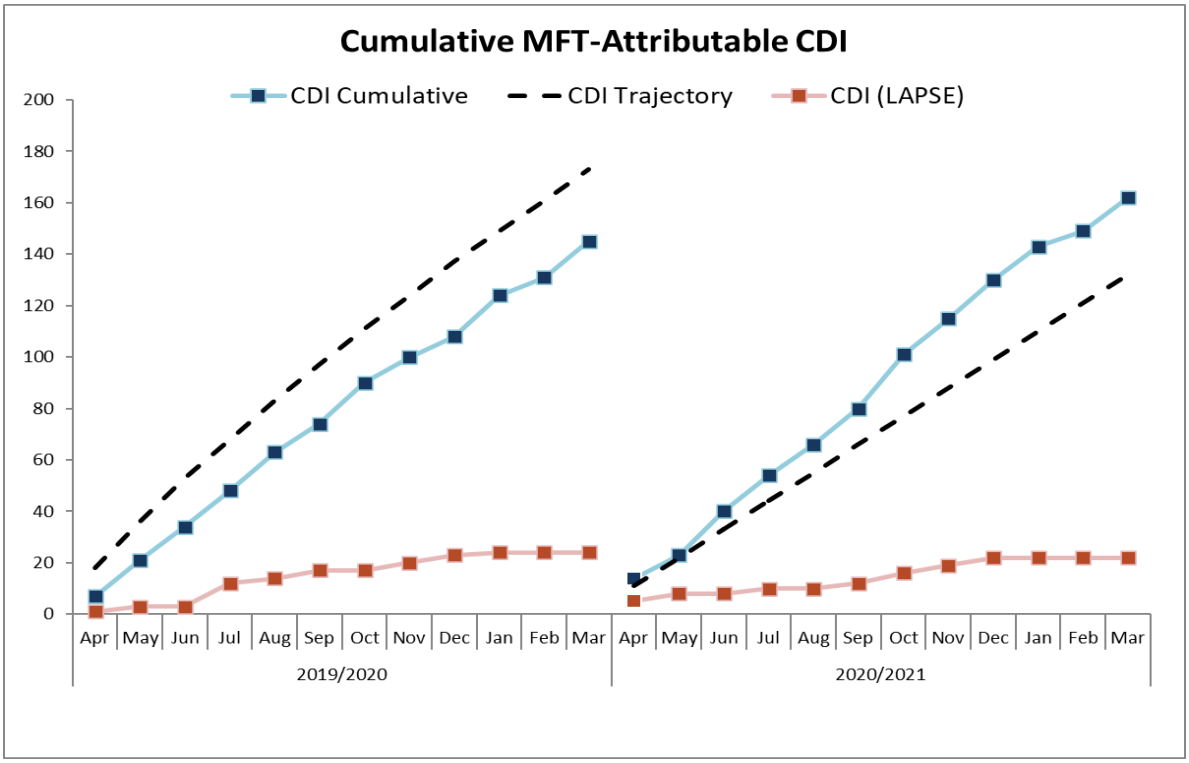


Chart 6: Cumulative Trust Attributable CDI with lapses of care against Trust trajectory

The Chief Nurse/DIPC chaired an end of year review for each hospital/MCS that included outcomes from investigations, analysis of findings and lessons learned for incidents of reportable HCAI's. A summary of individual end of year reports can be found in Appendix 3.

There were several key themes identified applicable across the Trust from investigations into incidents of MRSA bacteraemia and CDI. These can be found below.

Key Themes Identified from Investigations into Incidents of MRSA Bacteraemia and CDI 2020/21	
MRSA Bacteraemia • Non -compliance with MRSA admission screening policy • Manipulated sites not sampled during screening • Delays in commencing MRSA decolonisation therapy.	**CDI** • Antimicrobial stewardship • Non-compliance with policy of isolating a patient with onset of diarrhoea • Delays in sample collection for laboratory testing.

5.6 Gram Negative Bloodstream Infections (GNBSI)

In November 2016, the Department of Health (DH) announced ambitions to halve the number of GNBSI by 2020/21. This objective was amended the DH in January 2019 to a 25% reduction by April 2022 and a 50% reduction by April 2024. There were a total of 719 Gram Negative Bloodstream Infections reported during 2020/2021. Of these, 264 cases (37%) were determined to be hospital-onset, against a trajectory of 228.

5.7 Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia

Mandatory reporting of all MSSA bacteraemia began in January 2011. A total of **220** MSSA bacteraemia cases were reported during 2020/2021 compared to 220 for 2019/20 Of these, **93** cases (**42%**) were determined to be hospital-onset. There is currently no target associated with MSSA bacteraemia incidence.

5.8 Vancomycin-resistant Enterococci (VRE) bacteraemia

A total of **31** trust-attributable bacteraemias were reported compared to **30** trust- attributable cases for the previous year.

5.9 Carbapenemase-producing Enterobacterales (CPE)

The Trust has experienced an on-going problem with CPE since 2009 with *Klebsiella pneumonia* as the most frequently isolated organism. Intensive local IPC measures in line with national and international recommendations have been implemented in response.

5.10 There was a total of **243** CPE acquisitions reported for 2020/2021. This represents a reduction based on last year (**324** cases) but an increase in the rate: from **42** cases to **51** cases per 100,000 overnight beds. Monthly performance can be seen in Chart 7 below which presents CPE acquistion data for Wythenshawe and MRI Hospitals for 19/20 and 20/21.

There were **4** attributable CPE bacteraemias reported during 2020/2021 compared to **8** reported for the previous year.

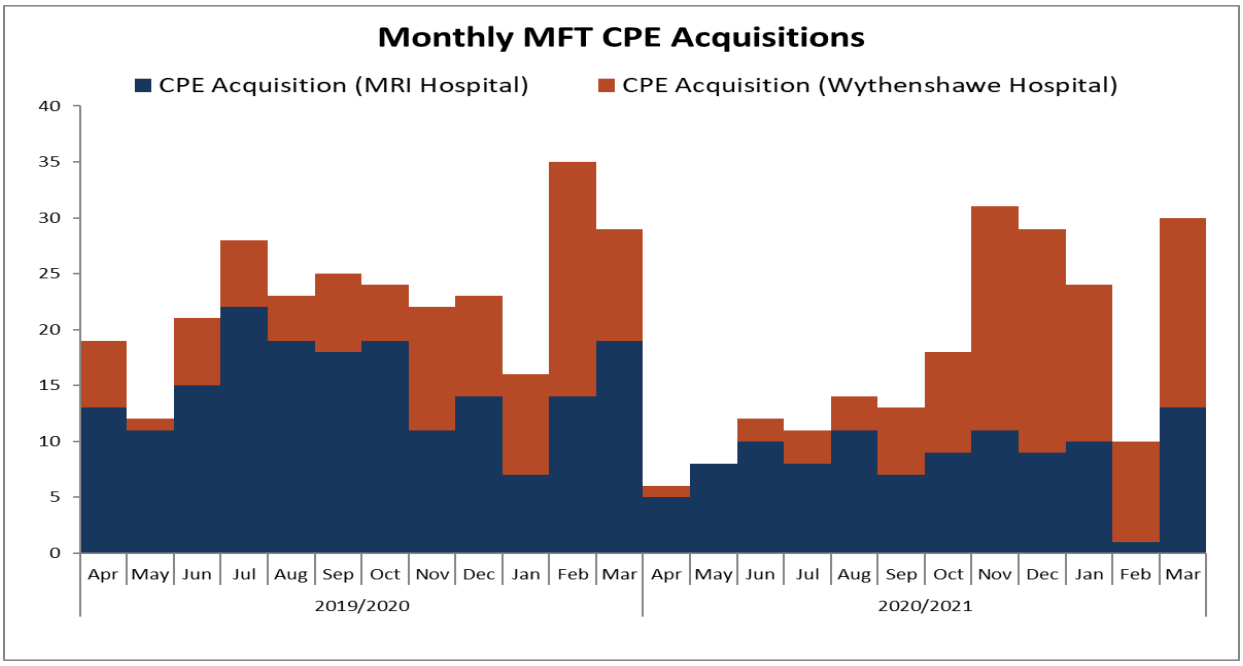
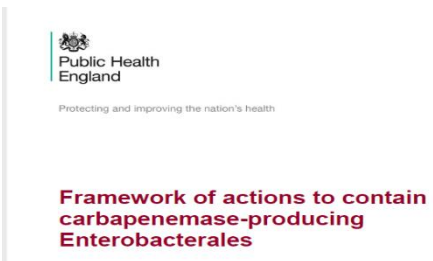


Chart 7: Monthly MFT CPE Acquisitions for April 2019/March 2020 and April 2020/March 21

5.11 Framework of actions to contain Carbapenemase-producing Enterobacterales

The national guidance for managing CPE was combined into a single framework of actions for all healthcare providers and was published in September 2020. Mrs Julie Cawthorne, Assistant Chief Nurse, IPC/TV/Clinical DIPC was a member of the national working group responsible for developing the framework.



5.12 Outbreaks of Infection (non-COVID-19)

There were five discreet outbreaks of Norovirus and two CPE (see below) between March 2020-April 2021. Control measures were implemented and the outbreaks successfully managed.

DATES	WARD	CAUSE	No.PATIENTS AFFECTED	No.STAFF AFFECTED	BED DAY CLOSURES
ORC					
12/06/2020	Ward 37	Norovirus	8	10	240
19/06/2020	Ward 36	Norovirus	5	0	25
07/12/2020	Ward 84	Norovirus	10	18	319
25/01/2021	Ward 84 BMTU/Stem cell	Norovirus	2	4	60
02/03/2021	Ward 84	Norovirus	6	6	290
WTWA					
23/12/2021	A7	CPE	6	0	151
18/12/2021	A4	CPE	3	0	0

SECTION 6: MANAGING THE RISK OF INFLUENZA – STAFF VACCINATION PROGRAMME

6.1 The Chief Nurse/DIPC was the Board champion for the flu campaign actively supported by Senior Medical, Nursing and Management representatives across the organisation.

MFT launched the Employee Seasonal Flu Vaccination Programme across all sites on the 1st October 2020**.** The Department of Health set out clear priorities and measures in relation to preparing for winter and the flu vaccination programme advising that the seasonal influenza programme be considered as a critical component in protecting the NHS Workforce against infection, high sickness absence rates, reduced operational performance and risks to patient's safety. In addition, given the requirement for a minimum of seven days between the administration of the flu vaccine and the Covid-19 vaccine priority was placed on vaccinating the workforce in readiness for the implementation of the COVID-19 vaccine programme.

PHE set a National expectation for all Trusts to accelerate the delivery of their flu vaccination programme to all Frontline Healthcare Workers (HCWs). The target was to vaccinate 75% of HCWs by the end of December 2020. By the end of the programme Trusts were expected to have offered the vaccine to 100% of all staff. The Trust achieved an uptake of 81.1% frontline HCW's

6.2 Delivery of the 2020/21 Employee Influenza Vaccination Programme Influenza

The Employee Flu Vaccination Task and Finish (T&F) Group was established in August 2020 and included stakeholders from across the Trust, with Flu Leads from all Hospitals/MCS Corporate and Community Teams. The T&F Group reported to the Strategic Group and developed a robust plan which included and built on the successes from the previous year's programme as well as incorporating lessons learned.

The previous year's 'Spot the Dot' campaign was relaunched and proved very successful in terms of improved engagement and greater visibility of who has had their vaccine. All vaccinated staff were given a yellow 2020 flu sticker to be placed on their identity card - making it fun and easy to see who has had their vaccine and to encourage conversations with staff who have not yet had their vaccines.

A key improvement for this year's programme was the capture of the vaccination record into the Empactis Platform, at the point of vaccine administration. Managers were able to view in real-time who in their teams had been vaccinated. This approach provided real-time data to support targeted activities by both manager and the Flu Champions. Consequently, the trust was

able to evidence the 100% offer to all staff with Managers completing a Manger Wellbeing Discussion and recording the outcome on the Empactis Platform (as a Health Manager record). The information on why employees decline their vaccine will be used in planning future campaigns.

Due to Covid-19 restrictions all flu clinics were delivered in local areas, rather than staff attending pop-up and roaming clinics. Open clinics operated on a booking system to ensure that social distancing takes place.

Flu champions training was delivered via the Learning Hub making it possible to increase our pool of Flu champions with over 500 trained Flu Champions (compared to 261 for the previous year). The Flu Champions provided vaccination clinics across all areas of the Trust and covering all shifts. This is in addition to the daily clinics provided by the EHW service via an appointment system.

The Employee Health and Wellbeing (EHW) Flu Lead continually supported the Local Flu Leads and Champions, providing weekly training reports, delivering remote weekly training sessions, and addressing any issues or challenges. They also delivered regular remote training sessions for managers to upskill them on the Manager Wellbeing Discussion approach, assisting them to have supportive conversation with their staff and input the outcome onto the Empactis platform.

A new initiative was delivered by the EHW, OD&T and communications s team called 'Flu's Round'. The teams produced a fun and informative video programme weekly over a 6-week period which highlighted key achievements and successes and recognised all the hard work being done across all areas. The programme was supported by the Chief Nurse who featured in each episode as a key figurehead.

The Communication Team facilitated the creation of a short video called 'The Race Is On' which again helped to raise the profile of the campaign and focused on the importance of staff have their vaccine as soon as possible.

A summary of seasonal employee influenza vaccination programme data can be found on page 35

Data as on : 22/02/2021 at 08:00 AM

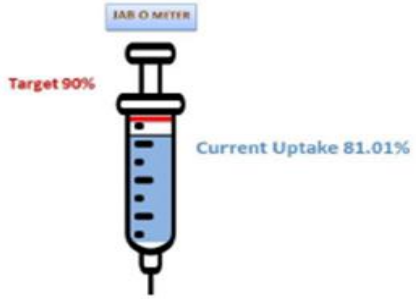
SEASONAL INFLUENZA EMPLOYEE VACCINATION PROGRAMME - DATA SUMMARY

NHS Manchester University NHS Foundation Trust

MFT HEADCOUNT	
Total MFT Staff	22310
Total Frontline HCW Staff	15884
Non Frontline HCWs Staff	6426

PHE Target	
Number of Frontline HCWs Staff to achieve-90%	14296
Uptake to Date vs PHE 90% target Frontline HCWS	90.0%
Uptake to Date vs 100% Frontline HCWs	81.01%

CURRENT VACCINE UPTAKE	
MFT Staff Vaccinated	16987
Frontline HCWs Vaccinated	12867
Non Frontline HCWs Staff	4120



VACCINE ADMINISTRATED BY:	
Flu Champions	15884
Total Administer by MFT	15884
External Services	1103
Total Vaccinated	16987

Declined after manager completed employee wellbeing discussion	1249

MONTHLY BREAKDOWN VACCINES ADMINISTERED	October	November	December	January	February	Total
Frontline Healthcare Workers	9192	2498	947	155	75	12867
Non Frontline Healthcare Workers	2873	880	288	52	27	4120
Total	12065	3378	1235	207	102	16987

FRONTLINE HEALTHCARE WORKERS BY HOSPITALS/MCS/MLCO/CORPORATE

HOSPITALS/DIVISIONS	Total Staff	FL HCWs	90% PHE Target	FRONTLINE HCWs UPTAKE										Total	
				October		November		December		January		February			
Charitable Funds	30	1	1	0	0.00%	1	100.00%	0	0.00%	0	0.00%	0	0.00%	1	100.00%
RMCH	2139	1769	1592	917	51.84%	211	11.93%	183	10.34%	9	0.51%	24	1.36%	1344	75.98%
CSS	3854	2606	2345	1504	57.71%	414	15.89%	147	5.64%	24	0.92%	10	0.38%	2099	80.54%
Corporate Services	1431	244	220	135	55.33%	38	15.57%	10	4.10%	7	2.87%	0	0.00%	190	77.87%
UDH	268	177	159	78	44.07%	24	13.56%	5	2.82%	4	2.26%	0	0.00%	111	62.71%
Estates & Facilities	330	13	12	11	84.62%	0	0.00%	1	7.69%	0	0.00%	0	0.00%	12	92.31%
LCO	2777	2331	2098	1071	45.95%	473	20.29%	137	5.88%	6	0.26%	5	0.21%	1692	72.59%
MRI	3664	2916	2624	1460	50.07%	393	13.48%	186	6.38%	52	1.78%	13	0.45%	2104	72.15%
Research	548	218	196	151	69.27%	20	9.17%	5	2.29%	0	0.00%	1	0.46%	177	81.19%
Royal Eye Hospital	540	389	350	230	59.13%	29	7.46%	21	5.40%	5	1.29%	1	0.26%	286	73.52%
St Marys Hospital	2152	1604	1444	796	49.63%	283	17.64%	89	5.55%	22	1.37%	4	0.25%	1194	74.44%
WTWA	4577	3616	3254	1979	54.73%	344	9.51%	158	4.37%	24	0.66%	17	0.47%	2522	69.75%
Others **				860		268		5		2				1135	
Grand Total	22310	15884	14296	9192	57.87%	2498	15.73%	947	5.96%	155	0.98%	75	0.47%	12867	81.01%

** Others comprise of Frontline Healthcare Workers who do not hold an ESR record and therefore cannot be assigned to one of the Hospitals/Divisions. This includes; Lead Employer, Doctors, Locums, Bank, Agency, NHSP

Frontline HCW as Defined by PHE (Categories Used for Data Submission)

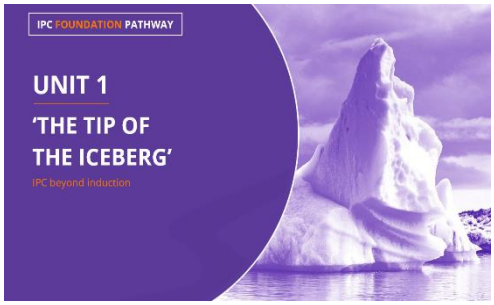
Frontline HCW Staff	FL HCWs	90% PHE Target	MONTHLY UPTAKE FIGURES										Total	
			October		November		December		January		February			
Doctors/Dentists	1985	1787	1317	66.35%	339	17.08%	121	6.10%	13	0.65%	3	0.15%	1793	90.33%
Nurses/Midwives	7269	6542	4348	59.82%	1115	15.34%	424	5.83%	80	1.10%	24	0.33%	5991	82.42%
Professionally Qualified Clinical Staff	2482	2234	1501	60.48%	439	17.69%	153	6.16%	19	0.77%	17	0.68%	2129	85.78%
Support to clinical Staff	4148	3733	2026	48.84%	605	14.59%	249	6.00%	43	1.04%	31	0.75%	2954	71.22%
Grand Total	15884	14296	9192	57.87%	2498	15.73%	947	5.96%	155	0.98%	75	0.47%	12867	81.01%

6.3 The Infection Prevention and Control Development Pathway (IPCDP)

Further to a review of GM specialist workforce for IPC, an 'Infection Prevention and Control Development Pathway' (IPCDP) was commissioned in October 2020. A member of the MFT IPC/TV Nursing Team was seconded to develop the programme which was overseen by the Chief Nurse/DIPC at MFT supported by the regional IPC team.

The framework was intended to support the development of skills and knowledge in IPC for all healthcare workers. It was designed to assist development from a fundamental awareness of IPC to a more specialist understanding, enhancing behaviours and skills. There are three pathways in place:

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



Funds were secured to implement an e-learning platform and the programme was tested by GM IPC leads.

The IPCDP Foundation level is due to be launched in July 2021 across Greater Manchester, overseen by MFT's Chief Nurse/DIPC through a working group attended by IPC leads from hospitals and then rolled out across the NW region.

SECTION 7: ANTIMICROBIAL STEWARDSHIP (AMS)

7.1 Local AMS challenges have been driven primarily by staff redeployment, including the AMS pharmacist team, a move to virtual communication platforms and diagnostic uncertainty heightened by bacterial co-infection rates reported in influenza.

7.2 Maintaining core AMS functions

The main emphasis throughout the pandemic was placed on preserving core AMS functions through:

- Early and responsive guideline development and decision support tools utilising the MicroGuide platform, (MicroGuide statistics show that the MFT guidelines get over 1000 hits per day)
- Close liaison with surveillance/IPC team
- Monitoring of broad-spectrum antimicrobial usage
- Regular audit of antimicrobial prescribing including on COVID-19 cohort wards
- Embedding AMS within daily COVID-19 Multi-Disciplinary Team (MDT) meetings
- Empowering ward pharmacists with behaviour change training

7.3 Baseline snapshot antibiotic prescribing reviews

Baseline snapshot antibiotic prescribing reviews conducted Trust-wide in May and October 2020 on COVID-19 cohort wards demonstrated a progressive reduction in antibiotic prescribing for patients with COVID-19 pneumonia, 66.2% and 41.8% respectively.

7.4 Snapshot antimicrobial prescribing review on COVID 19 cohort wards May 2020 and October 2020

Over two days in May 2020 and October 2020 the antimicrobial pharmacists reviewed 145 (May) and 208 (October) patients on COVID – 19 cohort wards at ORC and Wythenshawe. Drug chart, medical notes (where available) and EPR/Chameleon information were used as sources of information. Critical care areas were excluded from the review as microbiology regularly input into this cohort.

7.5 Results May 2020

Total number of patients reviewed	Number on antibiotics (in the last 7 days)	Antibiotics for COVID pneumonia	Antibiotics for non COVID indications
145	71	47	24

49% of patients reviewed had received antibiotics within the last 7 days, with the majority still on active treatment. Two thirds of antimicrobials prescribed were for COVID-19 related pneumonia with 24% being hospital acquired pneumonia and 76% being community acquired pneumonia.

7.6 Results October 2020

Total number of patients reviewed	Number on antibiotics (in the last 7 days)	Antibiotics for COVID- 19 pneumonia	Antibiotics for non COVID indications
208	86	36	25

41.3% of patients reviewed had received antibiotics within the last 7 days, with the majority still on active treatment. 41.8% of antimicrobials prescribed were for COVID-19 related pneumonia with 15.1%being hospital acquired pneumonia and 13.9% being community acquired pneumonia.

The results of the audit were feedback to the clinicians and an action plan developed.

7.7 Actions

Regular snapshot reviews of COVID – 19 cohort areas
Snapshot review of: • ED • ICUs To provide more insight into how antimicrobials are prescribed on admission and in critical care. This requires engagement with senior pharmacists in these key areas.
Review diagnostic flow chart in COVID-19 antimicrobial guidelines Engagement with clinicians on wards
Education package for clinical pharmacists to reinforce the importance of antimicrobial stewardship in COVID-19 pneumonia

7.8 Development of a COVID-19 AMS ward round

To further build on positive progress and to re-establish face to face AMS activities, in December 2020 the IMPACT (**I**nvestigating **M**icrobiology and **P**harmacy led **A**ntimicrobial stewardship interventions in **C**OVID-19 **T**reatment) project was launched Trust-wide in the form of twice weekly Consultant Microbiologist and Antimicrobial Stewardship Pharmacist led AMS ward rounds on COVID-19 cohort wards. The aims of the project were to:

- Improve AMS awareness
- Reduce the inappropriate use of antimicrobials
- Provide infection specialist support to complex patients
- Utilise AMS 'behaviour change' training
- Audit compliance with Trust guidelines

Data was collected prospectively between December 2020 and March 2021 for 129 patients prescribed antimicrobial therapy and/or dexamethasone. Acceptance of interventions suggested, diagnostic samples requested and compliance of remdesivir and dexamethasone prescribing with Trust guidelines was reviewed.

7.9 Results

Length of stay at time of review

Length of stay (LoS) (days)	Number of patients
≤3	80
4-7	17
≥8	24
Blank	8

7.10 Breakdown of prescriptions for broad spectrum antibiotics and associated length of stay

Antibiotic	Number prescriptions	LoS (≤3 days)	LoS (≥4 days)
Ceftriaxone	33	25	8
Co-amoxiclav	9	6	3
Piperacillin/tazobactam	20	4	16
Meropenem	5	2	3
Ciprofloxacin	2	2	0
Levofloxacin	1	1	0
Total	**70**	**40**	**30**

7.11 Compliance with MFT Remdesivir and dexamethasone guidance

Compliant?	Remdesivir		Dexamethasone	
Yes	36	87.8%	83	94.3%
No	5	12.2%	5	5.7%

Reasons for non-compliance with Remdesivir and dexamethasone prescribing guidelines are broken down in the tables below:

Remdesivir reason for non-compliance with Trust guidelines	No. of prescriptions
Patient not requiring oxygen	1
Treatment commenced outside 10/7 symptom window	4

Dexamethasone reason for non-compliance with Trust guidelines	No. of prescriptions
Patient not requiring oxygen	4
Patient discharged home on dexamethasone	1

7.12 Interventions made by the IMPACT ward round team

Interventions were recommended for 75.5% of prescriptions for antibiotics with an acceptance rate of 90.1% by the clinical team.

Reasons for interventions not accepted by the clinical team included:

- A reluctance to stop/de-escalate broad spectrum antibiotics (piperacillin/tazobactam) despite low procalcitonin (PCT)

- Unwilling to stop/de-escalate broad spectrum antibiotics piperacillin/tazobactam) despite normal inflammatory markers and a lack of positive cultures (only sputum sent – nil growth)

7.13 Diagnostics

Only 9.6% of prescriptions for antibiotics were supported with more than one appropriate diagnostic sample and 35.1% had no diagnostic samples sent at the time of review.

7.14 Use of procalcitonin (PCT)

PCT was requested for a total of 17 patients reviewed (16 ORC and 1 Wythenshawe) and when low and acknowledged, contributed to antibiotics being stopped for six patients.

7.15 Actions for taking forward

- Behaviour change orientated face to face AMS activities were positively received with a clear and demonstrable beneficial impact on optimising antimicrobial use and reducing inappropriate antimicrobial use in COVID-19 treatment.
- Diagnostic stewardship needs to be promoted and emphasised to help inform diagnostic uncertainty.
- AMS ward rounds with a focus on behaviour change need to be rolled out as a consistent and resilient service to wider areas with a view to supporting the development of AMS champions and establishing local AMS ownership.

7.16 Sharing the MFT experience

The AMS leads at MFT were invited to present the trusts progress and achievements at a National Department of Health/Public Health England *English Surveillance Programme for Antimicrobial Utilisation and Resistance* (ESPAUR) meeting in February 2021 and at a National webinar to share AMS lessons learned in secondary care in March 2021.

SECTION 8: MAINTAINING a CLEAN ENVIRONMENT

8.1 GOVERNANCE ARRANGEMENTS

Decontamination, Ventilation and Water services were governed by policies along with local operational plans. Each topic had local safety groups reporting into a group level committee that met quarterly and reported into the Group Infection Control Committee (GICC). All appropriate professional appointments, including Authorising Engineers (AE), were in place and monitored

through the Estates and Facilities Group Management Board (EFGMB). The services were assured by a programme of independent annual audits.

The Trust welcomed the new appointment of a Trust Decontamination Lead in July 2020

8.2 DECONTAMINATION SERVICES

Maintenance and servicing of all the decontamination equipment across the Trust has continued with the active support of our service contractors.

All decontamination services within the Decontamination Services Department (DSD) at Oxford Road Campus (ORC) have continued to function as normal throughout the COVID-19 response period, but with some reduction in throughput with the cessation of surgery and out-patient clinics.

In respect of the Endoscopy Services, there were reduced levels of patient activity and associated equipment throughput, resulting in reduced use of the Automatic Endoscope Repressors (AERs). Therefore, the decision was taken early in the COVID-19 response period to keep all decontamination equipment (AERs and Endoscope Drying Cabinets) running so that a return to Business as Usual could be effected without the need for recommissioning microbiological samples and the 4 to 5-week delay that this would entail.

Sterilisation of reusable surgical devices was undertaken centrally on-site at the ORC in the DSD. The Department is accredited to ISO 13485:2016 medical devices quality management system requirements for regulatory purposes and was also assessed and certified as meeting the requirements of the European Medical Devices Directive 93/42/EEC Annex V. The Department is undergoing a life cycling programme for all 5 Sterilisers and 9 Instrument Washer disinfectors and as part of this all Sterilisers were replaced successfully in December 2020. All washer disinfectors are due to be replaced between June 2021 and December 2021 together with upgrades to the DSD Cleanroom.

Wythenshawe, Trafford, and Withington Hospitals continued in partnership with Christies and North Cheshire to receive sterile services from Steris, the independent decontamination services provider based in Wythenshawe. This was monitored by the Wythenshawe, Trafford, Withington & Altrincham (WTWA) Estates & Facilities Decontamination Group through Positional Reports provided by the Contract Manager.

Decontamination of flexible endoscopes was undertaken on the ORC in satellite units, within associated clinical areas and at Trafford, Wythenshawe, and Withington in centralised units. The Endoscopy Departments at Manchester Royal Infirmary (MRI) Endoscopy Unit, Trafford and Wythenshawe Hospitals are accredited by the Joint Advisory Group (JAG) with some actions noted (see below).

In the community premises, decontamination is confined to the community dental practices where instruments are processed through benchtop sterilisers. The community dental practices are within the remit of NHS Property Services who maintain the sterilisers to HTM 01-05: Decontamination in Primary Care Dental Practices. Annual audits to HTM 01-05 were undertaken by the dental service in June 2020. The audit did not identify that any serious corrective actions were required.

8.2.1 Achievements:

The Wythenshawe Endoscopy Decontamination Service (EDS) is to undergo a major upgrade. A Mobile Endoscope Decontamination Unit was delivered to the Wythenshawe Hospital site in December 2020 as back up and contingency during the upgrading programme.

A new electronic tracking and tracing was successfully procured by the Trust during 2020. The installation will be completed at ORC and Trafford by the end of April 2021. Wythenshawe will then follow.

8.3 Ongoing Planning & Developments

A set of additional risk-mitigation workstreams were established to address ongoing issues including

- Lifecycle upgrade of DSD facilities at ORC (started in July 2020 with expected completion in December 2021)
- Introduction of a fourth Automated Endoscope Reprocessor (AER) at Trafford (*completed in November 2020*)
- Review of DSD & endoscopy facilities across MFT (*started in 2020)*

8.4 Additional Quality Improvements Regarding the use of Nasendoscopes

Previously nasendoscopes used at Trafford Ear Nose and Throat (ENT) Department were decontaminated between use using a manual process. The installation of a fourth AER at Trafford enabled nasendoscopes to be decontaminated through an automated process which meets the Essential Quality Requirements (EQR) in HTM01-06.

The reusable nasendoscopes used at Altrincham Hospital were replaced with Single-Use nasendoscopes until such time as the department has a suitable automated method of decontaminating these scopes.

8.5 WATER SAFETY:

8.5.1 Management of Risk for *Legionella*:

Water sampling for Legionella and Control of Legionnaires' disease was undertaken in accordance with COSHH Regulation (2002), Approved Code of Practice L8, Health Technical Memoranda (HTM-04) and Health & Safety Guidance (HSG) 274 across Trust sites. Remedial action was successfully undertaken on outlets that did not meet the required standard.

All building and engineering projects were required to provide additional testing if they included modification or connection to the existing water system, including the need to undertake Water Risk Assessments in line with the above guidance.

Site Water Safety Groups (WSGs) continued to meet quarterly to monitor any risks, issues, positive samples, remedial works, reactive works, derogations, and lifecycle works.

MFT continued to obtain assurances that regulations and guidance are being complied with in community premises, by regular meetings with landlords, requesting copies of documents such as Legionella Risk Assessments (LRA`s) and Water Safety Plans (WSPs) that are required under the regulations and general updates on water system compliance and maintenance. Any non-

compliances were discussed and addressed at the meetings. Issues that require escalation were taken to the Group Water Safety Committee.

During the COVID-19 pandemic, areas that became vacant were identified as 'little-used outlets' and a programme of flushing was employed in these areas to ensure that water systems did not become stagnant. Where Estates operatives needed to enter COVID-19 areas, for emergency repairs or statutory maintenance, the teams worked with clinical leads to develop Standard Operating Procedures (SOPs) including the use of the correct personal protective equipment.

8.5.2 Management of *Pseudomonas aeruginosa* from Water Outlets in Higher-Risk Clinical Areas

The review of areas classified as Augmented Care for the purpose of sampling for *Pseudomonas* took place across the Trust and were agreed by Water Safety Groups. Sampling for Pseudomonas continued in accordance with HTM04-01 Part C.

Water Safety Groups considered the issue of whether any additional sampling for *Pseudomonas* was required in areas that had been designated for use by COVID-19 positive patients during the pandemic. It was agreed that these areas would not require sampling. Sampling for *Pseudomonas*, therefore, continued as across Augmented Care Areas, using safe systems of working, in accordance with the addendum to HTM 04 with appropriate follow up on positive results.

8.5.3 Key Achievements

Estates & Facilities on the ORC site have moved to a joint appointment approach to the Authorising Engineer role in conjunction with PFI Partners. This has resulted in a new AE (for ORC) being appointed and a more collaborative approach being fostered. The AE carried out an initial site audit in December 2020 and work is ongoing to address its findings.

Water Safety training sessions have been delivered by the Water AE to enhance awareness and advise of legal responsibilities to Estates and PFI teams at WTWA and IPC colleagues.

The WTWA Estates and Facilities Matron continued to attend the clinical COVID-19 outbreak meetings which supported the daily updates delivered to the WTWA Senior Management Teams. Information was then cascaded throughout the sites to keep colleagues appraised of the dynamic site changes.

8.6 VENTILATION:

The management of Ventilation Systems was undertaken in accordance with HTM 03-01 Specialist Ventilation for Healthcare Premises and HSG 258; this includes the design, maintenance, and operation of ventilation systems.

All new and refurbishment schemes were required to provide verification reports, inclusive of commissioning information and any derogations where new systems were introduced or were being connecting to existing plant. Where new critical ventilation was installed, i.e. theatres, independent validations were also carried out which were approved and accepted via AE (Ventilation) and Trust APs.

The quarterly site Ventilation Safety Groups (VSG) continued to monitor risks, issues, failed verifications, remedial works, reactive works, derogations, and lifecycle works. Issues that require escalation were taken to the Group Ventilation Committee.

Across the Community estate, there are no Air Handling Units (AHUs) that are classified as Specialised Ventilation. Where AHUs are installed, they were maintained in accordance with SFG20, HVAC and CIBSE standards where applicable. Ventilation systems in the community premises were reported on by Landlords to MFT through regular meetings and any issues that need escalation were reported to the MFT Group Ventilation Committee.

8.6.1 Key Achievements

During the pandemic significant changes were undertaken to critical and non-critical ventilation systems. This was undertaken in line with guidance as it was released and following discussions and collaboration with IPC colleagues and Authorised Engineers for ventilation.

Many systems were rebalanced against design to achieve the necessary pressure cascades required. This delayed the annual maintenance & verification in some of the operating theatres during 2020. Live trackers were developed to capture ventilation flow rates and pressure regimes (pre and post changes) to ensure that the areas could be reverted to their original state post pandemic.

8.7 CLEANING SERVICES:

8.7.1 Contracting Arrangements

The Trust cleaning services were provided by both internal and external contractors/teams.

- Sodexo Healthcare were the main contractor for the provision of cleaning services across the Oxford Road Campus, including the Dental Hospital, and at Wythenshawe Hospital.

- Withington, Trafford and Altrincham Hospitals and the Intermediate Care Units all had services provided by in-house teams.

8.7.2 Monitoring Arrangements

As part of the contracts, Sodexo were required to self-monitor the performance of cleaning services against key performance indicators. These were reported to the Trust on a monthly basis for analysis and challenged where appropriate by the Estates and Facilities Team.

The services at Withington, Trafford and Altrincham Hospitals and the Intermediate Care Units were managed and monitored through internal in-house arrangements with the service managers and local users.

In addition, the standards of cleanliness were monitored and reported for all sites through the monthly Quality of Care Rounds, the Ward Accreditation Process, and the What Matters to Me (WMTM) Tracker, although during the pandemic some aspects of these additional quality measures were reduced or suspended. These results informed areas of best practice and areas where additional focus was required.

8.7.3 The Role of the Infection Prevention and Control Team

The Infection Prevention and Control Team worked in conjunction with the Trust Estates and Facilities Teams, Clinical Divisions, Sodexo, and internal providers to ensure cleaning standards were met across the Trust and any changes required such as increased touch point cleans were introduced throughout the pandemic.

8.7.4 Cleaning Schedules

Cleaning schedules were publicly displayed in all clinical areas and processes were in place to report and escalate cleaning problems. These included: an agreed process which provided users with information on what services should be delivered and how to escalate non-compliance; and, a cleaning matters/log book process which required clinical and cleaning staff to record the completion of tasks and log additional or amended requirements.

8.7.5 Patient Led Assessment of the Care Environment (PLACE)

The PLACE assessments were suspended nationally in 2020/21 due to COVID-19.

SECTION 9: TRAINING and EDUCATION

9.1 The focus of the IPC team training this year was on general IPC practice and the donning and doffing of the PPE required in COVID-19 areas to the following groups of staff

- Senior Management Teams across MFT (to enable them to support their staff)
- Staff Re-deployed to other areas including dental hospital staff redeployed to across sites
- Clinical Education teams, to enable them to support their colleagues
- Medical illustration team.
- Medical electronic team
- Bespoke sessions for ward and department teams as required.

In April 2020 Nightingale Hospital North West opened to receive COVID-19 patients from across the North west of England, the IPC team from Oxford Road site in conjunction with Salford University provided the core induction including IPC and PPE training for all members of the Team, including assessment of PPE donning and doffing.

In addition to these sessions the team supported general IPC sessions for

- Internship programme at Trafford General Hospital
- Student nurses
- International nursing team and support in their OSCE preparation
- Induction sessions across Trust site

SECTION 10: END OF YEAR IPC REPORTS from HOSPITALS/MCS/LCO

10.1 The Chief Nurse/DIPC requested an end of year review for each hospital/MCS/LCO that included a review of IPC activity from April 2020 – March 2021 that incorporated areas of good practice and lessons learned.

The review meetings were held individually with the Directors of Nursing, supported by their Senior Team and local Infection Control Doctor and IPCN(s). The review panel was led by the Chief Nurse/DIPC supported by the Associate Medical Director for IPC and the Assistant Chief Nurse IPC/Tissue Viability/Clinical DIPC**.** The sessions were an opportunity to reflect and focus and feedback was very positive from all those involved.

10.2 The Main focus of the reviews included:

- Overall IPC governance and accountability model
- MRSA bacteraemia – outcome from investigations and analysis of the findings (avoidable/unavoidable)
- C. difficile – number compared to 19/20 and learning
- VRE bacteraemia – numbers compared to 19/20 and learning
- COVID-19 – number of outbreaks/nosocomial infections – learning
- Fit testing – position - challenges/best practice

The Hospital/MCS/LCO teams were supported to prepare and attend the review by a named IPC Nurse and Infection Control Doctor. A summary of all the reviews can be found in Appendix 3

SECTION 11: CONCLUSION

11.1 This report demonstrates the response to the pandemic of COVID-19. It evidences the commitment, dedication, and hard work of all staff at all levels of the organisation to work together to achieve safe standards of patient care in unprecedented circumstances.

11.2 There are risks to patient safety from emerging infections both bacterial and viral in origin, that are unpredictable. This has been evidenced over recent years by the trust's response to MRSA and CPE as well as high levels of seasonal Influenza and most recently by COVID-19.

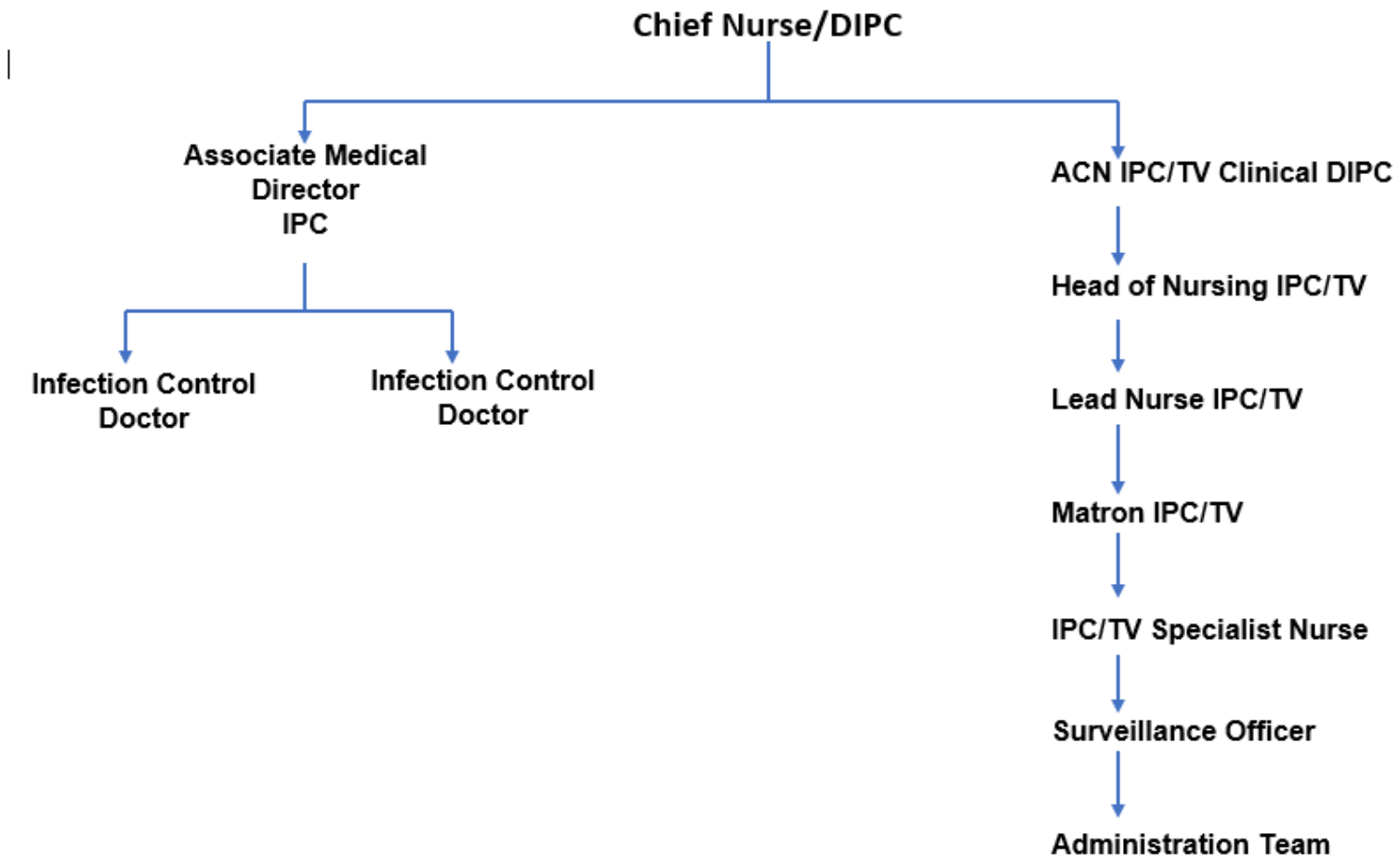
11.3 Transmissible infections are a significant risk to patient care compounded by key challenges within the acute and community healthcare settings such as: the age and condition of some of the trust's buildings, lack of sufficient isolation/cohort facilities and antimicrobial resistance.

11.4 There is no room for complacency, to maintain patient safety and reduce the risk of infection it is essential to continue adherence to IPC practices by all members of staff. It is imperative that practice and attitudes remain at a heightened level and all staff must continue to be vigilant including upholding the principles of 'hands' 'face' 'space' 'ventilation'.

11.5 The trust would like to acknowledge the contribution of all staff across all disciplines, including volunteers and patients in supporting our efforts to prevent, control and manage infections. Staff are committed to the learning and continuous improvement highlighted in this report and will continue to strive to deliver the safest and best care in IPC.

11.6 The Board of Directors are asked to receive this report for April 2020 to March 2021 and approve for publication.

Appendix 1 **MFT IPC/TV Nursing Team Structure 2020/21**



Appendix 3

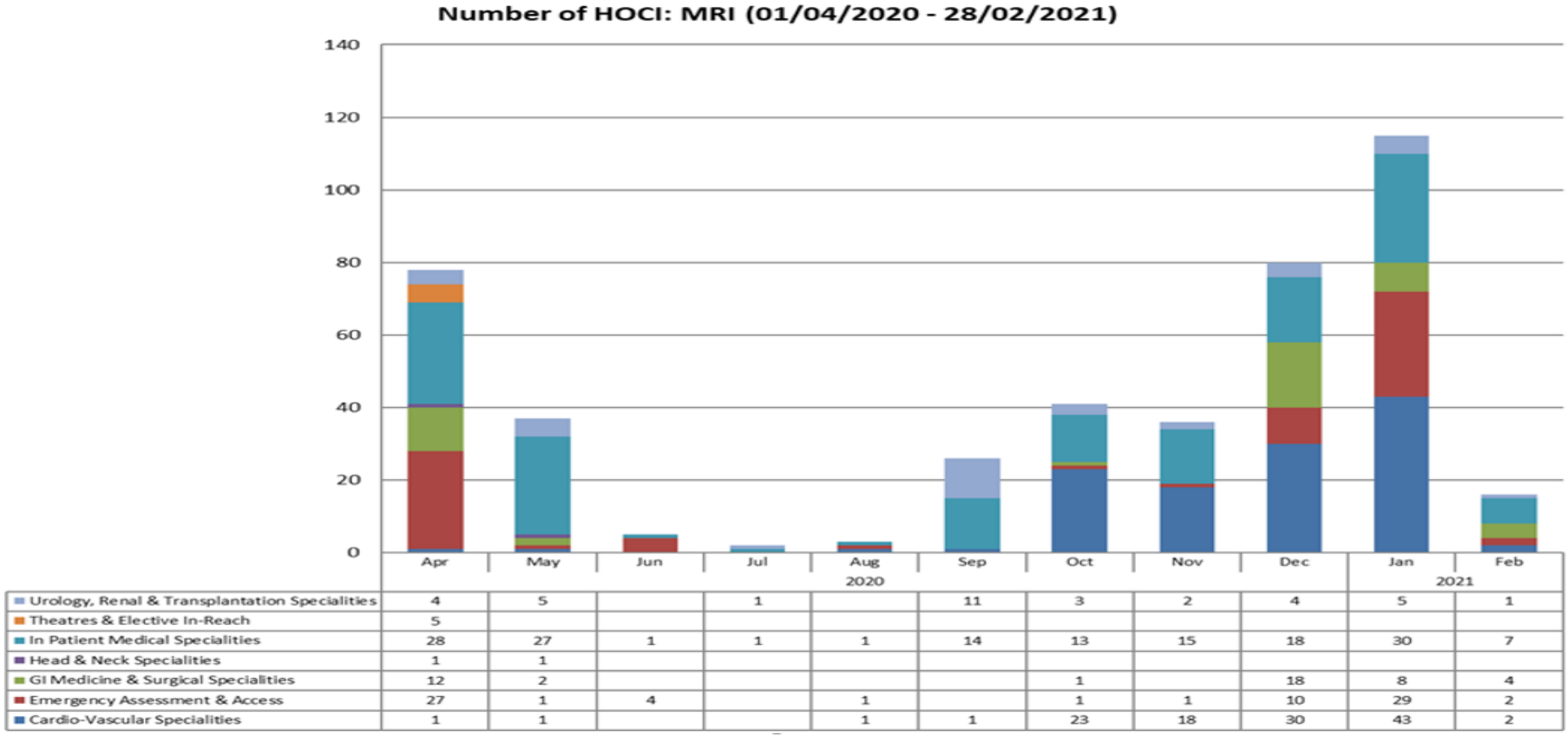
Manchester Royal Infirmary End of Year IPC Update 2020/21

Framework for IPC	
MRI Infection Control Committee (Monthly)	Focus on risk and assurance CSU Assurance Report Quarterly report to Hospital Management Board Alternate month Chairs report to Risk Committee
MRI Performance Review Framework	CSU accountability review meetings
MRI Integrated Performance Review dashboard	Monthly integrated performance data Aligned IPC outcomes to process measures
Accountability Meeting (Weekly)	Chaired by Head of Nursing Lessons learnt to MRI ICC each month Quarterly report to Hospital Management Board
Presentation of MRSA Bacteraemia	Chaired by Director of Nursing/Deputy DoN CSU Triumvirate attendance with clinical team
Covid Outbreak Process (3 x week)	Chaired by Director of Nursing/Deputy DoN Focus moved to review any HOCI within 48 hours
Weekly IPC Walk rounds	Head of Nursing and MRI IPC Medical Leads
Other mechanisms •	Weekly 3 & 7 day screening audit Practice audits – HH & PPE Fundamental of Care Matron reviews QCR and Patient Experience Trackers HCAI surveillance reports – daily and weekly

- Weekly accountability meetings chaired by Head of Nursing discuss all cases of CDI and MRSA,VRE,CPE bacteraemia
- HOCI outbreak response led by the Director of Nursing in outbreak meetings held 3 x a week
- Following PII's and HOCI Outbreaks, summary reports are presented in an extraordinary accountability meeting
- CSU's present IP&C HCAI investigations to the IP&C Committee Meeting (currently monthly)
- MRI Scorecard used to hold the CSU's to account at Performance Reviews

COVID-19

Hospital Onset COVID-19 Infection (HOCI)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
					2020					2021	
Urology, Renal & Transplantation Specialities	4	5		1		11	3	2	4	5	1
Theatres & Elective In-Reach	5										
In Patient Medical Specialities	28	27	1	1	1	14	13	15	18	30	7
Head & Neck Specialities	1	1									
GI Medicine & Surgical Specialities	12	2					1		18	8	4
Emergency Assessment & Access	27	1	4		1		1	1	10	29	2
Cardio-Vascular Specialities	1	1			1	1	23	18	30	43	2

- MRI has 423 HOCI's from April 2020 to present date
- Surges in April 2020 (78), December 2020 (80) and January 2021 (115)
- 27 ward outbreaks and 10 bay outbreaks

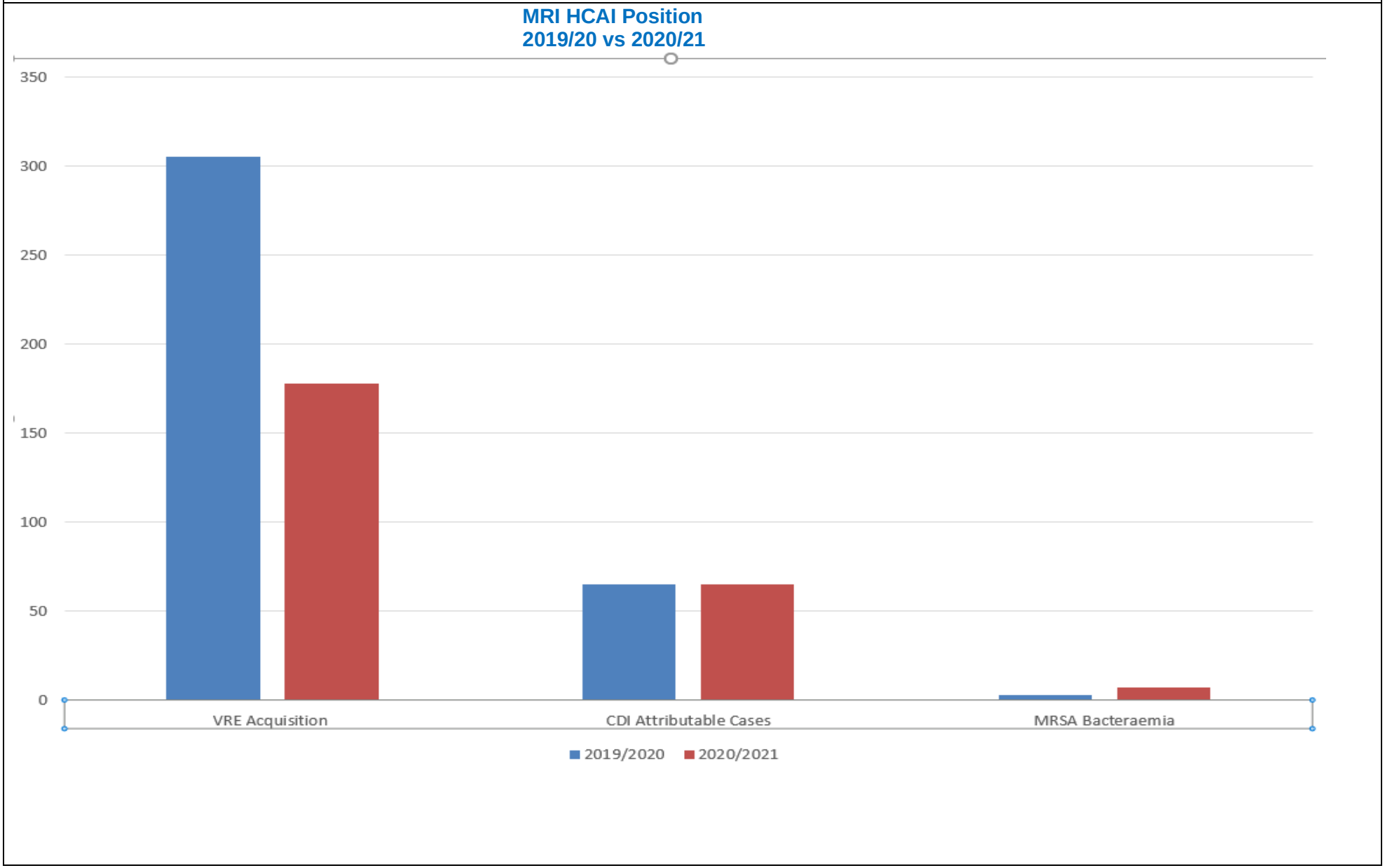
Multiple outbreaks on several wards:

AM1/AM2 (6) - Respiratory
W3/4 (5) - Cardiac
EVC/MVC (5) - Vascular
W36/37 (4) - Renal
W15 (3) – General medicine
W11/12 (5) – Surgery

Lessons Learnt:

- Screening of patients for COVID-19 at 3 and at 7 days
- Asymptomatic staff lateral flow twice weekly testing
- Multiple patient moves from ward to ward
- Tertiary transfers admitted into bays
- Renal pathway moves for dialysis: ward to AKU/RDU
- Inconsistent compliance with PPE
- Monitoring of cleaning
- Volume of staff attending ward areas e.g. ward rounds
- Patients leaving ward areas e.g. smoking
- Social distancing not adhered to

Healthcare Associated Infections



MRSA Bacteraemia Timeline

There were 7 attributable MRSA bacteraemia's from April 2020/21, 4 more than 2019/20

Learning Identified:

- 3 patients out of the 7 were IVDU – compliance with care challenging
- MRSA screening missed on admission
- Sites missed at screening e.g. wounds, cannula site
- Delays in MRSA suppression treatment
- Compliance in completing VIP and MR VICTOR
- RN oversight of Tessio line in RDU (Dialysis Assistants)

Clostridium Difficile Infection (CDI)

65 attributable cases of CDI from April 2020 to present date
Same number as 2019/20
10 cases determined to be a lapse in care
6 wards declared a PII of CDI

Lessons identified:

- Monitoring and documentation of environmental and equipment cleaning
- Antibiotic stewardship e.g. prescribing antibiotics for patients with Covid-19 pneumonia
- Timely isolation of patients
- Timely sending a stool specimen

Vancomycin Resistant *Enterococci*

178 VRE acquisitions in 2020/21
(305 in 2019/20)
14 cases of VRE bacteremia

Lessons identified:

- Missed/delayed VRE screening process
- Antibiotic Stewardship – delay in prescribing
- Poor documentation of Catheter care and wound care
- ANTT practice
- IVDU accessing own central line

Hotspot Areas

- What are your high-risk clinical areas (e.g. Critical Care/extremely vulnerable of patients)?
- What are the key issues in these areas (e.g. environment/facilities etc and mitigation)?

Compliance with IPC Clinical Practice *(% per clinical unit)*

- Hand Hygiene
- Fit Testing
- Donning and doffing PPE
- ANTT

FIT TESTING

- 2913 staff passed a fit test for an FFP3 mask (4000 Fit Tested)
- Donning and Doffing Competency Assessments, including assessment of hand hygiene developed June 2020
- 847 MRI Staff (includes nursing, medical and AHP's) have been assessed since April 2020
- Monthly audits of PPE and HH in all areas
- Ongoing challenges:
  Consistent availability of FFP3 masks
  national guidance for resuscitation
  consistent advice e.g. visors
  medical staff engagement

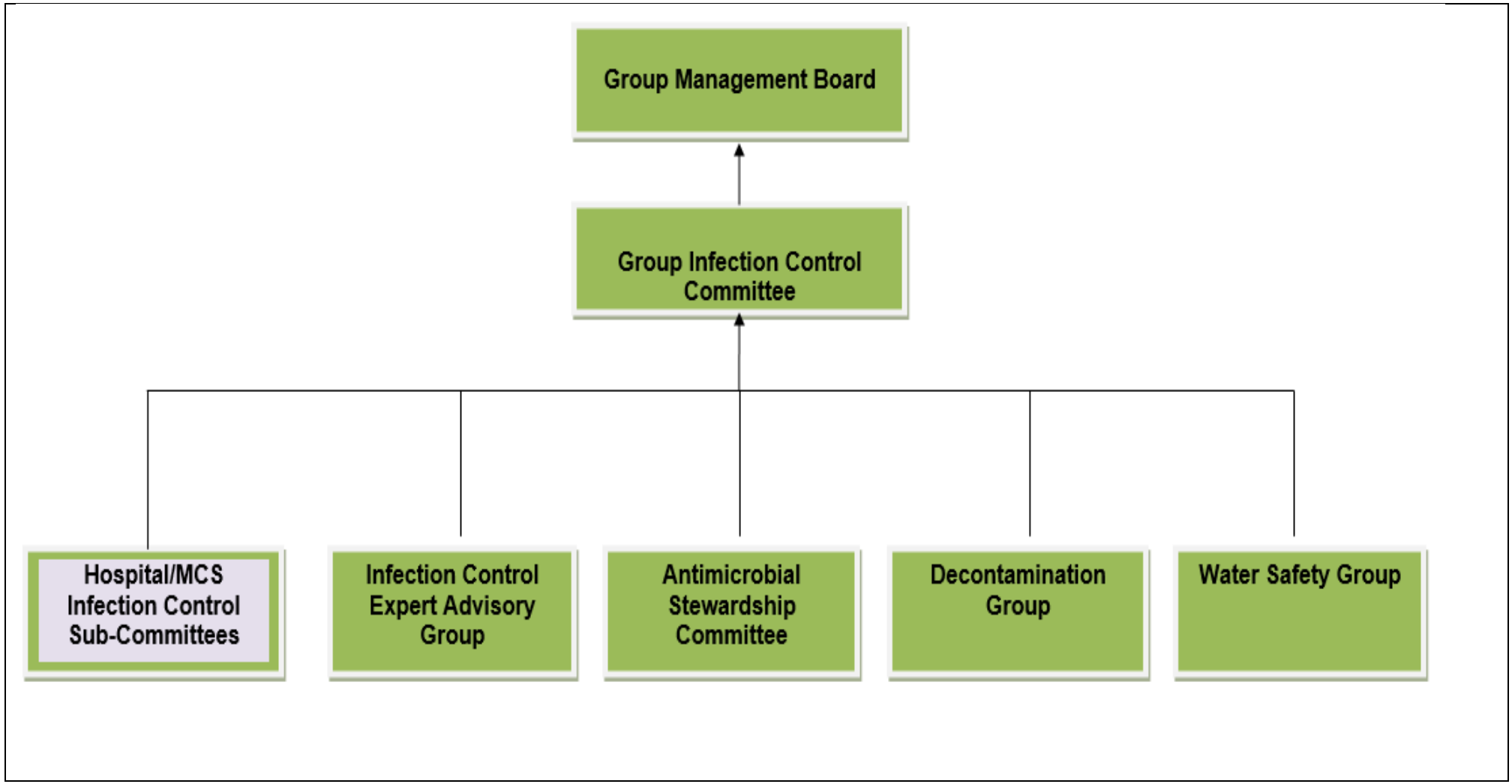
Keeping our patients safe

- Key working relationships with estates and facilities and Sodexo
- Environment
  - Enhanced cleaning
  - Cleaning monitoring tool
- Practice and documentation
  - Weekly Covid & MRSA Screening audits
  - FIT Testing
  - Donning/Doffing Processes
  - Hand Hygiene and PPE observational audits
  - Fundamentals of Care reviews
  - Retraining & assessment of all ANTT assessors
  - Mandatory training compliance
- Reducing foot fall
  - Standard of 3 staff on ward round implemented
  - Entrance standards
- Patient Moves Standard Operating Process in place
- Antibiotic Stewardship
  - Improvement programme of work commissioned by DoN
- Social distancing
  - Assessment areas, respiratory, haematology and renal transplant
- Vaccination
  - Review of weekly data
  - Follow up of harder to reach groups
- Tertiary transfers
  - SOP to manage transfers
  - Use of Redirooms
- MRI Command & Control Structure
  - Senior Nurse oversight at weekends
  - Education & Training programme to enhance awareness and understanding of IPC measures
  - Provide staff with tools to support and challenge colleagues and patients/visitors
  - Role modelling during weekly MDT walkabouts
  - Clear and direct communication of IPC standards expected
  - Programme of audits monitoring IPC pathways
  - Programme of work focused on staff behaviours
  - Programme of work focused on patient compliance/behaviours
- Review and relaunch accountability process
- Antibiotic stewardship meeting arranged in March 2021

Framework for IPC

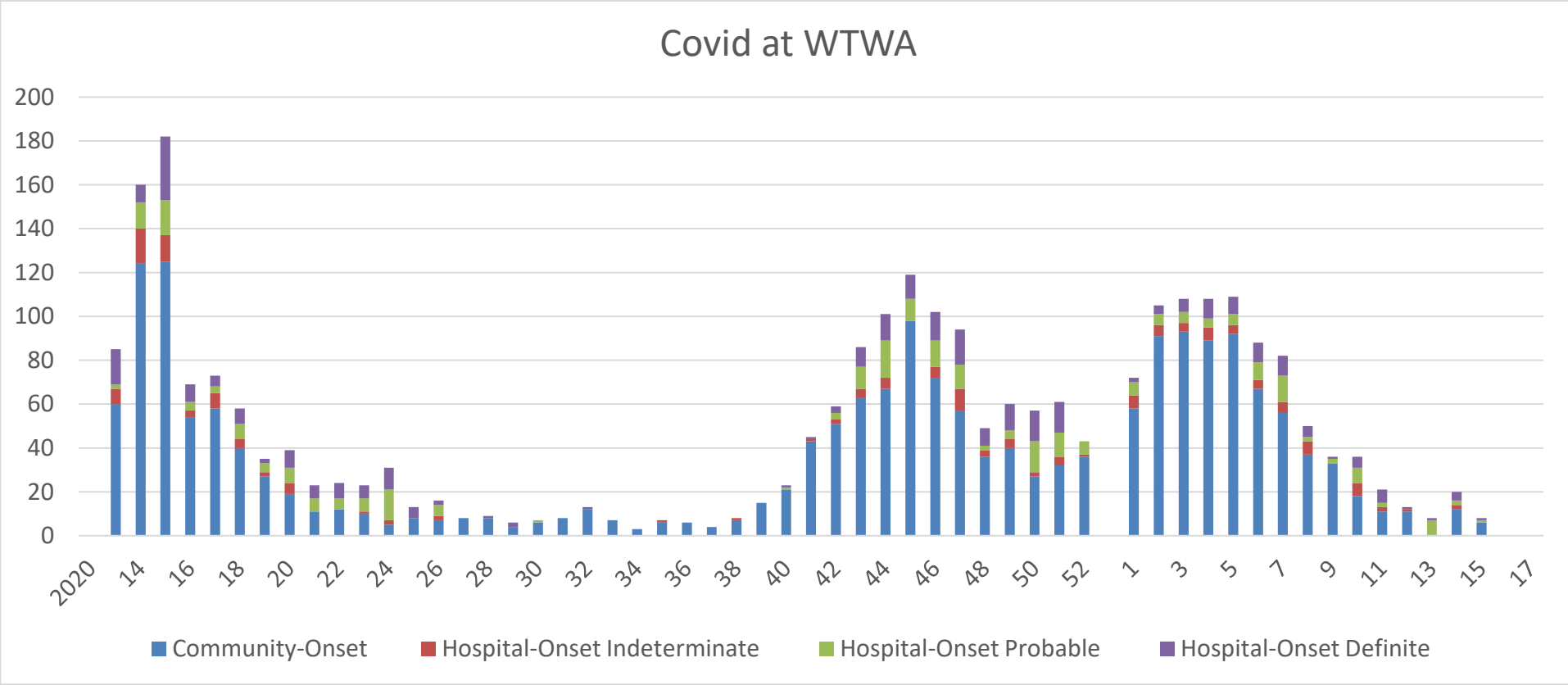
Director of Nursing - Jane Grimshaw
Medical Director - Richard Montague
Deputy Medical Director - Sally Briggs
Infection Prevention and Control - Janet Millar/Jennifer Kirton

Meeting	**Frequency**	**Compliance over last 12 months**
IPC committee	Quarterly	Occurred as planned
IPC Delivery Group	Monthly	Meeting suspended and superseded by daily/weekly communications/meetings due to changes in practice accommodating Covid-19 practices. Recommenced October 2020. To report to IPC Committee
Accountability panel	Monthly	Panel well established. Additional meetings occurred for Covid-19 learning
WTWA Nosocomial/ other outbreak meetings	Three times weekly (Monday, Wednesday, and Friday)	Commenced 10th November 2020. If bank holiday has occurred, meetings have been moved to previous/post working day opposed to cancelling.
Flu/Vaccination working group	Weekly	Meetings were increased during stages of Covid-19 vaccination planning, roll out and service changes.


Group Management Board
Group Infection Control Committee
Hospital/MCS Infection Control Sub-Committees
Infection Control Expert Advisory Group
Antimicrobial Stewardship Committee
Decontamination Group
Water Safety Group

COVID-19

During the period of 16th March 2020 to 13th April 2021, WTWA reported 2,695 positive Covid-19 results. Of these, 1,971 were attributed to the community, 155 hospital-onset indeterminate, healthcare associated and 569 (21%) attributed to WTWA (261 hospital-onset probable and 308 hospital onset definite).



The 569 HOCIs attributed to WTWA represent 52% of MFTs total number of HOCIs (1086). In 2020 WTWA had 432 HOCIs (373 Wythenshawe and 59 Trafford), 55% of the MFT total of 782 and in 2021 to date 137 (124 Wythenshawe and 13 Trafford), 45% of the MFT total of 303.

With the definition of an outbreak being 2 HOCIs in 14 days, and being reported for a minimum of 28 days, WTWA reported 34 outbreaks (including staff outbreaks) since June 2020.

To ensure best practice of IPC, communication between the multidisciplinary teams and continuity of management of outbreaks, three times weekly meetings were chaired by the DoN/DDoN, supported by Microbiology and a senior member of the IPC team. Any ward with a HOCI attended the meeting and a management plan was discussed.

Several issues were identified as contributing factors to the identification and management of outbreaks

- **Screening** - Following a retrospective review of screening compliance and several spot audits, it was found that wards were not consistently compliant with screening policy. To address this a daily sign off sheet was implemented, and poor compliance challenged. A working group was set up to review and improve the timeliness of obtaining swab results as a number were found to be outstanding over 24 hours.
- **Lateral flow testing -** Over 5000 lateral flow test kits were distributed across WTWA on 24th November 2020 and a further 4683 have been received and distributed from 15th January 2021. Communications were sent electronically and verbally reminding staff to record all results to improve compliance.
- **Management of Covid-19 positive patients:** A risk assessment was completed for each patient and discussed with a clinician prior to the patient being stepped down into a green area.

Other key actions include:

- Matrons ward based for a 4-week period January 2021 with an ongoing increase in visible leadership
- Tri-weekly Hand Hygiene/PPE audits were undertaken by Matron/Lead Nurse in all inpatient wards and daily audits in outbreak areas.
- Post outbreak Matron sign off sheet implemented to ensure area has been checked for standard of cleanliness
- Spot audits undertaken by DoN and DDoN and findings escalated and shared
- Installation of plastic screens around bed spaces (7th December 2020), prioritising Acute Medical Unit (AMU) and F block wards
- Clinell Redirooms set up in AMU and ASU
- AMU actions and learning shared through WTWA (appendix 1)
- AMU posters for what PPE to wear and when and when and what to don and doff shared
- IPC monitors in areas and manning doors during high footfall times.
- Patient moves are risk assessed and reviewed by a clinician for appropriateness and volume
- Reduction of bed base across Wythenshawe and Trafford hospitals to comply with social distancing
- Staff and patient IPC standards on a page to be disseminated
- Status at a glance poster being developed to aid staff in knowing Covid-19 status of the ward
- Improvement action plan implemented and monitored via regular IPC meetings
- Outbreak meetings were led tri-weekly by Director of Nursing/Deputy Director of Nursing, supported by Virology and Infection Control expertise, overseen by the DIPC and ACN IPC.
- Increased peer HH/PPE audits and escalation of non-compliance of individuals
- IPC undertaking additional HH/PPE audits in areas identified by IPC/DoN/DDoN
- Ongoing donning and doffing training lead by the education team taking place
- Ongoing fit testing lead by the educational team undertaken
- Tertiary referrals and intra-hospital transfers risk assessed and placed in side rooms where possible.
- Additional senior support 7 days a week to assist with decision making in line with policies and guidelines
- Increased challenge of staff out of clinical areas in scrubs
- Increased challenge of staff entering / leaving site in uniforms
- All blue and outbreak wards to display Covid-19 restrictions poster (previous report) to remind staff that it is a restricted area

- Patient letter displayed on every ward area (previous report)
- Nutrition and Hydration supplied to all blue and outbreak areas to reduce the need for staff to leave the ward area
- Retrospective HOCI review meetings took place for further learning (Information identified below)

Review meetings of WTWA Covid-19 outbreaks took place with representation from IPC, Microbiology and WTWA Deputy Director of Nursing. Four outbreak areas were considered. Several key areas where identified as outlined below:

- IPC standards from the routine audit data exceeded minimum standards, with hand hygiene compliance >90%. One ward has an environmental score of 70% which was addressed as an immediate action with enhanced cleaning instituted once the outbreak was declared.

- Screening of patients for COVID-19. There was a delay in routine screening for Covid-19 in all ward areas i.e. screens that should have been done on days 5-7 were delayed in some cases to beyond 10 days. This would have meant that patients who were positive when then were screened, remained in the bays potentially exposing other patients and staff until the results of the screen came back. This delay subsequently resulted in positive contacts.

- Movement of patients There were significant patients moves for reasons that may have been clinically indicated, resulting from significant patient flow issues and staffing shortfalls. There were instances where patients were moved from blue wards to green wards when they were negative. Some of these patients have remained negative however some of these patients have tested positive on re screen. Only whole genome sequencing will tell us if there is a link in such outbreaks, that's being actioned.

- Declaration of Outbreak and post outbreak sampling in one of the wards the outbreak declaration was delayed by 72 hours; this was possibly due to the ongoing outbreak at an adjacent ward. Not all patients are being screened immediately post outbreak declaration.

- Ward Capacity on outbreak wards. Assessment areas on the Wythenshawe site aim to reduce bay capacity to 75% to mitigate risk of nosocomial infections and adherence to 2 metre social distancing, however due to non-elective admission rates, the ability to achieve this standard has been limited.

- Laboratory testing issues. Delays in receipt of patient and staff swab results remain an ongoing theme within outbreaks. Issues include delays receiving iLog numbers, swabs and EHW processes to communicate staff results. Consequently, staff have been caring for patients for a longer period of time without knowing their COVID status.

Several immediate actions were agreed for both IPC and WTWA as outlined below, with a further meeting scheduled w/c 7th December 2020:

- IPC team:

- To ensure that once the outbreak is declared, the outbreak check list is implemented. The infection control team to monitor compliance to the checklist daily
- Outbreak to be declared promptly and communicated to WTWA senior leadership team/Deputy Directors of Nursing
- SOP for iLog to be created
- To confirm HOCI and Covid-19 outbreak investigation process with group governance

- WTWA:
  - Outbreak checklist to be completed within 48 hours of declaration of outbreak.
  - All patients to be swabbed on the day an outbreak is declared, even if they were swabbed the day previous or are going to be swabbed the following day
  - Where possible patients to remain on Blue wards (unless clinically indicated) until discharge
  - Review of bed capacity when wards change speciality
  - Consistent adherence of elective/non-elective patient swabbing on day 1/3/7/14. The new flagging system will assist areas to monitor compliance
  - Reduce inpatient moves where possible
  - Escalation of delays of receiving staff swab results to Group HR.

Healthcare Associated Infections

The charts below show the number of hospital infections from 1st April 2020 to 31st March 2021. and the annual difference from the same period of time 2019 – 2020 respectively.

Financial Year	Data Ending	HCAI Prevalence for Wythenshawe, Trafford, Withington and Altrincham
2020/2021	26/03/2021	(Tables show total number of attributable HCAI)

	Organism	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Total
2020/2021	CPE Acquisitions	3	2	2	3	3	6	9	19	21	15	12	16	111
	CPE Bacteraemia	0	0	0	0	1	0	0	0	1	0	0	0	2
	VRE Acquisitions	1	0	4	0	3	0	6	0	1	2	1	0	18
	CDI Attributable Cases	5	5	6	8	5	5	12	5	7	7	3	3	71
	MRSA Acquisitions	3	0	4	3	5	4	4	1	2	2	5	5	38
	Attributable MRSA Bacteraemia	0	0	1	1	0	0	0	0	0	0	0	0	2
	Attributable MSSA Bacteraemia	1	4	1	1	2	4	3	2	2	5	0	2	27
	Gram Negative Bacteraemia	1	1	3	7	4	6	7	3	5	6	2	3	48

Annual Difference	Organism	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Total
	CPE Acquisitions	-2	0	-4	-3	+1	-3	+3	+6	+13	+4	-12	+8	+11
	CPE Bacteraemia	0	0	0	0	0	0	0	0	+1	0	0	0	+1
	VRE Acquisitions	+1	-1	+2	-1	+1	0	+6	-1	0	-2	-1	0	+4
	CDI Attributable Cases	+3	0	0	-1	-4	+3	+10	+1	+4	-2	+2	-1	+15
	MRSA Acquisitions	-4	-2	-7	-3	-5	-3	0	-1	0	-3	+2	+4	-22
	Attributable MRSA Bacteraemia	0	0	+1	0	0	0	0	-1	0	0	0	0	0
	Attributable MSSA Bacteraemia	0	+1	-1	-1	+1	+2	+1	-1	+1	+5	-4	+1	+5
	Gram Negative Bacteraemia	-4	-5	+1	+3	-2	-3	+2	-2	+4	-1	-8	+1	-14

Root cause analyses are completed for all incidences of CPE, VRE, CDI, MRSA, MSSA and Gram-negative bacteraemia and presented at an accountability meeting chaired by the DDoN. This is supported by microbiology and IPC to advise on areas of good practice, areas for improvement and lapses in care.

Learning themes from accountability meetings

MRSA Bacteraemia

WTWA had two MRSA Bacteraemia's between 1st April 2020 to 31st March 2021. One was on A9 which was a Covid-19 positive ward and one being on F5, cardiac speciality. Both were found to have lapses in care (as detailed below) and have undergone further education and training with the practice-based educators (PBE' and IPC teams.

A9	No documentation on canulae insertion No VIP Score staff unfamiliar with the Infection Prevention process for routine MRSA swabbing on admission due to being redeployed from outpatient areas where this is not applicable. VIP charts also not used in OPD areas
F5	MRSA Screen not taken on admission (patient had a history of MRSA) Patient had long standing skin condition delay in referral to dermatology Missed MRSA decolonisation treatment

Gram negative Bacteraemia

Following a review of the Gram-negative Bacteraemia's, it was found that the majority of cases were attributed to catheter care/UTIs and that the correct samples were not always requested/sent resulting in inappropriate antimicrobial treatment. This information was shared at the ACE day and will be prioritised in the IPC delivery group whilst the PBEs continue education and training on catheter care incorporated within the ICP launch.

Clostridium difficile

During the reporting period there has been an increased incidence of 15 cases of *Clostridium difficile* at WTWA from the previous year. Each case was presented at the accountability meeting identifying themes and lessons as below. There were also several areas where increased incidents were notes who received additional training and input from the IPC team.

- Antimicrobial stewardship
- Antibiotic prescribing practices during Covid-19 Pandemic Wave 1
- Delay in sample being sent
- Delay in isolation of patient
- Delay in commencing CDI IPC
- Delay in samples being received from labs
- Documentation of bowel movements
- Hand Hygiene compliance
- Commode cleanliness
- Sending sample promptly after admission if appropriate

Staffing and Training

- Redeployment of staff from non-ward departments e.g. OPD, theatres etc towards unfamiliar with procedures for *C diff* prevention and management
- Staff redeployment to different specialities
- Not enough staff on the ward
- Low levels of mandatory training
- ANTT training within staff groups
- Delay in correctly identifying patients who require screening as per policy
- Misunderstanding that Bristol stool chart 5-7 need to be sent for *c diff* testing – not just type 7
- Delay in sending faeces samples when patient has a loose stool
- Delay in screening as per policy

Hand Hygiene and PPE

- Hand hygiene audit scores
- Gelling hands rather than washing them
- Sessional use of PPE during COVID

Environmental cleaning

- Environmental cleanliness audits scores inadequate
- Unclean commodes

Patient Isolation

- Delay in isolation of patients with diarrhoea
- Only isolating patients when a positive *C diff* result comes back
- Failure to identify and act on a previous positive result
- Failure to isolate a patient with a recent negative C difficile result with ongoing diarrhoea
- Balancing and prioritising patients who require isolation

Documentation and communication

- Failure to identify a previous positive result
- Care plans, stool charts, ICPs not filled in
- No documentation of bowel habit when patient admitted
- Sharing of information in MDT about patients with infection or loose stool
- RCA documentation poor – sections sometimes left blank or poorly filled in. Often no indication as to if a prescriber is included in the completion of the document
- Delay of microbiology results especially over weekend

General Patient care

- Review of patient's bowel habit daily to ensure they report loose stool
- Blood review by doctors not occurring
- severity assessments
- Severity assessment carried out during the working week but not at the weekend
- Failure to review care pathways of pts with diarrhoea with medics
- Failure to stop laxatives when patient has an episode of diarrhoea

Antimicrobial prescribing

- Empirical choice of antimicrobial not according to micro-guide e.g. Co-amoxiclav for UTI
- Prolonged course of antibiotics
- Diagnostic stewardship e.g. need to send a urine prior to treating a UTI with antibiotics
- Wrong dose of antimicrobials given
- consistent review antibiotics when microbiology results back
- documentation details of antibiotic usage
- Need to release antimicrobial resistance on urine results and thus patient remaining on antibiotics to which a bacteria is resistant
- Consistent approach for medics to discuss management of antimicrobials with an infection specialist when patient has a previous diagnosis of C diff
- Delay in starting treatment

Lessons learnt are shared via multiple routes including Feedback Friday, ACE days, divisional governance meetings, IPC working group and IPC meetings.

Hotspot Areas

WTWA has several areas with patients who have complex requirements/needs and areas of estate which requires life cycling. Mitigations have been put in place and are regularly reviewed for appropriateness and compliance. The below table summaries these areas and mitigations that are currently in place.

Area	Issue	Mitigations
AMU	Yellow area with limited opportunity to reduce capacity due to safety and quality impact in the ED department	Screening between patients and Clinell rooms where required
ASU	Yellow area with limited opportunity to reduce capacity due to safety and quality impact in the ED department	Screening between patients and Clinell rooms where required
F Block	Limited bathrooms and en-suite facilities	Commodes and bathroom bubbles used where appropriate
F12 and F15	Poor fabric of estate	Will need long term life cycling plan
POU	High footfall area in small space	Reduce bed base and redirect outpatients.
Jim Quick	Immunosuppressed patients, tired estate	Increase in cleaning and reduction in footfall
CF patients	High risk patients	Patients in side rooms and doors remain closed where clinically safe
Haematology day unit	Clinically compromised patients and highly vulnerable patient group	Reduction of footfall, increase in cleaning and segregation of staff
Cecelia unit	Clinically compromised patients and highly vulnerable patient group	Reduction of footfall, increase in cleaning and segregation of staff
Endoscopy	Yellow area sharing clinical estate with TDC green elective surgical recovery unit	Regular deproxing and segregation of staff where possible
Burns unit/ patients	High risk of infections and location of unit	Usage of doors and segregation of staff where possible
	Pseudomonas found in tap on unit	Estates conducted regular testing and resolution

Compliance with IPC Clinical Practice *(% per clinical unit)*

Fit testing – 4008 staff had been fit tested since March 2020. There were challenges in the availability of fit testers and the Portacount machine, but these were addressed with the possibility of WTWA staff member to be trained to deliver this HSE approved fit tester training to ensure that there is a rolling programme of staff trained to support fit testing across all sites.

ANTT – A total of 1324 staff have been currently assessed as ANTT competent and training continues across WTWA. Numbers of staff requiring training will be reviewed monthly within a database at the IPC working group with a trajectory to achieve 95% compliance by the end of June 2021.

Antimicrobial auditing - The table below shows WTWAs antimicrobial audit results for the period of July 2020 – December 2021. Due to Covid-19 pressures audits were postponed since January

2020, with plans to recommence May 2021. Local action-plans are in place and will be reviewed monthly at the IPC Delivery Group with an aim to achieve 95% compliance.

Hand Hygiene and environmental cleanliness

The table below shows QCR ward compliance to hand hygiene, hygiene/personal care, IP control and cleanliness. The heat map has identified areas which require further input and focus. This is reviewed within the IPC working groups and WTWA IPC meetings. Areas that fall below 95% undertake daily audits whilst challenging and escalating non-compliance of individuals to the line manager. Areas who continually fall below the 95% are requested to send their audits to the DDoN daily for review of compliance and escalation.

Branch	Returns	Hygiene/Personal Care - QCR	IP Control - QCR	Clean - QCR	Hand Hygiene Domain
F6	10	78.57%	100.00%	71.70%	100.00%
F7	12	92.47%	99.30%	96.43%	100.00%
F9	11	100.00%	100.00%	92.11%	100.00%
Fracture Clinic - Wythenshawe	6	-	100.00%	92.59%	100.00%
Jim Quick Ward	13	100.00%	98.28%	90.48%	100.00%
Lithotripsy	6	-	100.00%	100.00%	100.00%
Main Outpatients	15	-	92.22%	47.27%	100.00%
Max Fax Outpatients - Wythenshawe	9	-	100.00%	97.14%	100.00%
Medical Day Unit	10	-	100.00%	100.00%	100.00%
Nightingale (Breast Surgery)	9	-	98.77%	100.00%	100.00%
NWVU	7	100.00%	100.00%	100.00%	100.00%
OPAL House	9	94.52%	98.26%	96.72%	93.33%
Paediatric Emergency Department - Wythenshawe	1	100.00%	-	-	-
Pearce Ward	11	100.00%	100.00%	98.31%	100.00%
Pearce Ward - Spire Hospital	3	100.00%	100.00%	100.00%	100.00%
PITU	6	-	100.00%	100.00%	100.00%
POU	13	97.70%	100.00%	77.78%	100.00%
Pre-op Assessment	10	-	100.00%	100.00%	100.00%
Trafford ENT Outpatients	10	-	100.00%	100.00%	100.00%
Trafford Outpatients Suite 1-4 (Main OPD)	13	-	100.00%	100.00%	100.00%
Trafford Outpatients Suite 5-8 (MOC OPD)	10	100.00%	100.00%	100.00%	100.00%
Transplant Outpatients	9	-	98.81%	100.00%	100.00%
Urgent Care Centre - TGH	5	100.00%	100.00%	100.00%	100.00%
Ward 11	14	87.50%	95.72%	64.65%	100.00%
Ward 12 IP	13	100.00%	99.14%	100.00%	100.00%
Ward 2	8	70.67%	100.00%	91.94%	100.00%
Ward 3 INRU	10	85.44%	93.04%	90.48%	100.00%
Ward 6 Fragility Fracture Unit (Archived)	1	-	-	63.16%	-

WTWA QCR IPC compliance May 2020- April 2021

On a monthly basis the Matron and Sodexo supervisor complete a SHINE audit and issues identified are escalated and reviewed. In additional to this the lead nurse completes a SHINE audit monthly and once a quarter each ward area will be reviewed by an independent Matron and findings reported to the Lead nurse.

Cleanliness audits raised several concerns and the following measures were implemented to address these:

- Add hoc training was provided by the PBEs and IPC teams on Covid-19, hand hygiene, IPC practices, PPE, donning and doffing and environmental cleanliness.

- The IPC team, estates and SODEXO carried out regular environmental reviews to ensure standards are maintained and challenged where appropriate and the Directors and senior nursing team conducted daily spot checks on a rota throughout the trust to ensure compliance with PPE and uniform policy.
- Estates and Facilities and Sodexo are co-producing a recovery plan to be launched May 7th, 2021.
- Weekly environmental walk rounds with the DDoN, Sodexo and the Head of Facilities were reinstated to review cleanliness standards across the Wythenshawe site, hold staff groups to account and take action to address issues in real time.

Compliance with Maintaining a Safe Environment

WATER SAFETY:

Management of *Legionella* from Water Outlets in High Risk Clinical Areas

Water sampling for *Legionella* and Control of Legionnaires' disease was undertaken in accordance with COSHH Regulation (2002), ACoP L8, Health Technical Memoranda (HTM-04) and HSG 274 across the WTWA sites. Monitoring of any risks, issues, positive samples, remedial works, reactive works, derogations, and lifecycle works are monitored via the Quarterly WTWA Water Safety Group.

As we entered the pandemic, all areas which became vacant were monitored and additional flushing regimes (ppms) were created to ensure that the water systems were not stagnant. These areas were added to the 'little used outlets' asset list and a' live' tracker was created. A Standard operating procedure (SOP) was developed with clinicians to allow Estates operatives into CV19 positive areas, with the correct PPE identified, to carryout statutory maintenance and emergency repairs only.

As the sites resume BAU activities and vacant areas became reoccupied, WHBs and showers were back in use, therefore negating the need for Estates flushing.

Management of *Pseudomonas aeruginosa* from Water Outlets in High Risk Clinical Areas

In accordance with HTM04-01 Part C – Safe Water in Healthcare premises: Pseudomonas aeruginosa – advice for augmented care units, ppms and reactive works for water safety was carried out across the WTWA sites. The list of WTWA Augmented care areas were agreed in June 2020 whereby 6 monthly pseudomonas routine sampling is carried out under a ppm regime. Where positive samples were identified, key members of the Water safety group were informed together with clinicians of affected areas, to allow Estates to complete the remedial works and resample. Where there has been suspected patient positive results, under the direction of IPC, exception sampling has been carried out to eliminate the possibility of onsite transmission. A review of Pseudomonas risk assessments and completion of any associated actions is ongoing.

As we entered the pandemic, it was agreed with IPC at the WTWA Water Safety Group that no additional pseudomonas sampling should be carried out in CV19 positive areas but continued only in augmented care areas under the agreed safe system of work.

Ventilation:

In accordance with HTM 03-01 Specialist Ventilation for Healthcare Premises and HSG 258, ppms and reactive works were carried out across the WTWA Sites. Monitoring of any risks, issues, failed verifications, remedial works, reactive works, derogations, and lifecycle works were monitored via the Quarterly WTWA Ventilation Safety Group. Any escalation items are resolved via exception meetings with associated action plans and reported to WTWA Senior Management and Group Committees. Ongoing review of AE (Ventilation) audit actions is being carried out.

As we entered the pandemic, significant changes were carried out to the critical and non-critical ventilation systems at the Wythenshawe and Trafford sites to allow the occupation of CV19 positive patients. These changes were made under the advice and direction of IPC, AE (Ventilation) and PHE. Live trackers were developed to capture ventilation flow rates and pressure regimes (pre and post changes) to ensure that the areas could be reverted back to their original state post pandemic with ease by a ventilation commissioning specialist. The pandemic also saw the introduction of standalone units for support Aerosol Generating Procedures and window fans in around 40 side rooms throughout F2,3,4,5,7,9,11, again with IPC and AE(Ventilation) advice and support. Throughout the pandemic, COV1D-9 areas were very fluid to accommodate the clinical influx of patients, some of the Theatre verifications were not carried out due to access restrictions however, there have recently been completed. To support the requirements of ventilation flow rates in CV19 positive areas, several building fabric changes have been introduced with the installation of temporary screens.

Risk Register

The risk register currently has 6 live infection prevention and control related risks that are being actively managed and have mitigation in place.

Location	Risk
WTWA	WTWA infection control - compliance and standards
Ward F9	Aerosol Generated Procedures
CTCCU	HICO Heater cooler machines-- ECMO patients
WTWA	poor condition of the sterile services hub environment
Lung function	Lack of safe, adequately ventilated clinical space
WTWA	Central Decontamination Unit Endoscope

Feedback to IPC Team

a. IPC practices and accountability processes

- Establish monthly WTWA IPC Delivery Group with a focus on the following:
  - Compliance against IPC Policy and Practice
  - Gram -ve bacteraemia action plan/thematic review
  - Antimicrobial stewardship
- 2021/22 IPC Campaign to focus on 'Back to Basics' in collaboration with IPC colleagues
- Utilise IPC methodology where appropriate to embed a culture of continuous improvement and demonstrate learning
- Deputy Medical Director to lead and drive the IPC agenda within professional group
- Re-launch antimicrobial audits and undertake actions based on results
- Strengthen and re-launch SEPSIS audit process and undertake actions based on results
- Ensure all RCAs have clinical engagement and input to ensure a robust and rounded patient review and implantation of learning
- Assurance of screening for CPE, MRSA and Covid-19 in line with policy to be given via HoN to DoN on a weekly basis
- Director of Nursing/Deputy Medical Director to chair Divisional IPC accountability panel May/June 2021 to review screening compliance.

b. Education and Training

- IPC roadshows to discuss, teach and assess hot topics and refocus on all IPC KPIs as directed by WTWA IPC Delivery Group
- Re focus on ANTT training and assessing in line with the role out of starstedt
- Continue focused work on the right PPE wearing, at the right time, for the right infection
- Continue education on wearing of gloves and washing versus gelling of hands
- In line with the QCR information and outbreak meeting learning, continue targeted training, education, escalation, and actions
- Process for recording Covid-19 outbreak learning following accountability on Ulysses to be agreed
- Education and training plan to be informed by joint thematic review of Gram-Negative Bacteraemia's with IPC and development of action plan.

c. Environmental

- weekly environmental walk rounds with the DDoN, Sodexo and the Head of Facilities have been reinstated to review cleanliness standards.

WTWA are committed to providing patient safety through the adherence to best practice, policies, and guidelines, whilst learning from incidents and strengthening our accountability oversight framework. Throughout the last year WTWA have adapted their practices in line with Covid-19 guidelines, policies, and learning. The teams have worked together and utilised multiple methods of communication to ensure staff have and are working to up to date guidelines. WTWA are keen not to lose the momentum, focus and collaborative working between Hospitals/MCS and partners that has been strengthened throughout the last year, and to use the foundations built to focus on improving performance against IPC KPIs.

End of year review North Manchester General Hospital

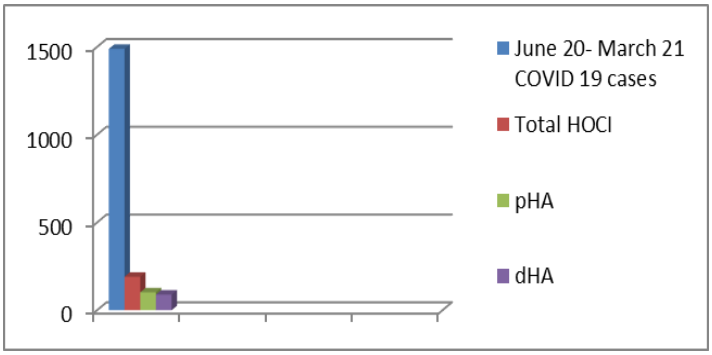
Framework for IPC

- IPC Committee is a subgroup reporting to MFT GICC and the Hospital Quality and Safety Committee
- Chaired by the Director of Nursing for NMGH
- Frequency - Monthly
- Multi-disciplinary attendance
- Oversight of sub committees:
  - Cleaning Committee
  - Water Safety Group
  - Decontamination committee
  - Antimicrobial Management Group
  - Operational infection control meeting

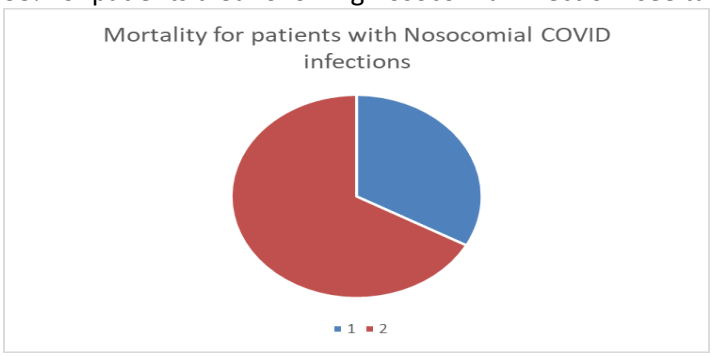
COVID-19

- NMGH reported 2156 COVID 19 positive results in 20/21
- From June 2020 NMGH reported, **191** cases which were classed as HOCI cases which is **12.8%** of overall total number of new cases reported.
- **6.9%** of HOCI cases were classed as probable hospital acquired with **5.8%** classed as definite hospital acquired.

NMGH reported 191 (12.8%) of new cases being classed as nosocomial infections (6.9% pHA and 5.8% dHA) – see table below:

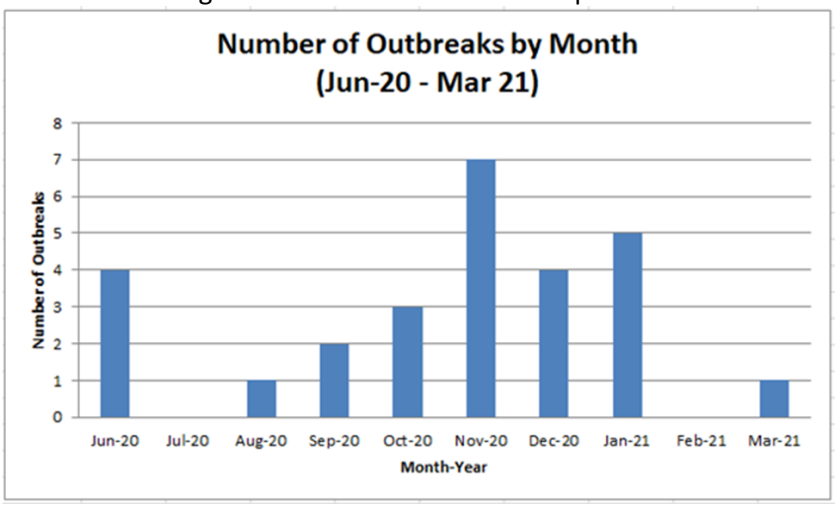


33% of patients died following nosocomial infection- see table below:



In 20/21 NMGH Acute Hospital reported **24** COVID 19 outbreaks. During November 20, NMGH recorded the highest number of wards reporting outbreaks, 7 outbreaks were recorded across 6 individual ward areas (1 ward reported 2 outbreaks). See table below:

The table below gives an overview of outbreaks per month:



Learning from outbreaks was as follows:

- 14 of the 21 in-patient ward areas have been affected by outbreaks, with 8 (38%) having 2 or more outbreaks during the 8-month period.
- During the period of the pandemic the Hospital established several fundamental standards aimed at reducing the risk of transmission of COVID-19 infection, both from staff to patients, patients to staff, and patient to patient.
- Social distancing compliance was considered an integral aspect of preventing nosocomial transmission of COVID-19 in ward areas
- Maximizing segregation of personal care facilities (toilets and washrooms).
- Rapid assessment, review and action, establishment of a 3 times weekly outbreak meeting in place since June 20.
- Testing (staff and patients)
- Deep dive into review of outbreaks undertaken by Deputy Director of Nursing and presented to NMGH IPCC in January 2021.

An audit of compliance with patient COVID screening i.e. admission, day three and day 5-7, was undertaken in March 2021 and illustrated generally good compliance. See table below for full details:

Patient COVID Screening Surveillance Audit - March 2021				
Ward	Admission swab taken?	Has a swab been taken 3 following the admission swab?	Has a swab been taken 5-7 following the admission swab?	Has a swab been taken recurrently every 5-7 days since date of admission?
C3	100% (12/12)	100% (12/12)	100% (11/11)	100% (7/7)
C4	100% (7/7)	100% (7/7)	100% (6/6)	100% (1/1)
D5	100% (4/4)	NA	23 HOUR WARD	
D6	88% (8/9)	55% (5/9)	62% (5/8)	100% (5/5)
CCU	100% (5/5)	100% (5/5)	100% (2/2)	NA
F1	100% (14/14)	86% (12/14)	100% (12/12)	100% (8/8)
F5	CLOSED			
F6	100% (11/11)	100% (10/10)	100% (8/8)	100% (1/1)
E1	100% (17/17)	81% (13/16)	100% (12/12)	100% (5/5)
I6	N/S	N/S	N/S	N/S
AMU H3/J6	100% (7/7)	71% (5/7)	100% (7/7)	100% (2/2)
F3	92% (11/12)	91% (10/11)	91% (10/11)	100% (4/4)
F4	93% (14/14)	100% (14/14)	100% (14/14)	100% (9/9)
J3	COVID WARD			
J4	COVID WARD			
E2 (STU)	100% (11/11)	100% (5/5)	NA	NA
F2 (STU)	100% (11/11)	100% (4/4)	100% (1/1)	100% (1/1)
I5	COVID WARD			
E3	100% (8/8)	87% (7/8)	75% (3/4)	100% (4/4)
H4	94% (16/17)	76% (13/17)	100% (17/17)	100% (6/6)
ICU	100% (3/3)	100% (3/3)	100% (2/2)	NA

The COVID-19 observational audit was introduced in July 2020 to monitor the standards of IPC in wards and departments. The table below shows the IPC standards observed, together with the compliance scores for March 2021 and the cumulative score since the audit began in July 2020. See table below for results:

Rank	Question	Score this month	Score last 12
1	Are face masks available at the entrance of the ward?	100% (87)	100% (744)
2	Did the HCW dispose of single use PPE correctly following every patient use?	100% (87)	98% (738)
3	Did the HCW perform Hand Hygeine as per '5 moments of hand hygiene' following every patient contact?	100% (87)	96% (738)
4	Did the HCW decontaminate equipment appropriately following patient use?	99% (71)	98% (614)
5	Did the HCW perform the 7 stages of Hand Hygeine (hand wash or alcohol rub) on entrance and exit to clinical area?	99% (87)	94% (739)
6	Is the HCW wearing their mask correctly?	98% (87)	99% (741)
7	Is the HCW wearing the PPE correctly?	97% (87)	96% (738)
8	Did the HCW apply the correct face covering / mask on entrance and exit to clinical area?	95% (87)	96% (741)
9	Is the HCW wearing the correct PPE (sessional use and single use) whilst giving direct patient care?	92% (87)	90% (738)
10	Is the HCW observing social distancing?	82% (81)	83% (705)
11	Does bed spacing allow for greater than 2m distancing between patients?	64% (76)	65% (652)

Numbers in brackets show number of inspections score is calculated from.

Improvements in IPC where contributory factors noted*

- The provision of additional signage, hand hygiene sinks and alcohol hand rub at ward entrances
- Improvements in Social distancing measures on wards and departments
- Provision of face masks at the entrance to clinical areas
- The display of IPCC information posters - including PPE and social distancing
- Lockdown and control of entrances to the hospital as per national guidance (this includes the provision of 24/7 security officer presence to support public adherence to hand hygiene and face coverings)
- Focus on minimising moves, time in ED and delayed discharges

Next Steps:

- Implementation of revised SJR Template - and Mortality Review process post acquisition
- Additional Focus on Compliance with IPC Measures, Multiple Moves, Clinical Environment, COVID-Test Compliance, ED Segregation, Delayed Discharge, Percentage of COVID admissions
- Ongoing monitoring via the Mortality Oversight Group

Actions taken to reduce nosocomial infections and outbreaks are summarised below:

- Director of Nursing and Medical Director monitored nosocomial cases closely and undertaking detailed root causes analysis of any probable or definite cases. The Hospital had additional challenges in terms of prevention of COVID 19 cross transmission, due to the nature of infectious nature of the virus balanced by an estate that is not conducive to the control of infection. The Hospital implemented social distancing in all patient and staff areas and risk assessments were undertaken for areas where this has been a challenge to achieve.
- The NHSI 10-point key actions for infection prevention and control and testing were noted and implemented, the Hospital implemented twice weekly lateral flow testing for patient facing staff from the end of November 20.
- A robust program of audit was in place throughout 2020 to ensure practice breaches were reduced to minimise the risk of nosocomial spread.
- To further reduce the rate of nosocomial infections and in response to increasing attendances a structural review was undertaken within the Emergency Department and assessment areas, against standards noted in the CQC patient first guidance. Actions identified were being implemented and overseen by the NM Chief Executive Officer through the Urgent Care Board. The review resulted in the commissioning of significance estates reconfiguration of the Emergency Department which has been supported by MFT

COVID strategic board and was undertaken by the estates team through the current partnership working agreement.

- The reconfiguration could increase the Adult ED footprint by one third therefore increasing the ability for social distancing at times of surge. Additional isolation units were commissioned to further reduce the risk of cross transmission within ED, along with redesign of the waiting areas, the provision of additional cubicle spaces, enhancing and increasing cleaning schedules and increasing the presence and support from the infection prevention and control nursing team.
- The Hospital commissioned a significant increase to the cleaning resource across all ward areas with particular focus on the assessment areas paying attention to shared patient areas and high touch surfaces.
- All daily data submissions were signed off by MFT's Chief Nurse and regular reviews of IPC data and evidence through the MFT board assurance framework were undertaken.
- The Hospital distributed **2124** lateral flow tests to date with the distribution being actively focused within all clinical ward areas. All areas that reported a COVID outbreak implemented lateral flow testing for eligible staff, which commenced from December 2020.
- NMGH has additionally implemented a process for local oversight and monitoring of individual participation and continued compliance of LFT use.

Healthcare Associated Infections

Incidence of MRSA,CDI, CPE clinical samples/screens and MRSA, MSSA, E coli and VRE Bloodstream infection are detailed below:

THE NORTH MANCHESTER CARE ORGANISATION														
	Target 2020 2021	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD Performance/ Target
MRSA BSI	0	0	0	0	0	0	0	0	0	0	1	0	0	1/0
MRSA Acquistion	35	0	1	0	0	0	0	1	0	1	1	1	0	5/35.
MSSA BSI	12	1	2	1	1	1	0	2	0	0	0	1	0	9/12.
E.coli BSI	24	0	2	3	3	0	3	2	3	1	1	1	2	21/24
CDI	35	1	0	3	2	2	1	2	8	1	1	2	1	22/35.
CPE Acquisition	6	0	0	0	0	0	0	0	0	0	0	0	0	0/6.
VRE BSI	12	0	0	1	0	0	0	0	0	0	0	0	1	2/12.
*Please note blood cultures may take up to 5 days to obtain a result														

There were 21 post 48-hour cases of E-Coli bacteraemia and two cases of pseudomonas bacteraemia and the following key areas and actions for improvement were recommended:

E Coli Bacteremia (21 cases post 48 hours)

Pseudomonas Bacteremia (2 cases)

Key areas for improvement	Actions
Catheter Management	Urinary catheter audit undertaken; Divisions progressing catheter care improvement work overseen by IPCC
Cannula management	
Sepsis 6 Tool not utilized	Sepsis management improvement work part of the quality improvement work
Blood Cultures stickers not placed in notes	
Mandatory Training below PASS rate of >90%	Divisions have mandatory training improvement plans in place
Taking appropriate samples for Microbiology	Local audits undertaken by IPCC and ward matrons

There were 22 cases of CDI reported. Key areas for improvement and recommended actions were as follows:

C Difficile (22 CDI cases)

Key areas for improvement	Actions
CDI Risk assessment not completed fully	Extra sessions for the antibiotic pharmacist to undertake antibiotic prescription compliance has been provided.
Missed opportunities to sample loose stools	Diagnostic stewardship – appropriate sampling of infections to direct correct antibiotic prescribing.
IPC mandatory training compliance <90%	'CDI awareness' presentation and staff training and education (includes risk assessment and escalation).
Failed HH/PPE audits	Ask the question 'Loose stools?' at the safety huddle, Handover, Bedside handover, ward round and assess as appropriate.
Antibiotic Prescribing issues	Domestic Services to maintain monthly robust ward cleanliness audits and weekly ward spot-checks.
Poor ABX review dates	Improvements in monitor commode cleanliness.
Delays in vancomycin prescribing were discussed with the ID panel Lead and clinician involved and at Board and ward rounds.	'Infection Prevention Link Worker (ICLW) Passport' initiative. Where ward based ICLW's are trained by the IPT to complete Hand Hygiene audits, Commode cleaning and Commode audits and VIP / Urinary catheter management audits. The IPLW are encouraged to monitor compliance monthly in their areas of work (or peer monitoring) and feedback / train / educate colleagues.
Poor documentation of ABX review dates discussed at M&M Governance Audit meetings.	

There was one MRSA bacteraemia reported – see key areas for improvement and recommended actions:

MRSA Bacteremia (1 case ICU)

Key areas for improvement	Actions
Improvements in MRSA admission screening	Introduction of swabbing audits
To sample for blood cultures when clinically indicated, not as routine (ICU).	Review SOP for blood culture process in ICU
Likely MRSA blood culture contaminant	Improvements made in ANTT and blood culture compliance
ICU to review process of investigation of line infection	Staff training for blood culture sampling.

Hotspot Areas

The nightingale wards lack of side room capacity:

- Nightingale ward bed numbers range from 10 to 17 socially distanced beds
- The patients are nursed in one open bay with partitions.
- Side rooms are limited within the ward - 1 or 2 per ward.
- Risk assessment process in place for reduction of social distancing
- Bioquell and Clinell pods were procured and available on site

Emergency department:

- The footprint of ED was challenging for maintaining IPC standards.
- One directional flow through the department was difficult.
- Within the resus area 'Biopods' were fitted to provide a form of patient segregation during AGP procedures.
- Availability of rapid COVID 19 testing limited
- Lateral flow testing pathways introduced to aide patient transfer to appropriate wards
- CQC patients first assessment undertaken action plan developed and monitored through Urgent Care Board linking into IPCC

Respiratory ward:

- The respiratory ward was transferred from I6 to H4 due to oxygen requirement for CPAP patients.
- Lack of side room availability was a challenge due to AGP requirements
- 5 pods have now been built within I6 and AGP procedures are a lot less challenging in terms of space available to conduct the procedure

Compliance with Maintaining a Safe Environment

Water safety

- Water safety reports are provided by the Estates and Facilities Department to the NMGH IPCC.
- Compliance with HSG274/HTM04-01 water regulations has been met. Ventilation regulations HTM03-01 have also been met.
- Appointment of the facilities matron has supported the improvement in legionella prevention program supported by L8 guard flushing compliance Sterile services/decontamination

The NMGH IPCC receives quarterly reports for sterile services compliance.
Activity is as follows:

1.0 Production Volumes 2020 / 2021 (dataset TriSoft IMS)

Nov 2020 – Jan 2021	NMGH
Instrument Tray Sets	15,092
Single instruments	2,196

KPI's non-conformance:

% Non-conformance x Total Production Volumes
NMGH
0.03%

Risk Register

NMGH has 39 risks relating to IPC highlighted on the risk register with the highest being related to COVID-19 and estates

ID	Title	Rating (current)
5247	Overcrowding in the Adults Emergency Department due to lack of flow into the hospital	12
5123	Cross Transmission of Covid -19 to in patients	11
5249	Mental Health patients in ED during Covid -19 Pandemic	11
5315	Inability to safely social distance in the Emergency Department due to current estate and layout of the department	11
1260	IV Long Line Service	10
1282	Infectious Diseases Assessment Trolley	10
4106	Providing isolation within O&A setting, NMGH	10
5538	COVID 19 Insufficient space for staff to comply with Social Distancing Rules re NMGH one way systems	10
6396	Lack of F2F appointments within Community Paediatrics at FGH	10
1972	Maintenance of equipment	9
3590	NMGH Non Compliant Ventilation Systems.	9
4107	Sluice for O&A paediatrics	9
5251	Inability to social distance in PED due to Covid -19	9
5259	Staff Acquisition of Covid -19 at work	9
5638	Risk of transmission of COVID infection due to lack of available side rooms and social distensing across surgical wards	9
5644	Risk to patient and staff safety of poor compliance with infection prevention and control guidance / policy for Covid-19	9
5717	Medically optimised patients in acute hospital settings during COVID pandemic	9
101	FFP3 mask use in Critical Care	8
272	Infection Prevention Compliance MRSA	8
2035	Clostridium Difficile Infection	8
4017	Category 4 HCID PPE training for critical care staff	8
5639	Access to PPE to protect staff against Covid-19	8
5837	If the anaesthetic circuit becomes disconnected in theatre then there is a risk to staff being exposed to infection	8
5923	New layout of critical care to accommodate blue, green and yellow patients	8
6514	NPSA re BD giving sets at NMGH	8
41	Length of stay in Orthopaedic Trauma at NMGH	7
373	Infection prevention and control ventilation systems in Theatres	7
416	lack of en-suite facilities.	7
1532	Laryngectomy valve changing clinic	7
3435	The non compliance of Outpatient and Phlebotomy Staff with Infection Control Policies and Procedures	7
5611	Visiting within Maternity Services - COVID19	7
5823	Staff may not be able to socially distance in theatre when delivering patient care	7
6356	Inability for staff social distensing on ward F6 at NMGH on 20 bedded covid ward	7
124	Decontamination of hard to clean instruments	6
3403	DSU Acute recovery has no sluice	6
4256	Lone working - risk of violence	6
5497	Patients unable to adhere to isolation guidance before procedures as a result of covid-19 pandemic	6
2067	Decontamination of negative pressure rooms	5
4630	Pacing room. emergency procedures	5
5469	Neonatal Unit Infection control and prevention of transmission during the Covid-19 Pandemic	5

Feedback to IPC Team

- Onsite support during 20/21 has been excellent
- Early transition to MFT
- Safety officer support has been welcomed by the hospital teams
- Out of hours support has received positive feedback
- Policy alignment needs to be considered in the context of the SLA with NCA

Framework for IPC

RMCH IPC
Director of Nursing - Julia Birchall-Searle
Deputy Director of Nursing – Karen Vaughan
Clinical Lead – Chetan Gupta – Consultant Paediatric Intensivist
IPC Nurses – Karen Mathieson, Deborah McKew, Jackie Dynan
Lead IPC Doctor – Nicholas Machin

IPC Committee Meetings
Chair – Julia Birchall-Searle
Microbiology – Nicholas Machin
Frequency –Bi Monthly, increased to Monthly

IPC KPI Meetings
Chair – Karen Vaughan
IPC – Karen Mathieson and Jackie Dynan
Line Specialist – Holly Kay
Frequency – Weekly / As required to hear any alert presentations from the previous two weeks.

IPC Accountability Meetings
Chair – Julia Birchall-Searle
Clinical Lead – Chetan Gupta
Microbiology – Nicholas Machin
Frequency – As required for cases where lapses in care identified.

COVID-19

Total Number of COVID-19 patients from June 2020 – 156
Of which how many were HOCI (day 8 of admission onwards) – 2

Date	Ward	Incident Findings	Actions
2.11.20	83	Resident parent became symptomatic, went home, and tested positive the following day. Patient aerosol generating in bay with 2 other children, other patients remained negative.	Reminder information to resident parents re social distancing, mask requirements.
12.1.21	77	Pre-admission and Day 3 swabs completed, Day 7 swab missed, completed on Day 10	Swabbing requirements reminded to all clinical areas.

How many outbreaks of COVID-19 since June 2020/Lessons learned? - 1

Date	Dept	Incident Findings	Actions
28.10.20	Carol Kendrick Centre	4 staff positive, no out-patients identified. Some gaps in PPE and social distancing compliance.	Staff briefing delivered by DoN with focus on mask wearing and social distancing. All staff updated on the asymptomatic screening programme and registered. Enhanced cleaning for the centre and deep clean of shared spaces arranged.

Compliance (% per clinical unit) with testing day 1, 3, 5-7 since November 2020

Assurance provided by Lead Nurses and Matrons of process implementation, however, no process of monitoring. Implemented weekly snapshot audit.

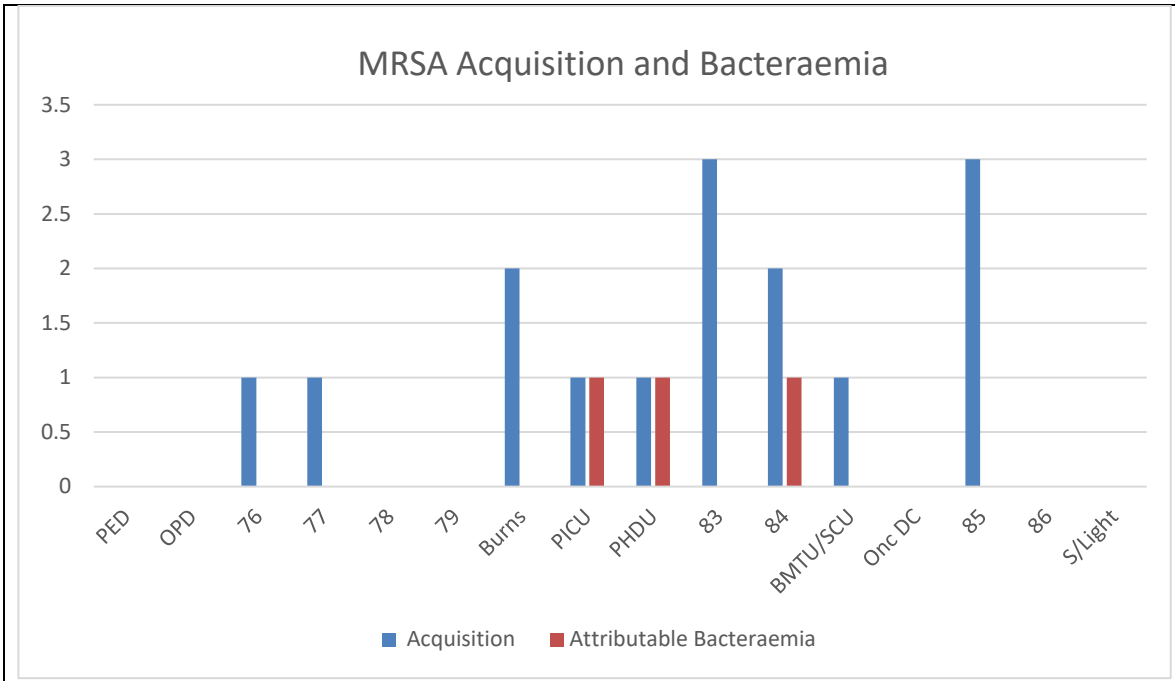
Key issues identified with implementing control measures in your area

- Bays reduced to maximum 75% capacity, Ward 79 opened to provide additional 13 beds, continued to have an overall loss of 14 beds across RMCH/MCS impacting upon flow from PED and Critical Care.
- Attempts made to identify appropriate partitions to increase bay capacity, however, it was not possible to have floor to ceiling height partitions due to the impact upon estate; particularly related to air ventilation, and guidance from IPC has been that less than floor to ceiling height does not create any additional capacity.
- Risk Assessments were completed in Ward 83, Ward 84, and PED where social distancing can become compromised due to patient activity and where there is a need to cohort a group of patients who have aerosol generating procedures (tracheostomy suction) with resident parents.
- It was necessary to close the playrooms, these were then used for single patient activity particularly to support therapy, a full clean of the room, surface contacts and toys occurs after a session. Individual toys were provided at the bedside and have full clean prior to return to the playroom. Options explored with IPC to increase access to the playroom for patients.
- Parents Rooms were initially closed, parent meals, drinks and snacks were provided. Restricted opening of the parent's rooms have commenced in some areas but required the nursing team to manage access to the room and cleaning between each use, the practicalities of maintaining these were difficult and some areas continued to keep the rooms closed. Plan to review the processes with a view to improving the facility for parents.
- Environmental audit completion by ward staff, Ward Manager and Matron implemented to provide spot check assurance that social distance measures, environmental cleanliness and PPE provision are maintained in clinical areas.

Healthcare Associated Infections

Incidents of MRSA/VRE/Gram Negative Bacteraemia from 1st April 2020 – March 31st, 2021
MRSA Acquisition and Bacteraemia Summary

Total MRSA Acquisitions – 15 – 25% reduction from 2019/2020 (20)
Total MRSA Bacteraemia – 3 – (0 cases in 2019/2020)



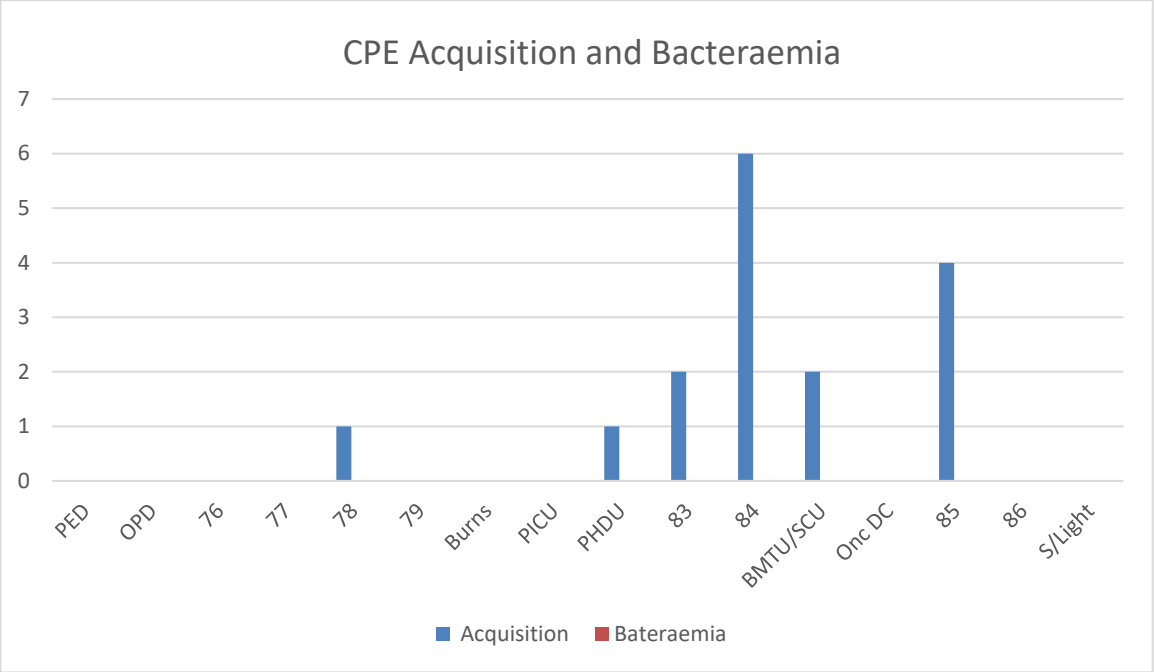
MRSA Bacteraemia Summary

Date	Ward	Accountability Outcome	Actions – identified through investigation
9.4.20	PICU	Unavoidable Heard in CSS	1.NHSP staff to be included in department ANTT assessments. 2.ICCA System to be updated to identify type of line dressing. 3.Inconsistency in MRSA Screening with sites missed. Education plan to increase understanding of screening and pathway. 4.Reminder/Training on completing blood culture documentation on ICCA.
25.10.20	84	Avoidable - Bacteraemia result due to contaminant but remains avoidable due to acquisition and occurrence of contaminant.	1.MRSA Screening – local audit by Ward Manager / Nurse in Charge, (NIC). 2.MRSA Education re screening requirements, care pathway, accountability. 3.Pathway monitoring being completed by Ward Manager / NIC. 4.Line access frequency – communication / awareness in CSU to ensure grouping of access where possible without compromise to treatment. 5.MRSA Leaflets / information – clear procedure for provision to parents and information board developed. 6.ANTT Assessments completed by clinical educator – clinical educator to be assessed by a member of the IV Team.
10.3.21	PHDU	To be heard	1.Ensure all sites are swabbed on admission. 2. Confirm with IPC ICCA documentation sufficient for MRSA Pathway documentation.

CPE Acquisitions and Bacteraemia Summary

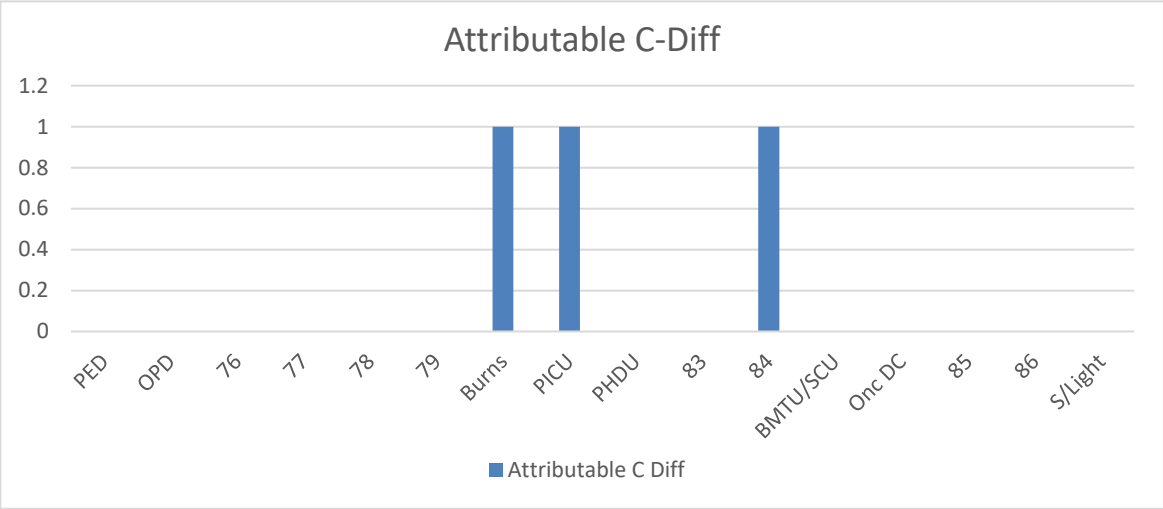
Total CPE Acquisitions – 16 – 33% reduction from 2019/2020, (24)

Total CPE Bacteraemia – 0 - (2 cases in 2019/2020)



Attributable Clostridium Difficile (C-Diff) Summary

Total C Diff recorded – 3 (2 results on same patient) – (2 cases in 2019/2020)

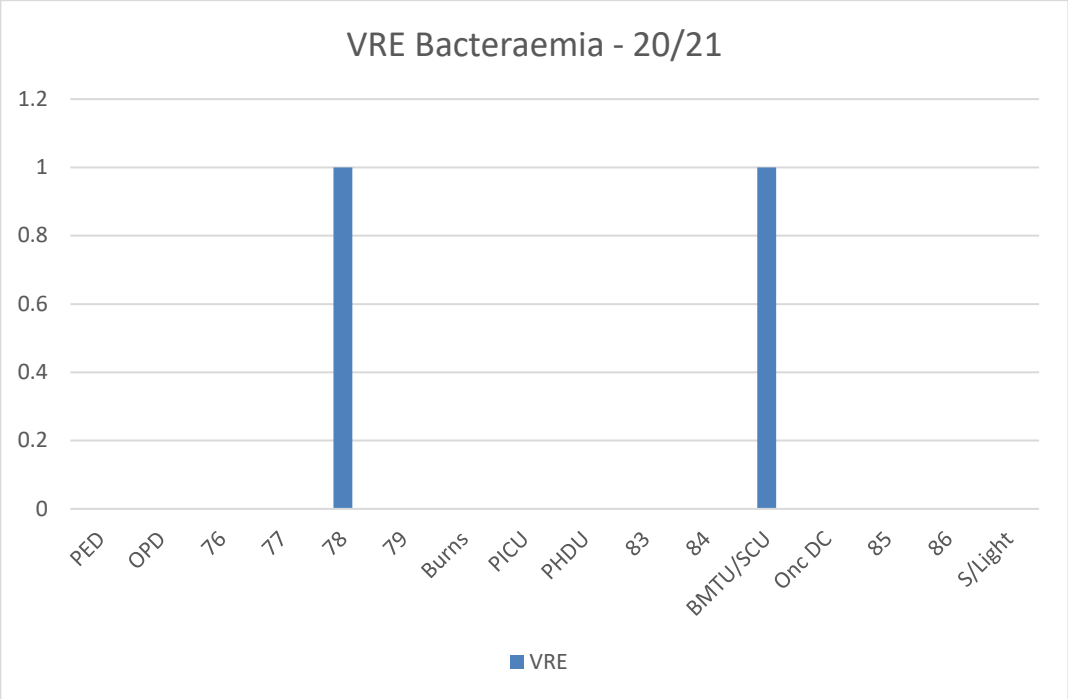


Clostridium Difficile Summary

Date	Ward	Actions – identified through investigation
14.6.20 25.7.20	81 84	1.Review of communication channels in shared care agreements, develop consistent clinical history handover. Add IPC status on hospital to hospital proforma.
11.11.20	PICU/Wd 84	1.Bathroom spot checks incorporated on housekeeper checks. 2.Reminder to all staff re consideration of other causes of diarrhoea rather than assumption of response to treatment / diagnosis.

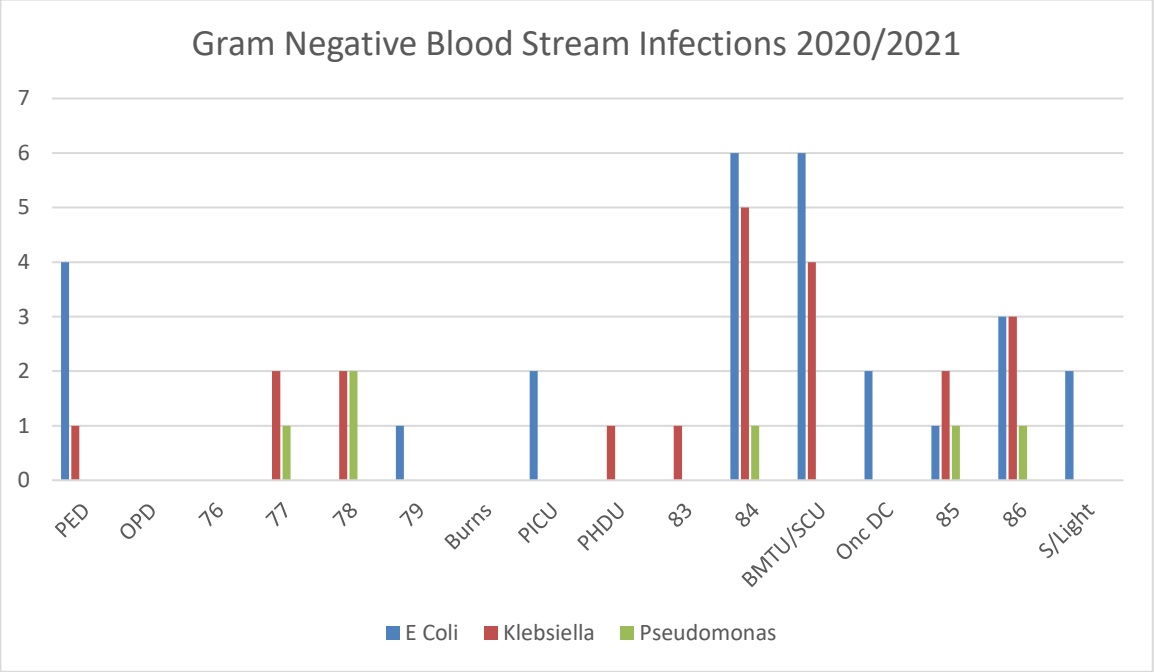
VRE Bacteraemia Summary

Total VRE Bacteraemia recorded – 2 – (0 cases in 2019/2020)



Gram Negative Blood Stream Infections (GNBSI's) Summary

Total Gram-Negative Blood Stream Infections – 50 – 12% reduction from 2019/2020 (57)



Distribution of GNBSI in Specialities and Lapses identified.

Speciality	Distribution (% of all GNBSI's)
Haematology/Oncology	54%
Paediatric Surgery	11%
Neurosurgery	7%
Tertiary Medicine	2%
Critical Care	5%
Admission Bloods	21%

Acquisition Themes / Lessons Learned and Actions Implementation

- Gaps in basic understanding of acquisitions, screening, and MRSA Pathway – education sessions for staff implemented with IPC support with affected area Clinical Educators implementing awareness work in the clinical area. Information boards developed for staff and parents on MRSA.
- MRSA Screening compliance not consistently achieved, local audits being completed by Ward Managers, hospital wide spot check audit to be implemented.
- Increased visibility of IPC Nurse supporting environmental walk rounds with Ward Managers and Matrons.
- Trend analysis of hand hygiene results being developed for sharing at Infection Control Committee, with CSU actions plans updated quarterly.
- Gaps in ICCA system completion on Critical Care – local monitoring of this to ensure consistency.

Bacteraemia Themes / Lessons Learned and Actions Implementation

- Gaps in care standards for Portacath's, competency document and standard care plan with detail of escalation for support developed, clinical skill training developed for all staff to access.
- Some gaps in line monitoring and cares for patients with lines at home, Oncology home records developed and implemented to enable ongoing monitoring and recording of the line at home for community staff, parents, and Out Patient staff. Audit of document to be completed in 2021.
- Some CVC Cares not in line with updated CVC Policy – hospital wide education on the changes to the policy implemented to increase awareness and understanding. CVC audit developed with IPC for use by Ward Managers and Matrons. CLABSI bundle previously trialled in Paediatric Critical Care now rolled out to clinical inpatient areas.
- Some dDelays in availability of line repair kits – stock provision, management of stock and re-ordering process agreed for the hospital.
- Parents in some speciality groups access lines and administer PN at home, there was no process of regular re-assessment of this group, package developed and implemented in specialist teams.
- Annual ANTT assessment process managed within ward teams without any external validation of key trainers – IV Team to support with re-assessment of key trainer.
- Use of parafilm over line bungs when line is not in use to reduce contamination risk.
- Reminder re ensuring central line loop in place with line end over the shoulder or fitted vest in place to reduce contamination risk.
- Weekly audits by Ward Managers of dressing and bung changes.

Outbreaks

Norovirus – Ward 84, Bone Marrow Transplant Unit

Learning and Actions

- Staff - Face Masks were not being changed at all opportunities during sessional use, i.e., when staff have been in isolation cubicles or when they have been into the dirty utility. 'Mask Station' located at the dirty utility entrance/exit.
- Parents – Face Masks, again not being changed at all opportunities. Education and awareness for parents provided on accessing the dirty utility, hand hygiene requirements and PPE requirements.
- Increase in Nursing Assistants per shift to ensure prompt measurement and disposal of bed pans and urinals in the dirty utility, most patients are on strict fluid balance and therefore build-up of bed pans and urinals can occur quickly without a dedicated member

of staff responsible for maintenance of the area. Also ensures there is separation of roles in nursing assistants between nutrition and hydration provision and maintenance of the dirty utility.

- Push along toys removed from the ward, the play room has been closed due to COVID-19, children are provided toys to keep at their bedside, this may include a push along toy for toddlers, however, there has not been assurance that these are not swapping between patients without any cleaning in between. Parents are provided wipes and instruction to clean the toy between use, but, this is not assured, and the decision has therefore been to remove them.
- Poster / Signage Review – lots of information displayed around the ward area for management and prevention of COVID-19 and Norovirus, including guidance for use of parent's room, guidance for use of toys, accessing the dirty utility – risk of poster blindness and loss of messages.
- Senior Nurse / IPC Visibility – Walk rounds by the Matron/Ward Manager and walk rounds by IPC nurse occurring in isolation from each other - to co-ordinate twice weekly team walk round and ensure observation / communication from these are circulated to all of Ward 84 team.
- Medical staff moving between Ward 84, BMTU and SCU reminded of vulnerability and risk of the situation and the need for exemplary hand hygiene and PPE usage by Clinical Lead.
- Single patient use stethoscopes not available for each cubicle, stock and provision process reviewed to ensure available at all times.
- Parents information on Norovirus – developed with IPC, specific for resident parents about the illness, how it spreads, prevention and what to do if they have symptoms.
- Demand of Bone Marrow Transplant Beds has increased, and further growth is predicted as new treatments are implemented, this is increasing the pressure on bed management across the Haematology and Oncology Units in RMCH, with a Business Case in development to identify and secure additional space. Environmental walk rounds are planned to review options.

Hotspot Areas

- **Haematology / Oncology -** Vulnerable patients, immunocompromised.
    - Patient activity and demand for beds increased further to Proton treatment implementation, more growth in treatment options planned with a forecast to increase bed demand. Options to achieve additional beds being reviewed.
    - Requirement for transplant patients to outlie in Ward 84 due to insufficient beds between BMTU and SCU.
    - Only 5 cubicles on Ward 84 putting additional demand in the bays to provide isolation facility in 4 bed bays.
    - 4 bed bays do not have dedicated toilets, therefore shared toilets have to be identified for bay isolation reducing the number of other shared toilets available to the rest of the ward.
    - Bay isolation also results in more patients being nursed together in other bays resulting in 100% capacity in bays rather than the recommended 75% to enable social distancing.
    - Management of the planned activity into BMTU/SCU and Ward 84 is increasingly challenging, at times patient treatment is delayed due to insufficient bed capacity.
    - Cohort of patients require regular attendance to hospital and further to outbreak of Norovirus, are often discharged still positive and returning into OPD within the week – no clarity on how infectious they are in this situation and no screening occurring and no dedicated isolation facilities in OPD.

- **Paediatric Critical Care –** Vulnerable patients, restricted capability to isolate patients.
    - Availability of sinks at each bedside not available as per CQC recommendation – scoping exercise underway to identify solutions.

- Mobile partition investment to create temporary cubicles when the demand for isolation is higher than cubicles – with development of a risk assessment matrix to support decisions on patient location.
- 2 cubicles in critical care have an ante-room creating an isolation facility level C.

- **Hospital Wide** – Minimal dedicated facilities to manage high consequence infectious diseases, 3 rooms available on Ward 85 and 2 rooms on PICU with an anteroom. Further detail in risk section.

Compliance with IPC Clinical Practice *(% per clinical unit)*

Hand Hygiene - Average % 2020/2021

Nurses	Medics	AHP's	Others
95%	91%	95%	89%

Fit Testing

- Local data has been held for nurses.

Tested	Failed Test	Not Tested / No test recorded
542	40	393

- Limited records for other professions.
- New database being developed including all professionals in preparation of testing roll out for 2021.

PPE Compliance – Average % 2020/2021

Appropriate PPE in use	PPE Doffing in correct order	Visors worn appropriately	Masks worn appropriately	Gowns worn appropriately	Gloves worn appropriately
96%	96%	92%	98%	98%	98%

ANTT

- Inconsistent centralised recording of ANTT compliance, local records provide good assurance for nursing compliance at over 90% in all areas.
- CSU records for medical staff not consistently reported.
- Plan to agree process of reporting with Lead Nurses which ensures consistent medical and nursing compliance records are available.

Compliance with Maintaining a Safe Environment

Compliance with Endoscopy Standards

- Nas-endoscopes in OPD have had autoclave sterilisation since 2020 and COVID-19, prior to this they were sterilised using a recommended wiping process in the department. The ENT team have now suggested a return to wiping rather than autoclave, the team have been asked to submit evidence of the safety of the practice to the Quality and Safety Committee prior to any further changes occurring.

Ward Audits

- Environmental audit for completion by ward staff, Ward Manager and Matron implemented to provide spot check assurance that social distance measures, environmental cleanliness and PPE provision are maintained in clinical areas.
- SHINE audits – previously implemented to be relaunched to ensure focus is more than just COVID-19 related.

Surfacide

- Review of system usage underway.
- 4 systems available for use across RMCH, with increasing demand from all departments.
- Accessibility to the system is being compromised by the increasing demand – with high risk areas such as Oncology and PED not able to access consistently.
- Regular repairs and maintenance required due to the high usage taking the units out of circulation for periods, when replacements are provided, they are a newer system and additional training is required for the areas using them increasing the risk of user error incidents.
- Two incidents have occurred in the past three years resulting in eye injury – in each case there was user error in the set-up of system. Extensive training and awareness initiatives have been implemented to prevent further incidents but there is not complete assurance due to the alternative systems now being sent when repairs are required.
- The use of Bioquell continues in an outbreak situation.

Wythenshawe

- The layout of Starlight Unit has changed in 2020 further to COVID-19, this has improved the environment providing separated shared facilities on each side of the ward, enabling a clear segregation between low and medium risk patients as required.
- The social distance requirements in Starlight significantly reduces the overall potential bed capacity from 51 to 37. Inpatient bed reduction is only 6 and has been manageable whilst activity has been reduced, but as activity increases, the need to utilise POAU and DC beds for inpatients is a risk potentially impacting upon GP and elective activity.

NMGH

- No immediate environmental IPC concerns have been highlighted in handover, but more focused environmental reviews now planned, with all audits and environment reviews identified in this report to be implemented.

Risk Register

There are currently 10 risks relating to IPC on the register.
These relate to the following areas:
Difficulties maintaining social distancing in bays, safe isolation of patients, theatre compliance with NICE guidance IPG196, antimicrobial stewardship, and the need for a HEPA filtration system for the stem cell unit.
All have ongoing progress/action plans.

Feedback to IPC Team

What went well

- There has been increased visibility from the IPC nursing team with regular visiting and direct working with the ward teams where there have been areas of concern including training in the clinical setting and delivery of more formal training tailored to the issues identified in an areas.

What could we do better going forward

- We would like to provide a more formalised and cohesive approach to visibility and environment / practice observations, with planned walk rounds with the Lead Nurse and Matron for an area with an IPC Nurse, to ensure local engagement and ownership of IPC standards/improvements.

Framework for IPC

Saint Mary's MCS Infection Control and Harm Free Care Committee
Chair- Dr Theo Manias, Consultant Gynaecologist
Vice Chair- Kathy Murphy- Director of Nursing and Midwifery
Governance support- Shirley Rowbotham, Clinical Effectiveness Manager
IPC nursing- Deborah McKew
IPC doctor- Rajesh Rajendran

- Meetings are held monthly and feed into the Saint Mary's MCS Quality and Safety Committee
- Due to the cohort of patients who access care across the MCS, it is possible to combine Infection Control and Harm Free Care into one meeting
- April and May 2020 meetings cancelled due to the COVID-19 pandemic
- Saint Mary's MCS can demonstrate compliance in line with the Terms of Reference
- The terms of reference have been reviewed in 2021 but will be revisited in light of the acquisition of NMGH

COVID-19

Total number of COVID-19 women (Obs and Gyn):

Inpatient days	number of women with positive PCR	1 PCR test	2 PCR tests	3 or more PCR tests
0	40	40	0	0
1	84	84	0	0
2	68	68	0	0
3	42	42	0	0
4	35	30	5	0
5	7	2	5	0
6	9	9	0	0
7	8	5	2	1
8	2	1	0	1
9	4	2	1	1
10	2	0	1	1
11	2	1	1	0
14	1	1	0	0
	304			

There were no confirmed HOCI – positive day 8 of admission onwards during 2020-2021.
304 women COVID-19 PCR positive on admission
All women were tested on admission
19.6% had 2nd PCR test (after day 3)
21% had 3rd PCR test(after day 7)

Total number of COVID-19 babies:
There were 4 babies over the course of the year
Baby 1- inpatient for 41 days on NICU ORC, had 12 PCR tests- indeterminate
Baby 2- inpatient for 12 days on NICU ORC, had 3 PCR tests- indeterminate
Baby 3- inpatient for 11 days on NICU ORC, had 8 PCR tests - probable
Baby 4 – inpatient for 3 days on NNU Wythenshawe, had 1 PCR test- community onset

COVID-19 Staff outbreak
There was one COVID-19 outbreak in Obstetrics at ORC throughout the pandemic which occurred in December 2020 – 14 staff within the same area were affected

The Senior Midwifery Team worked with IPC and EHW, devised an action plan for all staff working in them.
Matron walk rounds implemented with Estates and Facilities support and a deep clean of all break rooms instigated. Soft furnishings were removed and replaced with wipeable furniture in break rooms and patient waiting areas.
Communication with staff increased and encouraged to challenge each other.

Healthcare Associated Infections

Gram negative bacteremia

6 cases reported from April 2020 to March 2021 (a decrease from 15 in 2019-20)

NICU(68)- 3 cases

There were 11 cases in Newborn Services in the previous year so there has been a marked decrease in cases.

There were 3 different organisms identified in these cases, *e-coli*, *pseudomonas* and *klebsiella*. There were no lapses in care identified. Risk factors were attributed to extreme prematurity and congenital abnormalities.

Obstetrics- 3 cases (Wards 64, 66 and C2)

All 3 cases have been reviewed, they were unavoidable, and all care was appropriate, hence there is no additional learning from these cases

MRSA acquisitions

16 reported during the year all in Newborn Services (a decrease from 18 in 2019-20). All cases have been reviewed and no common themes have been identified

VRE acquisitions

There were none identified in Saint Marys MCS through the year. There is one case for April 2020 which was on Ward 62 during the period when it was a COVID-19 ward being used by MRI.

***Clostridium difficile*- 5 cases identified in SMH 2020-2021**

Learning from CDI RCA's:

- Importance of isolating patients with diarrhoea even if presumed non infective
- Careful consideration on prescribing of low dose antibiotics throughout pregnancy
- ICP commenced but not fully completed. Nursing team feeding back to teams and undertaking communication sessions on the importance of the *Cdiff* ICP

Hotspot Areas

High risk clinical area- Newborn Intensive Care

Key issues: CLABSI (central line associated bloodstream infection) rates

Alert Q2 2020-2021 for MFT for the proportion of babies with positive blood culture after 72 hours of age standardized to a rate per 1000 catheter days

- ❖ CLABSI rates slightly reduced during 2020 at 10.9/1000 CVC line days in comparison to 2019 at 12.54/1000-line days.
- ❖ Quality improvement workstream in place to review all cases. Division working to reduce central venous catheter line requirements and identify common themes and risk factors.
- ❖ The organisms grown were primarily *staphylococci.*
- ❖ Evidence of good compliance in use of safety care bundle during CVC insertion and completion of invasive procedure checklist

Actions-

- ❖ Focus on blood culture technique and CVC dressing line management. A tool has been introduced to aid assessment of the CVC line with set time frames to attend and redress the CVC. Dressing data is encouraging and compliance improving.
- ❖ Commencement of regular microbiology ward rounds to drive closer antibiotic stewardship (maintained on case by case basis during pandemic)
- ❖ Review of longline care guidelines in line with surgical line care
- ❖ Audit procedure forms used at line insertion

Compliance with IPC Clinical Practice (% per clinical unit)

- Hand Hygiene
- Fit Testing
- Donning and doffing PPE
- ANTT

Hand hygiene and PPE audits

Hand hygiene and PPE audits undertaken monthly. Compliance with hand hygiene for all staff group consistently above 90%. PPE available and stored appropriately across the MCS
Hand hygiene audits for each department reported each month to the Saint Mary's MCS infection Control and Harm Free Care meeting.

ANTT Compliance January 2021:
Obstetrics – 98%
Gynaecology – 96%
New-born services – 96%
Genomic Medicine – 100%

FIT testing and Donning and Doffing PPE

Area	Total passed Fit test	Total Donning & Doffing
Genomics	**43.75%**	**100%**
New-born Services	**79%**	**31%**
Obstetric & Gynae Consultants	**96%**	**38%**
Obstetric services at ORC	**33%**	**55%**
Obstetric Services at Wythenshawe	**42%**	**71%**
Gynaecology Services	**61.4%**	**24.05%**
SMH Theatre ORC	**91.0%**	**50.59%**

All staff who did not complete face to face training for donning and doffing were required to access the module on the learning hub. Compliance data for this is not collected.

Compliance with Maintaining a Safe Environment

Saint Mary's ORC Theatres- challenge to separate staffing areas due to lack of space, so measures instigated to segregate Obstetrics (amber) from Gynaecology (green) are supported whenever possible.
Old Saint Marys- Department of Reproductive Medicine

- ongoing issues with the turnaround of DSD equipment. This causes delays in theatre start times and stressful working environment.
- Toilets out of use due to issue with drains collapsing during building works
- Roof leaks- intermittent. Several are difficult to get to resolve

Risk Register

There are 3 specific IPC risks being managed by the Gynecology division.
There are no other risks from other division in addition to those that are trust wide, as a result of the pandemic.

Risk	score	actions
Handling of suspected/positive body fluids and pregnancy remains	4	Pilot SOP introduced to support clinical practice
Covid-19- social distancing across the division	6	Additional resources to support remote working Local requirements for virtual consultations Monitoring and support of staff in line with MFT recommendations
Old Saint Mary's- drain blockages caused by collapse of drains due to adjacent construction works. Risk that premises will not meet HFEA standards.	9	Local monitoring of cleaning - use of alternative toilet facilities (4 /7 out of use and utility room) Estates liaising with Bruntwood for resolution

Contribution to the Board Assurance Framework in relation to IPC measures for the management of patients and their relatives accessing our services
Specific risk assessment undertaken on direction from NHSE to address supporting women and their partners to access maternity and neonatal services through all stages of journey

Feedback to IPC Team

Saint Mary's MCS have made changes to the configuration of space to ensure compliance with Infection Control policies and procedures and national recommendations relating to COVID-19. This has been supported by IPC risk assessments and measures have ensured that the risk of transmission has been minimised
MDT training sessions to include planning for COVID-19 patients including transfer to theatre. Involvement of New-born Services and Anaesthetic staff.
Development of SOP's with support from IPC team for all possible scenarios for positive or suspected women from antenatal attendance through to pool birth and Caesarean section and postnatal care
Flu Vaccine- all divisions had flu champions who embraced the opportunity to provide local clinics and provide support for staff across the division
Staff engagement- excellent throughout the year, staff working well to support their patients and each other to maintain safety and minimise the risks of spread of Covid-19.

What could we do better going forward
PPE was adequate and maintained however the issues with supply of masks resulted in the need for multiple FIT testing mask requirements which took up many staff clinical hours to achieve. This remains ongoing with different masks in circulation.
As staffing allows, we need to increase IPC link time to support requirements to align processes, review IPC case requirements and support IPC education across the MCS

End of year Infection Prevention and Control Update

Manchester Royal Eye Hospital and University Dental Hospital of Manchester

Framework for IPC

- The MREH/ UDHM hold a joint monthly Infection, Prevention, Control Committee meeting, which is chaired alternately by either the Director of Nursing or one of lead clinicians from the MREH or UDHM.
- The joint Hospital Infection, Prevention, Control Committee meetings report into the Hospitals' Quality and Safety Committee and ultimately the Hospital Management Boards for oversight, accountability, and assurance purposes. The Committee also provides quarterly reports to the MFT Group Infection Control Committee.
- The Hospitals' Infection, Prevention and Control Committee is attended by the Multi-Disciplinary team from both hospitals in addition to the Medical Directors for each Hospital and the Director of Nursing.

Frequency of meetings can be found in the table below:

Joint MREH/UDHM Infection Control Committee (Monthly)	Pandemic Context National and local Audit Presentations: •HH •PPE •Hands, face, space (from March 2021) Incidents and Risk Assessments Fit Testing (from March 2021) Lateral Flow (from March 2021) ICPs KPI for HCAI performance (MRSA, MSSA, VRE, CPE, endophthalmitis, HOCI) Hospital Infection Prevention and Control Hospital Action Plans Guidance updates Vaccination update
MREH/UDHM Performance Improvement Development meetings (monthly)	Performance review meeting
Outbreak Process	Chaired by Director of Nursing, as required

Other mechanisms	Practice audits – HH & PPE, Hands, Face, Space SHINE Matron reviews QCR and Patient Experience Trackers HCAI surveillance reports

COVID-19

- For the year April 2020 – March 2021 there was one COVID-19 outbreak involving a total of 5 patients identified as COVID-19 positive, with 2 of those cases being classed as Healthcare Onset COVID-19 Infection (HOCI).
- Key findings from the investigation into the outbreak and lessons learnt are detailed below:

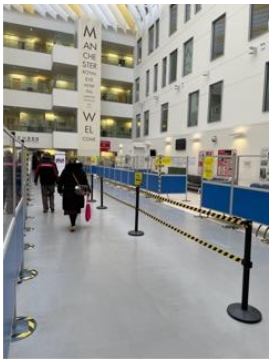
- *Two patients discharged to other healthcare providers identified as COVID 19 positive when swabbed by receiving units.*
- *Both patients were asymptomatic when on ward 55 and had received negative COVID 19 swab results during their stay.*
- *When outbreak identified, daily Senior Team meetings convened to oversee actions and outcomes. IP&C, EHW and Sodexo included in meetings. Action plan based on advice and guidance form IP&C & EHW.*
- *Trace & test programme for all staff who may have been in contact with either patient. 2 swabbing rounds 1 week apart. Review of ward 54 staffing COVID-19 status – 2 staff isolating had been caring for the 2 patients.*
- *Increase frequency of hand hygiene and PPE audits on ward (daily). Increased cleaning programme following IP&C advice. Staff support offered by senior leadership team.*
- *SOP developed for management of staff break areas, separate staff changing areas for green & amber pathway staff. Information for patients to promote social distancing and infection control developed.*
- *RCA undertaken for each patient. Action Plan as agreed with IP&C completed. Lessons learned shared via Audit & Clinical Effectiveness process. Briefing paper for dissemination and sharing of learning at Hospital oversight committees.*

- Significant work has been undertaken and remains ongoing across both MREH and UDHM in response to the COVID-19 Pandemic. Examples include:
    - All patient pathways and management processes reviewed to comply
    - with national and Trust guidance.
    - Environmental modifications to entrances, waiting rooms and clinical
    - spaces to ensure social distancing.
    - SOPs compiled to define and describe patient management.
    - The age and fabric of the estate and the lack of ventilation has resulted
    - in the need to reconfigure some services and purchase air filtration
    - systems.
    - Introduction of hand hygiene/ PPE stations and Hands, Face, Space
    - Banners.
    - All patient pathways and management processes reviewed to comply with national and Trust guidance.
    - Environmental modifications to entrances, waiting rooms and clinical spaces to ensure social distancing.

Hand hygiene and PPE station

MREH: cares for patients on super green (swab 72 hours prior to admission followed by 3 days community shielding) and amber pathways.

MREH Main Entrance, Atrium, environmental modifications:



Healthcare Associated Infections

- There have been no outbreaks of infection or episodes of MRSA, VRE or Gram-negative bacteraemia's within UDHM or MREH.
- MREH monitor rates of endophthalmitis.
- Each MREH associated case of endophthalmitis is subject to a rapid learning review.
- For the year April 2020 – March 2021 there have been 14 cases of endophthalmitis 12 of these were inflammatory, NOT infective.
- The 2 infective cases arose following 20,169 intravitreal injections in the Macular Treatment Centre. Infection is a known complication of intravitreal injections however each case was reviewed to establish if there was an avoidable causative factor.
- No avoidable causative factor identified in both cases

Compliance with IPC Clinical Practice *(% per clinical unit)*

For the year April 2020 – March 2021 Enhanced cleaning, hand hygiene and Personal Protective Equipment (PPE – donning and doffing, since May 2020) audits have been undertaken

UDHM

Compliance with Hand hygiene and donning and doffing:

Overall percentage for each clinical unit April/May 2020 – March 2021		
	Hand Hygiene	Donning & Doffing
Restorative	100%	100%
Oral Surgery	100%	100%
Oral Medicine	100%	100%
E D C	100%	100%
Orthodontics	100%	100%
Children's	100%	100%
Radiology	95%	100%

Compliance with FFP3 fit testing:

Compliance with FFP3 Fit testing Staff	%
Undergraduate and Post graduate dental Students	91% (146/161)
Nursing	93% (89/96)
Clinicians	85% (56/67)
Comment	All staff that have failed Fit Test have been provided with a respirator hood.

Compliance with ANTT:

Professional Group	No. of staff ANTT compliant LOCAL	CENTRAL	Total % LOCAL	CENTRAL
Clinicians	-	32	-	49.23%
Dental Nursing	92	74	93.9%	67.2%
Comments	A number of Dentists not onsite due to reduction in activity/ shielding – assessments planned on return. No local records for Dentists/ Students.			

MREH

Compliance with Hand hygiene and donning and doffing:

Overall percentage for each clinical unit April /May 2020 – March 2021		
	Hand Hygiene	**Donning & Doffing**
Ward 55	95.80%	100%
Ward 54	96.90%	100%
MTC	95.50%	98.90%
Theatres	97.20%	96.10%
Day case	100.00%	100.00%
WCH	95.00%	98.00%

OPD	96.50%	100.00%
EED	98.30%	99.10%
Trafford	98.80%	100.00%
Altrincham	100.00%	100.00%
MTC North	98.90%	97.30%
MTC South	99.60%	100.00%
Clinic F	93.30%	97.30%
Clinic G	100.00%	100.00%
Clinic H	100.00%	100.00%

Tight-fitting respirators (such as FFP3 masks) rely on having a good seal with the wearer's face. To ensure that respiratory protective equipment (RPE) will protect the wearer, a face fit test should be carried out the first time a worker uses a particular type of respirator and a pre-use seal check or fit check, which they should be repeated every time they put a respirator on.

Due to the Nature of Dentistry most procedures are Aerosol Generating Procedures (AGPs), which require the usage of FFP3 protection. Fit testers have been trained from the MDT.

Compliance with FFP3 fit testing:
A robust process for a Fit Testing Programme has been initiated across MREH, with current compliance detailed in the table below:

Staff	**%**
Nursing	50.2% (119/237)
Medical	37.4% (43/115)
Optoms/ Orthop/ Clinical Imaging	**20% (8/40)**
Comment	**Overall, 17.6% failure rate**

Compliance with ANTT:

Professional Group	No. of staff ANTT compliant LOCAL	CENTRAL	Total % LOCAL	CENTRAL
Medical Staff	-	13	-	27.1%
Nursing Staff	190	186	90.5%	83.4%
Optoms/ Orthop	61	55	93.4%	60%
Comments	No local records for Medical Staff.			

Compliance with Maintaining a Safe Environment

UDHM

Issue	**Action**
Issues associated with provision	• 70% of items processed per day within the Sterile Services is from UDHM

of Sterile Services	• 12-hour turn-around agreement in place compared to the 24-hour standard turnaround time • The reduction of clinical activity has decreased issues previously experienced with equipment • This will be monitored as the increase clinical activity to pre Covid levels
Water Quality	• Identified discoloured water within the Children's Department coming from one of the Dental spittoons. • Water quality testing was performed throughout the hospital, the Children's Department was identified as having levels of pseudomonas and the Oral Surgery Department were identified as having levels of legionella in two of the surgeries. • Delayed testing of the samples once they had been received in the laboratories which could have provided false results. • Dental chairs in Oral Surgery were replaced as part of a refurbishment programme and the hospital has reviewed the flushing regime within the departments. • A further water quality testing revealed that no further issues had been identified.
Ventilation	• Full review of the Ventilation within the Hospital was performed in light of the volume of aerosol generating procedures which are performed within Dentistry. • Ground floor Restorative teaching clinic was only area identified with sufficient ventilation of 12 ACH • All other areas of the hospital had an air exchange of 1 ACH • Due to the age and fabric of the building it was not possible to improve the current ventilation systems that are in place. • Dentair air scrubbers were purchased for use in the closed side surgeries to improve ventilation • SOPs have been developed to support staff in using these new pieces of equipment and the new ways of working.

MREH

Issue	Action
Issues associated with provision of Sterile Services	Nil reported
Compliance with Endoscopy Standards	Not applicable
Water Quality /Ventilation	MREH MTC not included as agreed by ORC Water Safety Group. Other site testing currently being questioned.

Risk Register

All infection related incidents and risks are discussed at the monthly joint IPC Committee.

There are currently 2 risks on the UDHM Risk Register and 2 on the MREH related to IPC:

UDHM

Risk number	Risk	Status	Date added to register	Score
MFT/ 000239	Reduction in the standards of cleaning across the UDHM	Active & regularly	02.07.2015	12
MFT/ 002457	Fabric of the building- Poor standards of ventilation within the hospital	Active & regularly	06.06.2019	12

MREH

Risk number	Risk	Status	Date added to register	Score
MFT/001560	Reduction in the standards of cleaning across the OPD modules and MREH atrium	Active & regularly reviewed	01.10.2014	10
MFT/001563	Decontamination of ophthalmic lenses and the risk of cross infection – SOP in place to manage	Active & regularly reviewed	30.10.2015	5

Feedback to IPC Team

UDHM

What went well
Monthly IP&C meeting for oversight and assurance
Compilation of IP&C action plan
Oral Surgery SOP – AGP
Restorative Student AGP clinic
Main Hospital entrance – gateway process in place to support social distancing in the clinic waiting areas

Housekeeper role – increasing regular environmental cleaning
Monthly hand hygiene audits
Introduction of PPE audits mirroring HH audits in May 2020
Complete review of all patient pathways
SOP for staff breaks and introduction of Hands Space, Face audits to ensure compliance with social distancing guidance
Review of UDHM IP&C Action Plan against the Trust Board Assurance Framework and NHSI/PHE review action plan to ensure compliant against all areas and identify and areas for improvement / action

What could we do better going forward?
Expand Housekeeper workforce
More robust supervision of cleaning
Ventilation expertise

MREH

What went well
Monthly IP&C meeting for oversight and assurance
Compilation of IP&C action plan
Monthly hand hygiene audits
Introduction of PPE audits mirroring HH audits in May 2020
Complete review of all patient pathways
Standard Operating Procedures (SOPS) completed to describe patient pathways for planned and unplanned care
Creation of a COVID 19 screening area to assess all patients prior to entering the Eye Emergency Department
Management of COVID 19 swabbing clinics to manage pre-op patients.
Swift response to the COVID 19 outbreak on ward
SOP for staff breaks and introduction of Hands Space, Face audits to ensure compliance with social distancing guidance.
Review of MREH IP&C Action Plan against the Trust Board Assurance Framework and NHSI/PHE review action plan to ensure compliant against all areas and identify and areas for improvement / action.

What could we do better going forward?
More robust FFP3 fit testing data collection – ongoing
Ensure current IP&C Guidance is maintained, as services are recalibrated

End of Year Infection Prevention and Control Update 2020-2021 Clinical and Scientific Services (CSS)

28TH April 2021

Framework for IPC

CSS Infection Prevention and Control Meeting

- Frequency - Bimonthly CSS ICP Meetings, meetings are chaired by Clinical Director for ACCP and the Deputy Director of Nursing with all Divisions represented with attendance form IPC, Microbiology and Virology. The meetings are well attended by all disciplines.
- Some challenges noted, which we are in the process of addressing, in terms of review of Terms of Reference, membership and wider sharing of Divisional IPC minutes.
- Number over last 12 months X6, none have been stood down although at peak times the meetings were shortened to an hour due to competing clinical demands.

Divisional IPC Meetings

- The Critical Care Units hold local meetings on alternate weeks, these are led by the Lead Nurse/Matron and Critical Care Consultant IPC Lead for the Units. The Units on both ORC and Wythenshawe hold a joint local meeting to ensure shared learning across the site. As we welcome NMGH into the CSS family the HoN and CD are liaising with the Critical Care team at this site to review and harmonise processes. Learning from IPC concerns are shared across the ACCP division at the CSS BI monthly IPC and HFC meetings and an overview is shared at ACCP Divisional Board.
- Accountability meetings are arranged as required and these are held within 2 weeks of a bacteraemia or CDT being identified. The time frame for managing these has been slightly longer during periods of escalation due to COVID-19, but this will improve now that the areas are de-escalated with the aim of achieving this review target throughout 2021/22.
  7 Accountability meetings held in 2020/2021.

Imaging

- Matron for Imaging leads on Imaging Division IPC
- IPC champions across all modalities on all sites are invited to IPC meetings and liaise with IPC lead.
- Monthly IPC meetings on Wythenshawe site and ORS were conducted initially but had to be stood down for few months due to COVID challenges however meetings covering all sites resumed via teams since January -2021.
- The remaining Divisions, Pharmacy, DLM, AHP's in CSS have IPC focus groups who undertake audit and share IPC information with their teams and via their local Quality and Safety agenda. Minutes of the meetings are shared via the CSS ICP

COVID-19

Total Number of COVID-19 patients (from June 2020)

- Total number 702 COVID Patients; 407 at ORC, 295 at Wythenshawe.
- With 63 COVID patients receiving ECMO.
- This total also includes 57 mutual aid patients (29 to ORC and 28 to Wythenshawe) who were transferred from other external hospitals into MFT Critical Care Beds from GM and wider afield such as Birmingham and Stoke.

Of which how many where HOCI (day 8 of admission onwards) –

2 RCA's have been undertaken into 2 suspected HOCI acquisitions within the Critical Care Units, both occurred at ORC. The following was noted after investigation and presentation at Accountability Meetings.

- The first case identified no lapses in care identified and it was deemed likely that this was a community acquired infection. A mortality review was undertaken, and no concerns identified in the care and treatment provided.

- The second case identified that there were no lapses in care and whilst the infection was hospital acquired it was not possible to identify where the patient had acquired COVID. One area of learning from this review was that more consideration should be given to the patient journey.

How many outbreaks of COVID-19 since June 2020/Lessons learned?

There has been one outbreak on HDU at ORC in December 2020, at this time HDU was identified as a non- COVID Critical Care Unit.

An elective patient was admitted post-surgery and COVID screened on admission to HDU which tested positive. This patient was not receiving any AGP's during her admission and had been discharged from HDU by the time the result was received. The patients in the adjacent bed spaces were isolated and screened as exposed patients. 2 patients tested positive and the other was negative.

The HDU was closed to admissions on 07.12.20 and all patients in the bay were screened along with all staff who had worked in that bay during the time frame. Enhanced cleaning and daily PPE and hand hygiene audits were completed and information regarding the outbreak was shared with all staff groups. All other patient and staff tests were all negative.

Following discussions with IPC and CSS teams the unit was re-opened in a phased approach following discharges and deep cleans of the areas from 11th December 2020, with exposed patients in one side of the unit. The other bay was deep cleaned and able to admit non- COVID patients. Robust plans were put in place to ensure that staff who had cared for COVID patients/ COVID exposed patients did not care for patients in this side of the unit as the unit should have remained closed until 21st December 2020. The staff caring for these patients were also undertaking regular lateral flow testing. The adjustments to the usual process for re-opening following an outbreak were decided in conjunction with the Senior Critical Care Team, CSS Operational Team, IPC, and Virology Team after careful risk assessment. Without re-opening sooner, the hospital would have been unable to provide non- COVID critical care emergency capacity, (which would require a major incident be declared). Further testing of staff and patients continued as per outbreak policy. There were no further positive results received and all staff tested negative offering reassurance relating to compliance with PPE and IPC process.

Compliance (% per clinical unit) with testing day 1, 3, 5-7 since November 2020

- **CTCCU 84% AICU 60% TDC 100%**
- **ICU 75% HDU 93% CICU 81% Ward 14 100%**

Compliance with patient COVID testing has been challenging to maintain and monitor especially with changes to the testing regime, however we are now auditing compliance with an audit tool developed by a Matron on AICU. Poor compliance is being addressed with an action plan and education.

One unit has decided to pilot use of a notice board that is updated overnight and has seen a huge improvement in compliance since then, this has now been shared and is being implemented on the other Critical Care Units. Compliance figures for last week are shown above and areas for improvement are in undertaking the day 3 and day 5-7 screens. Compliance in the areas that have been predominantly non- COVID is better than the units that have been full COVID units until the last March 2021. There has also been some confusion around screening patients on admission to critical care which then 'disrupts' the pathway and staff are unsure whether to screen on the due date (i.e. day 3 or 7) or whether to go from the date of the admission screen.

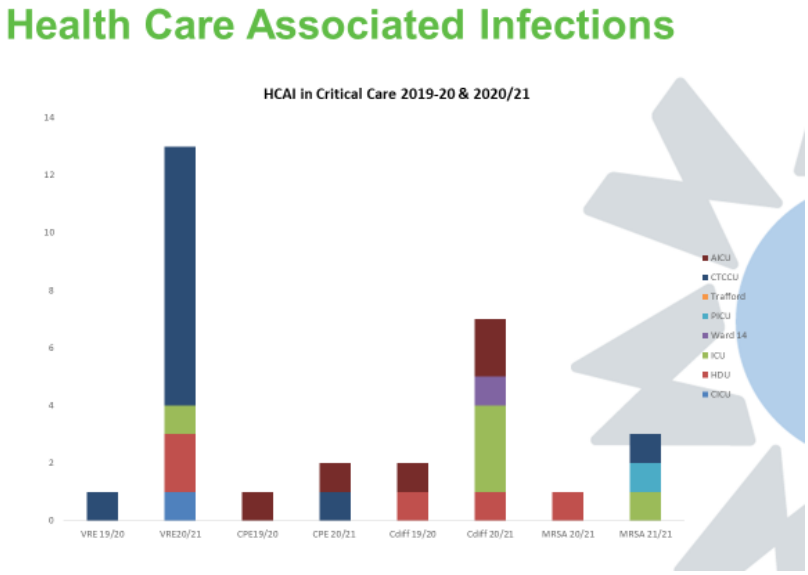
Screening on admission is a routine aspect of care for many infections so it is important that we educate and reassure the teams about the correct process. Following discussion with the clinical leads, it has been agreed that for COVID patients we should follow the Trust pathway and only screen outside of this if the patient becomes symptomatic. The nursing leads and PBE team are supporting bite size teaching along with sharing of the audit results so that we can monitor and ensure our compliance is improved. Compliance will be reported at the bimonthly CSS IPC meeting.

Key issues identified with implementing control measures in your area

- Training the large numbers of staff deployed into Critical Care to support rapid escalation, with a limited time frame to action.
- Changes in National Guidance on PPE for AGP's
- Maintaining compliance with Fit testing requirements and regular FFP3 mask changes
- PPE availability variable at the start of the pandemic.
- Impact on capacity due to the requirement for Donning and Doffing space.
- Isolation limitations particularly for those patients that we were unable to isolate with other infections such as VRE/CDT.
- Delays in obtaining COVID screen results and limited access to rapid screening.
- Increased number of deployed staff within each clinical area to support the rapid escalation in patient numbers with a requirement to source additional space to support social distancing for breaks and staff change.

Healthcare Associated Infections

Incidents of MRSA/VRE/Gram neg bacteraemia from 1st April 2020 – March 31st, 2021



All incidences of bacteraemia and CDT that have been identified in Critical Care have been reviewed in detail using a formal accountability process and the majority have been reported as unavoidable.

The findings of these investigations are shared at CSS IPC bimonthly meeting and an overview is provided at CSS HFC and ACCP Divisional Board.

There has been an increase in reported infections across all the units during the pandemic with the most significant increase being in VRE bacteraemia and GNBSI. One of the factors that is thought to have contributed to the increase in infections during the first wave of the pandemic was the practice of double gloving. At the outset of the first wave, when the team were unsure what they were dealing with it was agreed that staff would wear long-sleeved gown and gloves as their 'base' layer and don an apron and a second pair of gloves to deliver care. Following discussions with the IPC colleagues, the team have now changed their practice to wear a long-sleeved gown bare below the elbow and to don apron and gloves for each episode of care delivery, ensuring usual hand hygiene standards are met in between tasks/patients.

VRE Bacteraemia x13

- 13 have been identified between April 20-March 21, with only 1 identified in April 19-March 20. The majority (9) of these have been on CTCCU in patients receiving ECMO, 12 cases have been reported as unavoidable at accountability, with the last one due to be reviewed at an Accountability Meeting on the 29th April 2021**.**

- Screening for VRE on admission to the Critical Care Units at Wythenshawe is not routinely undertaken due to the patient population. Screening on admission is undertaken on the ORC Critical Care Units and acquisitions are reviewed at the local IPC meetings and learning shared. Although no outbreaks have occurred, the winter months tend to see a spike in VRE patients. When this occurs, the matrons lead on action plans to ensure that all IPC standards are being maintained to reduce risk of further acquisitions (see appendix). The Covid-19 Pandemic has meant that we have been unable to isolate patients with infections such as VRE and CPE due to prioritisation of side rooms.

MRSA Bacteraemia x3 – x1 ICU, X1 CTCCU, x1 CICU

- At accountability two out of the three reviews were recorded as unavoidable with the 3rd being validated as avoidable. The review of the third case identified that there were several lapses in care such as poor documentation of blood culture sampling, line sites not screened on admission from other hospital and a delay in commencing the MRSA ICP. The root cause of the bacteraemia was thought to be because of a delay in the prescribing of appropriate antibiotics. An action plan was implemented with specific actions being addressed via bite size teaching sessions and sharing with all areas.

CPE Bacteraemia – X2 – x1 CTCCU, x1 AICU

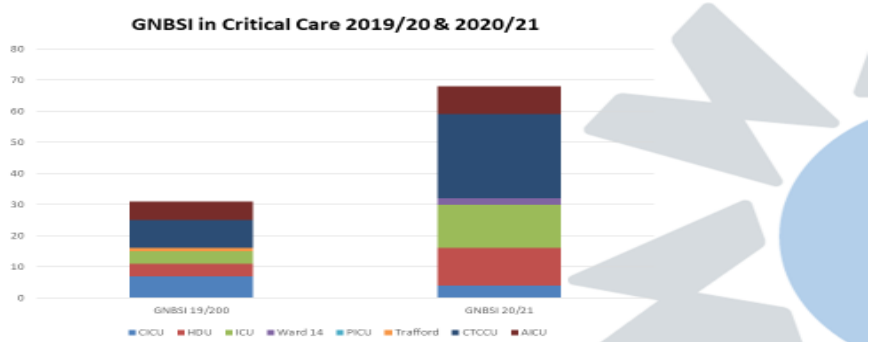
- At accountability one CPE bacteraemia on AICU was recorded as unavoidable, the other bacteraemia on CTCCU is due at an Accountability Meeting on the 29.04.21.

CDT – x7 x2 AICU, X1 Ward 14, x3 ICU and x1 HDU

- At accountability meeting all reviews found that there were no lapses in care and the CDT were validated as not attributable/avoidable. However, typing was sent and there was a typing match for one case, this was therefore re-validated as avoidable in a case on ICU.

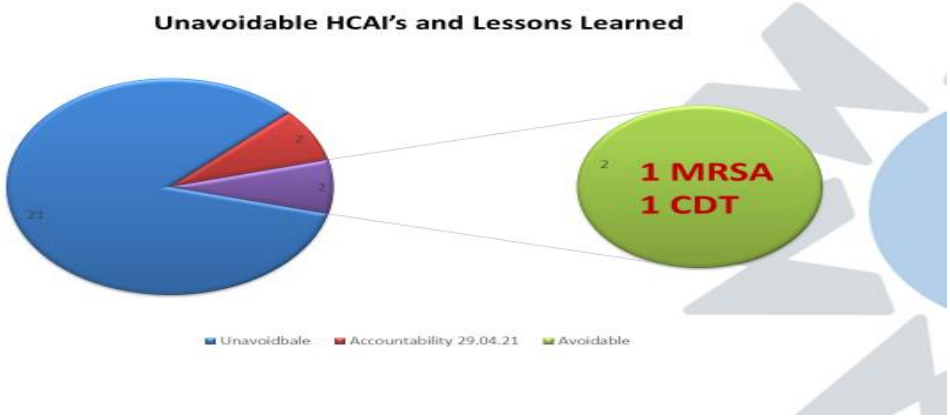
GNBSI - **total of 31 in 19/20 – 68 in 2020/21.**

Healthcare Associated Infections



There has been a significant increase in the number of GNBSI reported in the year 20-21 than 19/20. Of the 68 reported in 2020/21 all were investigated utilising the Trust GNBSI Surveillance and 6 were identified as avoidable. Issues identified included lapses in catheter care, lapses in catheter care documentation, missed opportunity to prescribe prophylactic antibiotics perioperatively, onset of hospital acquired pneumonia. Learning is shared and appropriate action plans implemented to address non-compliance and improve standard.

Health Care Associated Infections



Themes identified /lessons learned/implementation of lessons learned

Cascade of learning and areas for improvement are shared at the bedside with bitesize teaching as well as in formal education sessions, action plans and ongoing auditing and monitoring remains in place. The CICU undertook a Quality Improvement Project relating to environmental factors in the control of infection.

Outbreaks of infection (excluding COVID-19)

There have been no outbreaks on any of the Critical Care Units.

Hotspot Areas
What are your high-risk clinical areas (e.g. Critical Care/extremely vulnerable of patients)?
All **Critical Care** areas are high risk, with a particularly vulnerable group of patients receiving ECMO due to the nature of the invasive lines required to provide this treatment.

What are the key issues in these areas (e.g. environment/facilities etc and mitigation)?

There have been an increased number of patients requiring ECMO due to the COVID -19 Pandemic. Average annual numbers of patients per year is 20, however there have been 63 COVID patients receiving ECMO plus several non- COVID patients also receiving ECMO during the last 12 months.

The VRE Bacteraemia's reported on CTCCU all occurred in COVID -19 patients receiving ECMO.

Imaging

All areas are high risk as they have outpatients in most areas and in patients attending for imaging procedures from across hospital areas .However A&E plain film, CT , MR, and Interventional areas had patients who were positive/ symptomatic , as well as patients who were immunosuppressed attending for procedures . These areas have clear protocols in place out to manage the service safely.

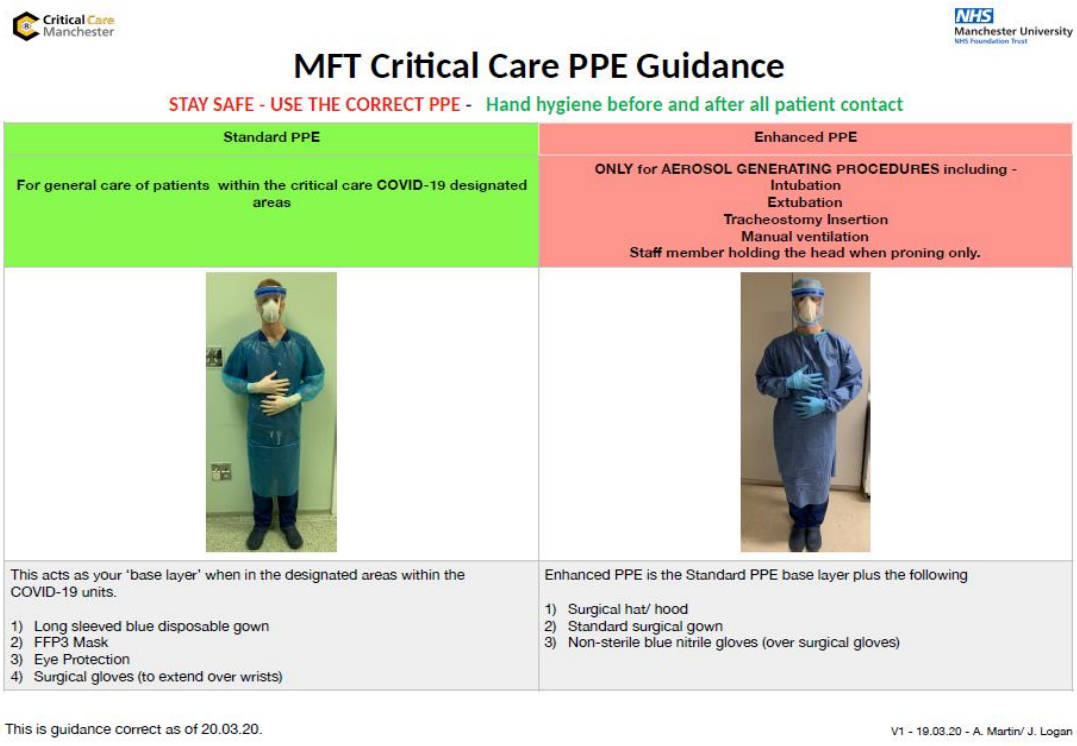
Compliance with IPC Clinical Practice *(% per clinical unit)*

- Hand Hygiene compliance:

	Hand Hygiene and PPE Audit Results	Has Hand Hygiene been undertaken?				Is PPE appropriate for the task undertaken?	Is PPE doffed in the correct order?	Are aprons/ long sleeved gowns worn as per guidance?	Are the Gloves worn as per guidance?	Is there an appropriate level of PPE available for the ward/ department?	Is the area where PPE is stored for use i.e. donned and doffed, clean and tidy?	Are there instructional posters displayed at the Hand Hygiene facilities in the ward/department?
		Nurses	Medical	AHPs	Other							
CSS	AICU	100%	100%	100%	75%	100%	100%	100%	100%	Yes	Yes	Yes
	CICU	100%	60%	100%	100%	60%	100%	100%	100%	Yes	Yes	Yes
	CTCCU	100%	83%	100%	67%	100%	100%	100%	100%	Yes	Yes	Yes
	EHDU	100%	100%	100%	100%	100%	100%	100%	100%	Yes	Yes	Yes
	HDU	100%	100%	100%	100%	60%	100%	50%	100%	Yes	Yes	Yes
	ITU	100%	100%	100%	78%	80%	100%	93%	100%	Yes	Yes	Yes

- The Critical Care Units submit Hand Hygiene and PPE Observation audits via the Trust Smart Survey. From April onwards, other divisions and departments such as Pain Service, Imaging, Pharmacy and DLM will begin using the Smart Survey to submit their audit data centrally, enabling CSS oversight for all areas.
- Fit Testing - We are currently in the process of obtaining CSS wide information to develop a central database. Divisional Leads are identified who are responsible for monitoring and maintaining fit testing compliance. See relevant slide
- ANTT - Individual divisions have processes in place to monitor ANTT compliance, however, from April onwards, this data will be collated centrally to ensure CSS wide oversight. ANTT assessment on CTCCU has traditionally been undertaken at year end and therefore resulting in a low compliance level at the start of the year. Assessment was also limited to be undertaken by the PBE team. Work was underway to cascade the responsibility of assessment across the band 7 team however this has been delayed due to Covid-19. The HoN is overseeing the roll out of this cascade and conversion to a rolling assessment programme to avoid this situation in the future.

- The Matron for Imaging is working with the teams at Wythenshawe and ORC to develop and populate an overarching database and mapping which staff are required to be ANTT assessed to ensure accurate information and monitoring of compliance.



Critical Care Manchester

NHS Manchester University NHS Foundation Trust

MFT Critical Care PPE Guidance

STAY SAFE - USE THE CORRECT PPE - Hand hygiene before and after all patient contact

Standard PPE	Enhanced PPE
For general care of patients within the critical care COVID-19 designated areas	ONLY for AEROSOL GENERATING PROCEDURES including - Intubation Extubation Tracheostomy Insertion Manual ventilation Staff member holding the head when proning only.
This acts as your 'base layer' when in the designated areas within the COVID-19 units. 1) Long sleeved blue disposable gown 2) FFP3 Mask 3) Eye Protection 4) Surgical gloves (to extend over wrists)	Enhanced PPE is the Standard PPE base layer plus the following 1) Surgical hat/ hood 2) Standard surgical gown 3) Non-sterile blue nitrile gloves (over surgical gloves)

This is guidance correct as of 20.03.20.

V1 - 19.03.20 - A. Martin/ J. Logan

Fit testing and ANTT Compliance for Critical Care can be seen below.

	ANTT %	Fit Tested %
ICU/HDU/THC/14	81	92%
CICU	86	
AICU/PACU	88	96
CTCCU	55	96

Compliance with Maintaining a Safe Environment

Issues associated with provision of Sterile Services

No issues with the provision of sterile services identified.

- **Compliance with Endoscopy Standards**
  Compliance with Endoscopy Standards is monitored by the Lead Nurse for CTCCU. CTCCU have a UV cupboard for decontamination of TOE probes and bronchoscopy endoscopes.

- **Water Quality /Ventilation**
  - Review of estates at the outset of the Covid-19 Pandemic identified that the side rooms in Zone 4 of CTCCU are positive pressure rooms and therefore not suitable for providing care to Covid patients.
  - Cleaning issues at ORC Critical Care are in the non-clinical areas and these are being addressed with fortnightly walk rounds with DDN, Sodexo and Estates with some improvement noted and work ongoing.
  - Issues at Wythenshawe Critical Care relate to non-compliance with cleaning schedules and a lack of cleaning of ventilation grills and high-level surfaces such as the clinical pendants. Monthly walk rounds are being reinstated with the Critical Care Matrons and or Unit Manager with Sodexo to closely monitor cleaning standards.

Risk Register

What are the local IPC risks which have been identified and what are the current statuses?

There are several risks on the register which relate to Trust wide risks. Risks relating specifically to areas in CSS include the laminar flow cabinet in nuclear medicine (risk level 6) and PPE use in radiology (risk level3). In addition, following review of risks within Critical Care, it has been agreed that the limited number of side rooms should be added as this provides a number of challenges for the team to ensure that all relevant patients can be isolated as required.

Feedback to IPC Team

What went well

- High standard of IPC maintained throughout pandemic.
- Simulation training in PPE.
- Proning protocol and procedure.
- Escalation into theatres and Paediatric Critical Care.
- Changes to patient pathway through theatres to ensure all patients can be treated during the pandemic (blue/yellow/green patients).
- Changes to the footprint of AICU Wythenshawe and ICU ORC to facilitate cohorting of patients.
- Change in practice re double gloving, PPE Compliance, patients with multi organism infections yet no further transmission.
- Worked collaboratively with the IPC, Microbiology teams to undertake Micro Ward Rounds in all Critical Care Units and support the RCA investigations.
- Successfully supported deployed staff into the Critical Care areas.
- Removal of digilocks to entrance doors to swipe access reducing infection risk for a high touch surface.
- All imaging areas were assessed for covid safe working with IPC team's support, which included outpatient as well as inpatient flow within the department.

What could we do better/going forward

- Review Zones in critical care to agree PPE step down and return to uniform.
- Review use of scrub style uniforms within Critical Care for specific staff groups such as AHP's, Pharmacy.
- Align uniform for medical staff across all Critical Care Units.
- Matrons Ward Round to include Covid Screening audit.
- Consider recruitment of Housekeepers to support environmental standards.
- Bio Quell pods trial at NMGH to increase provision of isolation facilities.
- Additional storage space required across multiple areas in CSS.
- Additional staff areas to enable safe social distancing are required, particularly once visitors are permitted to resume usual visiting as these areas are currently used for staff breaks/handovers.
- Additional office space to accommodate social distanced work areas are required.
- Monthly Matron rounds extended to all imaging areas to address any issues/concerns

End of Year Infection Prevention and Control Update

Manchester Local Care Organisation and Trafford Local Care Organisation

Framework for IPC
• **Chair** of the LCO Infection Prevention and Control Group - Lorraine Ganley, Director of Nursing and Professional Lead Manchester Local Care Organisation (MLCO) and Trafford Local Care Organisation (TLCO((M&TLCO) **Deputy Chair** – Alex Barker Head of Nursing (M&TLCO) **Clinical Leads** - Alex Barker, Head of Nursing (M&TLCO) and Nicky Boag, Head of Allied Health Professionals (M&TLCO). **Infection Prevention and Control** - Julie Mullings, Lead Nurse Community Services Tissue Viability, and Infection Control; Rachael Wardell, Senior Infection Prevention and Control Nurse. Access to Rajesh Rajendran, Associate Medical Director (Infection Control) and Julie Cawthorne, Assistant Chief Nurse IPC/Tissue Viability • M&TLCO IPC meetings are standalone meetings held bi-monthly. Over the last 12 months there have been five meetings.

COVID-19
• Within M&TLCO there are 167 health community services providing community in-patient facilities, visits to patients in their own homes, nursing and residential care homes and clinics for a range of conditions across community services' venues in Manchester and Trafford. • The number of patients who are known to be COVID-19 positive under the caseload of community services in M&TLCO are recorded and until 22nd February 2021 was provided on the M&TLCO dashboard. With the decrease in the number of cases and information no longer being utilised by services this is no longer provided on the dashboard. • For the purposes of this report only those patients within M&TLCO community in-patient facilities (including the Short Breaks Service for people with a Learning Disability) aligned to Manchester University NHS Foundation Trust (MFT) from 1st June 2020 to 31st March 2021 will be included which equates to 36 patients. • Of 36 patients 28 were hospital onset COVID infections (HOCI), that is who tested on day 8 of admission onwards. • From 1st June 2020 to 31st March 2021 there have been six outbreaks of COVID-19 in community inpatient facilities affecting 33 patients and 42 staff members During this time frame there have also been six outbreaks affecting staff only • From these outbreaks the following lessons have been learnt: ○ Swabbing of patients prior to transfer to community in-patient facilities ○ Consistency of compliance to PPE requirements for staff when they are not directly providing clinical care, for example breaks, going to and from work, car sharing, smoking. ○ Staff to be encouraged to supportively challenge colleagues if they are not complying with PPE and escalate to line managers as appropriate. ○ Requirement to increase cleaning frequencies and disinfection for multiple use areas/equipment that is bathrooms, staff bases, telephones, equipment, etc. ○ Revisit home working arrangements to ensure that all staff who can work at home are supported to do so to reduce number of staff in offices/staff bases.

- Limiting patients in communal areas and supporting relatives and carers to follow the visiting policy.
- Reassessment of environment as the number of staff returning to work increases, for example offices and staff break areas.
- Revisit home working arrangements to ensure all staff who can work at home are supported to do so to reduce the number of staff in offices/staff bases.
- Reassessment of environment as the number of staff returning to work increase, for example offices and staff break areas.
- All office risk assessments to be formally reviewed and peer reviewed. Risk assessments to be shared with team members with opportunity to engage about measures and any mitigations around health and wellbeing.
- PPE, hand hygiene and environmental audits are undertaken daily when an outbreak is declared with management team visits to check adherence to guidance.
- Constantly reinforcing social distancing and correct use of PPE both in clinical and non-clinical areas for staff.

- As part of the MFT patient screening strategy all patients in community in-patient facilities are screened at day 7 following admission and then subsequently every seven days whilst they remain an in-patient. Most patients admitted to intermediate care units are stepped down from the hospital setting. For those patients admitted from a community setting, they are screened 48 hours prior to admission or on admission and isolated.
- To ensure compliance with the screening requirements the M&TLCO introduced a specific screening day for community in-patient units. This ensures that patient screens are always completed within the 7-day cycle.
- Other mechanisms in place to ensure compliance are daily IPC alerts received by Lead Nurse in central and south Manchester where there are community in-patient facilities. The exception being north Manchester as North Manchester Community Services do not currently have access to MFT Information Technology (IT). To note the intermediate care facility in Trafford is provided by Trafford Council.
- Key issues identified with implementing control measures within the LCO are:
  - Initially national and local guidance was for acute settings and not community services – we had to interpret the information and align to practice within a community setting.
  - National and professional guidance differed for acute and community settings and health and social care settings.
  - All staff within in community services were required to undertake training for FIT Testing due to meet with Resuscitation Council guidance (this was for approximately 2,900 staff).

Healthcare Associated Infections

- There have been no incidents of Meticillin-resistant *Staphylococcus aureus* (MRSA)/ Vancomycin-resistant *Enterococcus* (VRE)/Gram negative bacteraemia from 1st April 2020 – 31st March 2021.
- There have been four patients who have had Clostridium difficile (CDiff) in community in-patient facilities from 1st April 2020 – 31st March 2021. These have been:
  1 patient at Buccleuch Lodge (non-attributable to MLCO)
  1 patient at Gorton Parks (non-attributable to MLCO)
  2 patients at Crumpsall Vale ((non-attributable to MLCO)
- This compared to 2 from 1st April 2019 – 31st March 2020
  Root cause analysis has been completed for each incident which has not identified any consistent themes. Lessons learned have been:
  - Raising awareness with staff to identify if patients have diarrhoea to ensure timely sampling. Posters have been developed to place in toilets advising patients to inform staff if they have diarrhoea.
  - Reminding staff of the 'to dip or not to dip' campaign.

- Raising awareness of Greater Manchester Medicines Management Group (GMMMG) first line treatment of urinary tract infections to staff so they can challenge if this is not prescribed.
- GMMMG first line treatment of urinary tract infections highlighted to GP out of hours provider.
- Process in place advising staff of how to access Vancomycin.
- 'Has patient been on antibiotics in past 6 months' added to the multidisciplinary team discussion.

Hotspot Areas

- The M&TLCO high risk clinical areas are:
  - The continuing healthcare (CHC) facility at Dermot Murphy Close due to the high number of patients receiving aerosol generating procedures (AGPs) and requirement to improve hand washing facilities. Mitigation includes - All staff have been FIT tested and individual risk assessments undertaken. Temporary hand wash basins are available, and a joint estate and IPC action plan is in place.
  - Gorton Parks intermediate care units where care is provided by Advinia staff and adhere to care home guidance. Environmental issues are managed by Advinia.
  - Buccleuch Lodge intermediate care facility has no en-suite rooms. Patients have a commode in their room.
  - Removal of clinical waste from patients own homes. To mitigate the risk a temporary waste removal process is in place. The MFT Waste and Resource Manager chairs a task and finish group looking for a permanent solution.
  - Home visits as the status of some patients is unknown for example end of life; patients requiring urgent home care.

Compliance with IPC Clinical Practice *(% per clinical unit)*

- As of March 2021, compliance with Infection Prevention and Control mandatory training is above 97% and for Level 2 above 84% across all localities/directorates.
- Hand Hygiene and PPE audits are undertaken monthly. Compliance with Hand Hygiene is consistently above 90%. PPE is available and stored for staff to access.
- Hand Hygiene audits and ANTT compliance are reported at the bi-monthly M&TLCO Infection Prevention and Control meeting.
  As of March 2021, 2894, M&TLCO members of staff have undertaken fit mask testing with 1529 (53%) staff passing and 1365 (47%) not passing the testing. 62 members of staff (within community dental services) have passed to wear a reusable Corpro mask. The Head of Nursing, Infection Prevention and Control and Tissue Viability is looking at the low pass rate.
- At the start of the Pandemic donning and doffing PPE training was held centrally and shared with the Learning Hub for uploading. More recently localities/directorates have held local records and work is taking place to ensure all training is available on the Learning Hub.
- ANTT – Lead Nurse Community Services Tissue Viability and Infection Control has convened a task and finish group to establish ANTT champions to provide training and competency assessment for all community staff. These champions will monitor compliance.

Compliance with Maintaining a Safe Environment

- No issues have been identified associated with the provision of Sterile Services within areas such as Dental and Podiatry.
- Compliance with Endoscopy Standards is not applicable for M&TLCO.
- There are no issues in relation to Water Quality or Ventilation. The Group Compliance Manager Estates and Facilities Directorate has provided the following information:

  Water Safety

  All landlords must comply with statutory regulations HSG274 Part-2: The Control of Legionella in Hot and Cold-Water Systems and L8; The Control of Legionella Bacteria in Water Systems. Additionally, if the premises are constructed and managed as dedicated healthcare premises then the requirements of HTM 04-01; Safe Water in Healthcare Premises also applies. MFT manage confirmation that these regulations are being complied with by regular meetings with landlords, requesting copies of documents such as Legionella Risk Assessments (LRA`s) and Water Safety Plans (WSP`s) that are required under the regulations and general updates on water system compliance and maintenance. Any non-compliance is discussed and addressed at the meetings. Community Estates also reports in to the wider MFT Water Safety Committee where any issues that require escalation are also addressed.

  Ventilation

  Across the Community estate there are no Air Handling Units (AHU`s) that are classified as Specialised Ventilation and therefore subject specifically to the requirements of HTM 03-01, Specialised Ventilation for Healthcare Premises. Where AHU`s are installed they are maintained in accordance with SFG20, HVAC and CIBSE standards. In the current Covid-19 situation the NHS has issued guidance in the form of a Standard Operating Procedure; Room Ventilation Guidance for Single Rooms (not operating theatres) which is intended to provide information and guidance to organisations during the COVID-19 pandemic on the infection control contribution of ventilation in single rooms where Aerosol Generating Procedures (AGPs) are undertaken.

  Air Conditioning Units are not strictly classed as ventilation systems as they do not generate air changes as does an AHU, only dehumidify and filter air. However, these are again maintained in accordance with SFG20, HVAC and CIBSE standards. Additionally, the requirements of the F-Gas regulations will apply. As for water systems ventilation systems are reported on by Landlords to Community estates and in turn these are the subject of Community estates reporting to the MFT Group Ventilation Committee.
- The lessons learned from staff outbreaks and actions in place to reduce risk are described under COVID-19 section above.

Risk Register

There are six risks on the risk register relating to IPC.

- Overdue external annual servicing of dental pressure vacuum sterilisers. Assurance has been given by the company that the internal assurance checks are sufficient. The servicing will be undertaken as soon as possible
- Three risks relate to space within community estate. This is managed through a rotation of staff who are alternating between working from home and in the office.
- Dermot Murphy Close is due to undergo capital works to ensure compliance with IPC. This is managed using temporary handwashing facilities.
- Dermot Murphy Close have a risk relating to potential infection arising from visitors due to the complexity and vulnerability of the patients. This is currently being reviewed.

Feedback to IPC Team

- *What went well*

Having a dedicated community Infection Prevention and Control Team has been beneficial especially given the disparity of acute and community/health and social care guidance. They have been available, accessible, flexible, and quite simply brilliant – thank you.

- *What could we do better going forward*
  Guidance and communication to include community services.
  Amalgamation of information for all community services in one place (information to include North Manchester Community Services).
  Alignment of infrastructure, systems, and processes with the hospitals.

Appendix 2

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

GROUP INFECTION CONTROL COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Group Management Board has established a Committee to be known as the Infection Prevention and Control Committee. The committee is an executive committee and holds the powers delegated to it in these terms of reference. The Infection Control Committee is chaired by the Chief Nurse/ Director of Infection Prevention and Control.

2. MEMBERSHIP

2.1 Membership shall consist of:

Chief Nurse/DIPC (CHAIR)
Consultant Microbiologist/Infection Control Doctors (Vice-Chair)
Deputy Infection Control Doctor
Directors of Nursing
Assistant Chief Nurse Clinical DIPC
Lead Nurses Infection Prevention and Control
Hospital/MCS Clinical Leads for Infection Control
Consultant in Communicable Disease (Public Health England)
MHCC Infection Control Lead
Antimicrobial Pharmacist
Director of Estates and Facilities
Associate Director of Clinical Governance
Director of Clinical Governance
LCO representative
Assistant Director, Employee Health & Wellbeing
Chair of Antimicrobial Committee

All group executives have an open invitation to and may attend committee meetings

2.2 No business should be transacted at the meeting unless a minimum of ten members are present, which must include the Chair or Deputy Chair, four Hospital Clinical Leads, and either the Director of Nursing (Corporate) or the Assistant Chief Nurse/Clinical DIPC

3. ATTENDANCE AT MEETINGS

3.1 The Infection Control Committee may require the attendance of any Trust employee (or agent of the Trust)

4. FREQUENCY OF MEETING

4.1 The Committee will meet every three months (four times a year) but may be convened at other times as deemed necessary.

5. OVERVIEW

5.1 The Committee will set the strategic direction for infection prevention and control and seek assurance on an exception or as required basis

5.2 The Committee is responsible for developing the group organisational strategy and clinical standards for infection prevention and control in line with national/international evidence based practice and standards.

6. SCOPE AND DUTIES

6.1 Provide strategic leadership for infection prevention and control, including identifying priorities and setting performance targets.

6.2 Develop the strategy and agree the clinical standards for infection prevention and control across all the Trust sites.

6.3 Approve the programme of work of the Trust Clinical Infection Control committee.

6.4 Receive Hospital/MCS ICC performance and exception reports

6.5 Receive, review and ratify group policies, clinical pathways and reports, including the Annual Infection Control Report.

6.6 Approve the annual audit calendar to provide assurance that standards are met and any required changes to practice, systems and processes are delivered.

6.7 To report to the Group Management Board on performance against infection control indicators and audits, including actions taken to address any areas for improvement.

6.8 To determine and commission programmes of work required to deliver the work programme of the Infection Control Committee

6.9 Oversee the Trust's involvement in and response to, internal and external assessments and inspections.

6.10 Agree the education and training framework for infection prevention and control for the Trust, ensuring compliance with infection prevention and control standards.

6.11 Approve the Trust's Annual Infection Control Report.

6.12 To describe, review and monitor the principle and significant risks related to infection control on behalf of the Trust and present these with the plan of controls to the Group Management Board and Risk Management Committee.

6.13 The Infection Control Committee will receive exception reports from the Hospital/MCS Infection Control leads where performance is out with the standards set out in the IPC strategy

6.14. The Infection Control Committee will receive at each meeting a report from the Trust Infection Control Group to include:

1. Policy and pathway development
2. Infection Control Group activity
3. Changes to national or local strategy
4. Trust wide themes identified from adverse events

7. AUTHORITY

7.1 The Infection Control Committee is empowered to examine and investigate any activity within the Trust pursuant to the above scope and duties.

8. REPORTING

8.1 The Committee will report to the Group Management Board.

8.2 The Committee will work closely with relevant Group Committees and the Clinical Advisory Committee and will provide assurance to the Board of Directors in relation to infection prevention and control

8.3 The minutes and exception report (as required) will be considered at the next Risk Management Committee and Quality and Performance Scrutiny Committee

9. REVIEW

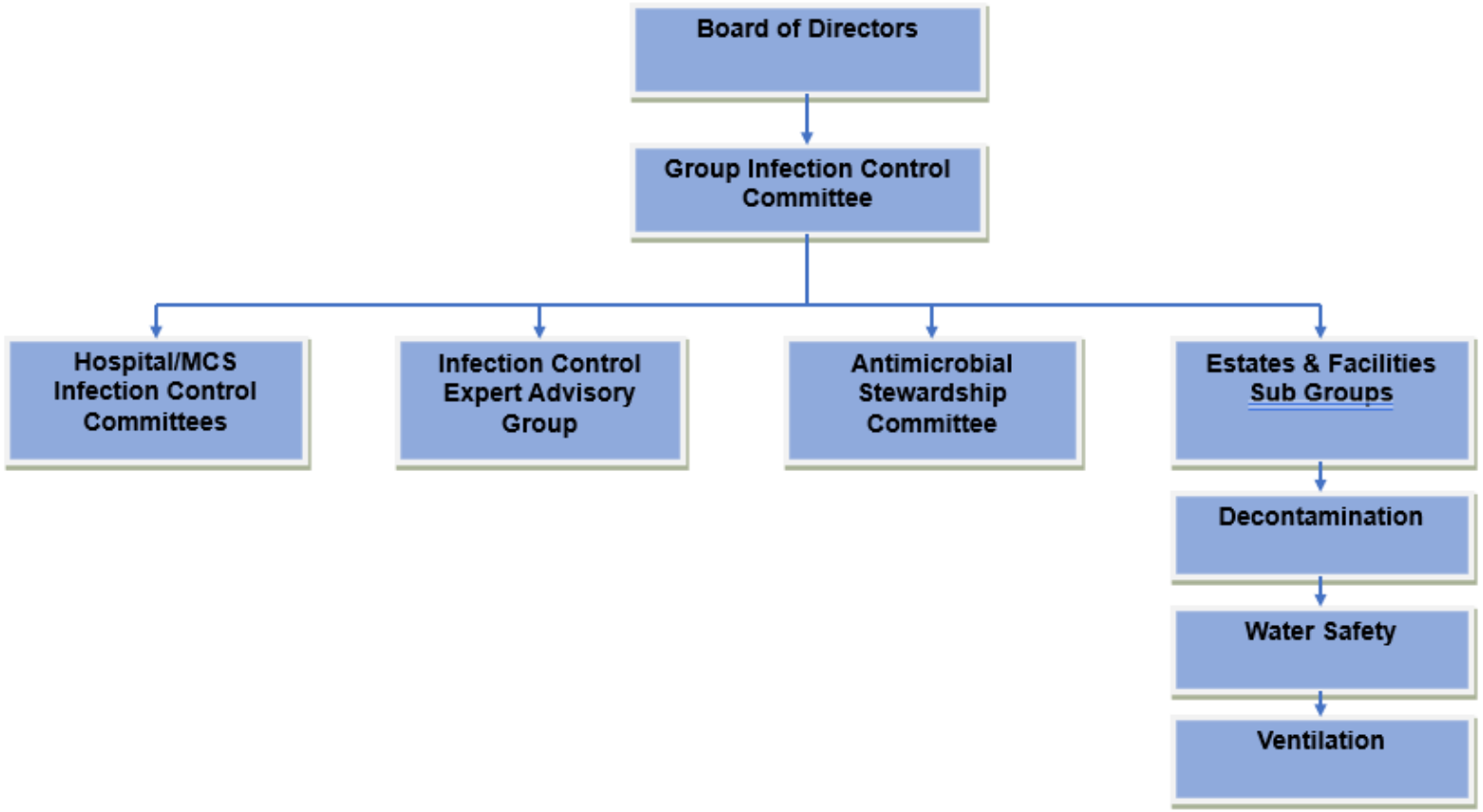
9.1 These terms of reference will be reviewed annually.

10. KEY PERFORMANCE INDICATORS

10.1 These Terms of Reference will be measured against the following key performance indicators:

1. 75% attendance of all listed members or nominated deputy
2. Presentation of the Annual Infection Control Report.

Reporting Framework for Infection Prevention and Control Group Structure 2021/22



MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce & Corporate Business
Paper prepared by:	Alwyn Hughes, Director of Corporate Services / Trust Secretary
Date of paper:	July 2021
Subject:	Board Assurance Framework (June 2021)
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Assurance • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	In the absence of robust and comprehensive BAF, the opportunities for supporting and enhancing organisational governance by using a body of good practice outcomes and evidence will be diluted.
Recommendations:	The Board of Directors is asked to accept the latest BAF (June 2021) which is aligned to the MFT Strategic Aims and also highlights the continued impact of the ongoing COVID-19 National Emergency.
Contact:	Name: Alwyn Hughes, Director of Corporate Services / Trust Secretary Tel: 0161 276 4841

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

THE BOARD ASSURANCE FRAMEWORK (June 2021)

1. Introduction

Performance against the Board Assurance Framework (BAF) has been traditionally reviewed at formal Board of Directors meetings via the Intelligent Board metrics. This long-standing arrangement ('The Board Assurance Report') was temporarily suspended during the COVID-19 National Emergency but has now been re-introduced in July 2021 (see separate Agenda Item 7.1). Significant risks to achieving the Trust's key strategic aims has continued to be reviewed and reported on at the Group Risk Oversight Committee (GROC) and across other corporate Executive committees, where necessary, dependent on the risk rating.

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. The updated BAF for June 2021 is attached (**APPENDIX A**) and has been updated to especially highlight the impact of the ongoing COVID-19 National Emergency.

2. MFT Strategic Aims (2021/22)

Key Risks associated with the following Strategic Aims will be regularly reviewed at MFT Board Scrutiny Committees and the Group Audit Committee (as required):

- *To complete the creation of a Single Hospital Service for Manchester/ MFT with minimal disruption whilst ensuring that the planned benefits are realised in a timely manner*
- *To improve patient safety, clinical quality and outcomes*
- *To improve the experience of patients, carers and their families*
- *To achieve financial sustainability*
- *To develop single services that build on the best from across all our hospitals*
- *To develop our research portfolio and deliver cutting edge care to patients*
- *To develop our workforce enabling each member of staff to reach their full potential.*

3. Recommendation

The Board of Directors is asked to accept the latest BAF (June 2021) which is aligned to the MFT Strategic Aims (2021/22) and also highlights the continued impact of the ongoing COVID-19 National Emergency.

APPENDIX A

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

THE BOARD ASSURANCE FRAMEWORK

(June 2021)

Introduction

The Board Assurance Framework (BAF) is one of several tools the Trust uses to track progress against the organisation's Strategic Aims. As part of the development of the BAF each financial year, the potential risks to achieving the Strategic Aims are regularly assessed for inclusion on the framework. As such, all principal risks on the BAF are set out under each of the organisation's Strategic Aims.

The construct of the Trust's BAF is based on several key elements as follows:

- **Strategic Aims**
- **Principal Risk** & **Risk Consequence** – *'What is the cause of the risk?'*, and, *'What might happen if the risk materialises?'*
- **Inherent Risk Rating** – Impact & Likelihood (without Controls).
- **Existing Controls** – *'What controls/systems are currently in place to mitigate the risk'*
- **Gaps in Controls** – *'What Controls should be in place to manage the risk but are not?'*
- **Assurance** – *'What evidence can be used to show that controls are effectively in place to mitigate the risk?'*
- **Gaps in Assurance** – *'What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?'*
- **Current Risk Rating** – Impact & Likelihood (with Controls)
- **Actions Required** – *'Additional actions required to bridge gaps in Controls & Assurance'*
- **Progress**
- **Target Risk Rating** – Impact & Likelihood (*'Based on successful impact of Controls to mitigate the risk')*

Risk Matrix

The table below demonstrates the Trust's risk matrix that is used within the framework:

	Likelihood				
Severity	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
1 Low	1 Very Low	2 Very Low	3 Very Low	4 Very Low	5 Very Low
2 Slight	2 Very Low	4 Very Low	6 Low	8 Low	10 Medium
3 Moderate	3 Very Low	6 Low	9 Low	12 Medium	15 High
4 Major	4 Very Low	8 Low	12 Medium	16 High	20 High
5 Catastrophic	5 Very Low	10 Medium	15 High	20 High	25 High

1	**Strategic Aim: To complete the creation of a Single Hospital Service for Manchester with minimal disruption whilst ensuring that planned benefits are realised in a timely manner**

PRINCIPAL RISK (What is the cause of the risk?):
There is a risk that MFT may not be able to access sufficient resources to address the finance, clinical, estates and IM&T issues identified at NMGH through the finance counterfactual and due diligence processes.

RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Negative and potentially destabilising impact on MFT.**
2. **Inability to deliver services at NMGH to the standard MFT would expect.**
3. **If funding is not secured other options would need to be considered by NHS E/I and Commissioners for delivering care at NMGH.**
4. **Existing difficulties with staff recruitment and retention compounding due to uncertainty about the transaction prompting further de-stabilisation of NMGH.**
5. **If service delivery at NMGH is compromised by uncertainty about the transaction, significant unplanned shifts in clinical activity might occur.**
6. **Support contingent on demonstrating multi-agency commitment and delivery of a wider set of objectives.**

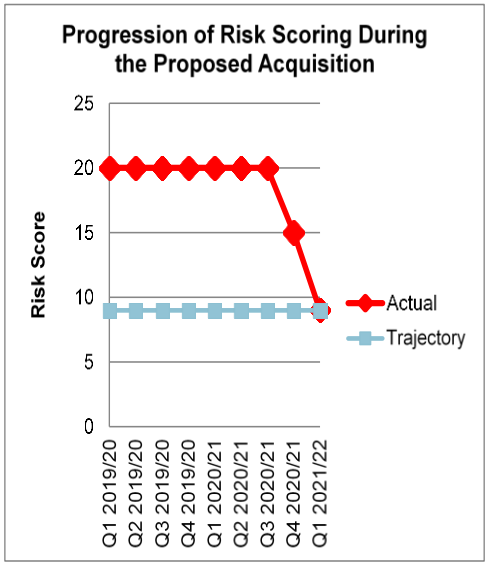
Enabling Strategy:
SINGLE HOSPITAL SERVICE

Group Executive Lead:
EXECUTIVE DIRECTOR OF WORKFORCE AND CORPORATE BUSINESS

Associated Committees:
NMGH PROGRAMME BOARD
NMGH SCRUTINY COMMITTEE
GROUP MANAGEMENT BOARD
GROUP BOARD OF DIRECTORS

Operational Lead:
DIRECTOR, SHS PROGRAMME

Material Additional Supporting Commentary (as required):



NOTE: 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 [Strategic Aim No.1] now show that the risks are substantially mitigated. In both cases there are well established controls in place and good assurance evidence. Subject to Board approval, 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.

INHERENT RISK RATING Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	CURRENT RISK RATING *Impact / Likelihood "With Controls"*	ACTIONS REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	TARGET RISK RATING Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
25 (5x5)	A.1 MFT has benefitted from GMTF support throughout the PAHT transaction process, and this funding continues during 2021/22. A.2 An acceptable position was negotiated on revenue support (FRF) as part of the transaction business case. A.3 An effective process for managing SLAs and the further disaggregation of services is being managed between the parties, with the oversight of the Finance Working Group and the PAHT Board. A.4 NMGH and MCS performance (inc financial performance) being managed through "business as usual" organisational processes, including AOF and Hospital Reviews. A.5 A legally binding agreement has been made for the provision of a Legacy Management Office, to ensure the fair distribution of assets and liabilities after the dissolution of PAHT. A.6 NMGH has benefitted from GM emergency capital investment to address backlog problems in the Estate and in IM&T, and this is reducing some of the most significant risks. A.7 Robust Outline Business Cases for the redevelopment of the NMGH site and Digital investment submitted (Jan 2021) and effective engagement in assessment /approval processes.	B.1 Processes for realising integration-related financial benefits to be agreed at the North Manchester Programme Board meeting on 8 July 2021.	C.1 Spend from GMTF monies remains within budget. C.2 Agreement reached with SRFT and PAHT on phasing of SLA/disaggregation programme. C.3 Positive outcomes form Hospital/MCS review sessions. C.4 Enabling works costs in excess of £50m approved, and NMGH has been listed as one of eight "frontrunner" hospitals in the New Hospitals Programme	None	**9 (3x3)**	None	Executive Director of Workforce and Corporate Business, Chief Finance Officer		Board of Directors	Not applicable	**9 (3x3)**

1	**Strategic Aim: To complete the creation of a Single Hospital Service for Manchester with minimal disruption whilst ensuring that planned benefits are realised in a timely manner**

PRINCIPAL RISK (What is the cause of the risk?):

There is a risk that the acquisition of North Manchester General Hospital (NMGH) could have a negative impact on the rest of MFT's services.

Enabling Strategy:

SINGLE HOSPITAL SERVICE

Group Executive Lead:

EXECUTIVE DIRECTOR OF WORKFORCE AND CORPORATE BUSINESS

RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Demands on senior leaders to deliver the transfer of NMGH to MFT could mean a reduced focus on MFT including integration benefit delivery.**

Associated Committee:

NORTH MANCHESTER PROGRAMME BOARD

NORTH MANCHESTER SCRUTINY COMMITTEE

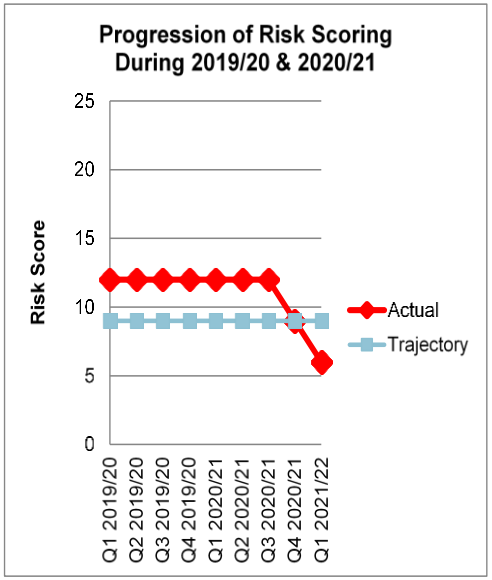
GROUP MANAGEMENT BOARD

GROUP BOARD OF DIRECTORS

Operational Lead

DIRECTOR, SHS PROGRAMME

Material Additional Supporting Commentary (as required)



NOTE: 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 [Strategic Aim No.1] now show that the risks are substantially mitigated. In both cases there are well established controls in place and good assurance evidence. Subject to Board approval, 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.

INHERENT RISK RATING Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	CURRENT RISK RATING *Impact / Likelihood "With Controls"*	ACTIONS REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	TARGET RISK RATING Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
12 (4x3)	A.1 Vast majority of transaction activities been completed, so potential for conflicting demands on the time of senior leaders is reduced A.2 Full leadership team established at NMGH, and has now been operating for 15 months, in the context of the MFT governance processes (eg GMB, GROC, Hosp Reviews, etc). A.3 Corporate teams have been strengthened to ensure they have the capacity to provide appropriate support to NMGH. A.4 SHS team still in place to provide organisational memory from the transaction and facilitate on-going disaggregation and withdrawal from SLAs. A.5 Revised governance arrangements put in place for i) on-going dialogue with PAHT/SRFT (including "BAU" Group for operational issues), and ii) redevelopment/transformational agenda. A.6 North Manchester Programme Board and North Manchester Scrutiny Committee still in place to bring together oversight of transaction, transformation, and capital development programmes.	None	C.1 Transaction successfully completed on 1st April 2021. C.2 All Day 1 milestones delivered. 128 Day 100 milestones on timescale for delivery by 9 July. Only 38 milestones remaining for Year 1 (and these are likely to be reduced through a review exercise). C.3 Final meeting of NM Transaction Group on 29 June 2021. Two mop-up sessions of Corporate Integration Steering Group set for Oct 2021 and Jan 2022.	None.	**9 (3x3)**	None.	Executive Director of HR and Corporate Business		MFT Board of Directors	Not applicable.	**6 (2x3)**

2	Strategic Aim: To improve patient safety, clinical quality and outcomes

PRINCIPAL RISK (What is the cause of the risk?): If we fail to identify, respond to and manage learning about the safety and effectiveness of the care we provide then our care will be suboptimal and not continuously improving

RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Continued or increased harm to patients**
2. **Failure to design and/or transform services effectively**
3. **Failure to support the maturation of our patient safety culture**
4. **Failure to eradicate 'Never Events'**
5. **Reputational damage because of safety concerns**
6. **Disengagement of Staff**
7. **Regulatory consequence**
8. **Failure to provide evidence based and effective care**
9. **Sub-optimal/negative patient experience**
10. **Sub-Optimal patient outcomes**

Enabling Strategy: **QUALITY AND SAFETY STRATEGY**

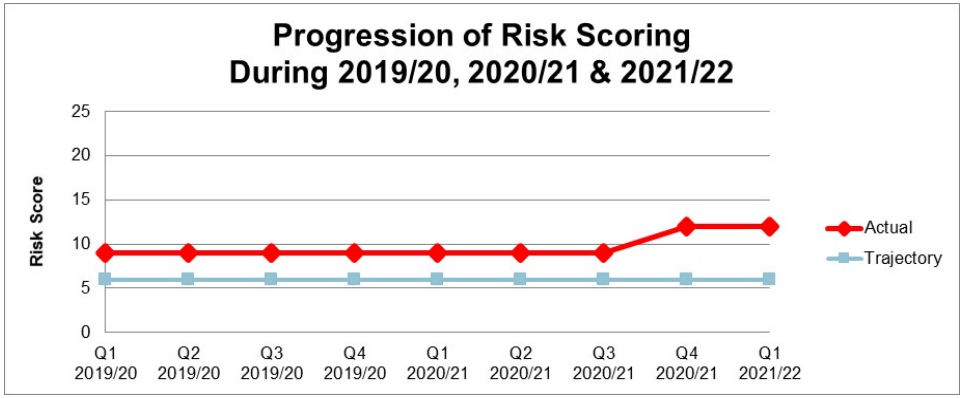
Group Executive Lead: **JOINT GROUP MEDICAL DIRECTOR**

Associated Committee: **QUALITY AND SAFETY COMMITTEE**

Operational Lead: **DIRECTOR OF CLINICAL GOVERNANCE**

Material Additional Supporting Commentary (as required):

The patient safety commentary detailed here covers all aspects of patient safety including but not limited to, clinical outcomes, infection control, clinical incidents (including never events), mortality review and harm free care.



Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGRESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
12 (3x4)	A.1 Freedom to Speak Up (F2SU) programme and personnel A.2 Quality and Safety Strategy A.3 Risk management strategy A.4 Patient experience strategy A.5 Safety Management system including PSIRF A.6 Safety Oversight System A.7 Infection Prevention and Control Standards A.8 LocSSIPS programme A.9 Quality and safety improvement collaboratives A.9 Incident reporting benchmarking A.10 Human Factors Academy A.11 Patient Safety alert management process A.12 Patient Safety Specialist Network A.13 Health and safety benchmarking A.14 Structured Judgement Review Programme A.15 Friends and Family test A.16 National Inpatient survey A.17 Other National Patient Surveys A.18 Complaint benchmarking A.19 CQC compliance action plan A.20 Performance (RTT/ECS/Cancer) benchmarking A.21 PLACE assessments A.22 Ward Accreditation Scheme A.23 Workforce: Safe staffing standards, appraisal, mandatory training, sickness absence benchmarking, Placement satisfaction benchmarking (medical students) A.24 Data Security Protection Toolkit A.25 Internal audit reports relevant to controls A.28 Mandatory Training Programme	B.1Lack of controls in relation to policy and procedural governance/compliance B.2 F2SU not fully embedded B.3 Quality and Safety Governance structure still in development B.4 National Patient Safety Training offer not formalised B.5 General Patient Safety training not B.6 Lack of patient and public involvement in patient safety B.7 lack of a standard approach to quality and safety culture assessment and development B.8 Patient safety commitment not fully embedded into recruitment practice B. 9 Assurance processes in relation to NICE Guidance not fully effective B.10 Management processes in relation to the National Audit Programme not fully effective B.11 Lack of real time quality and safety data B.12 Lack of data quality kitemarking of patient safety data B.13 Lack of contemporaneous mortality and effectiveness data B.14 Integration of NMGH data post acquisition B.15 PSIRF implementation delayed B.16 Quality and Safety Strategy expires 2021 B.17 Approach to learning from death requires strengthening	C.1 Trust safety oversight exception reporting detailing outputs of the safety management system ensuring learning and assurance) C.2 Monthly safety profiling of the Trust by exception C.3 Use of SPC to understand patient safety data C.4 Routine reports from patient experience/IPC/safeguarding C.5 Staff survey results C.4 Regulatory inspection processes C.6 Internal quality assurance processes (Internal Audit, Ward accreditation, Quality Review) C.7 AOF and patient safety metrics reporting (under review) C.8 CQC compliance reporting C.9 Assurance process in relation to effectiveness of actions following a significant patient safety event	D.1 Patient safety event reporting does not routinely capture 'what went well' to enable safety II type learning D.2 All harm to patients may not be captured on the reporting system D.2 Staff survey indicates lack of feedback from incident reporting and investigation – may impact on reporting levels D.3 Staff survey does not adequately capture full understanding of patient safety culture D.6 Patient safety metrics not yet fully reported on D.6 Lack of full understanding of finance and performance cost of harm D.7 Lack of understanding of the experience of staff in volved in patient safety events	**12 (4x3)**	B.1 Undertake scoping exercise and complete risk assessment (Policy and procedure) B.1 Implement policy oversight and Governance process B.2 Evaluate and redesign F2SU process and oversight B.3 Undertake 6 monthly assurance reviews of revised governance infrastructure Implement the strategic deliverables of the Human Factors Academy to: B.4 Undertake a training needs analysis aligned to the Quality and Safety Strategy/PSIRF B.4 Develop local suite of patient safety training aligned to the TNA B.7 Develop a standard approach to the development, implementation and testing in relation to a MFT patient safety culture assessment tool B.7 Develop a suite of interventions to support the development and maturation of patient safety culture Through the patient safety specialist network: B.6 Implement the National patient and public involvement in patient safety framework B.7 To develop and implement patient safety commitment standards to be included in job descriptions B.11/12 To make safety data count through the use of enhanced analytics, data quality kite marking and the development of a dashboard with benchmarked data B.11 To ensure safety and effectiveness governance is fully represented throughout the HIVE RDGs D.7 Deliver project 2v (second victim support) B.9 To develop a revised assurance process in relation to NICE guidance implementation B.10 To develop a revised assurance process in relation to the management of national and local clinical audit B.11 To procure a system to enable consistent and contemporaneous mortality, safety and effectiveness data B.14 To develop an analytic strategy to ensure effective integration of NMGH data B.15 To continue to implement and embed the National Patient Safety Incident Response Framework (PSIRF) through a revised patient safety policy and a PSIRP B.16 Rewrite the Q&S strategy aligned to the CQC strategy, National patient safety strategy and all other relevant national strategy documents B.17 Strengthening of approach to learning from deaths including from SJR process, MEO, inquests, LeDeR external PFDs	Medical Directors/ Chief Nurse / Director SHS and Group Director of Workforce and Corporate Business		Quality and Performance Scrutiny Committee	1. Policy scoping exercise complete (presented to Q&S committee June 21). Risk assessment completed and implementation plan initiated 2. New F2SU guardian in post 3. Revised safety, risk and effectiveness governance infrastructure implemented 4. Group safety Management System in operation since February 2021 5. Human Factors Academy Strategic Deliverables Units have leadership and operational support to deliver requirements 6. Sub-group of Patient Safety Committee established to ensure delivery of national patient and public involvement in patient safety framework 7. Sub-group of patient safety committee established to ensure that we make patient safety data count 8. SPC now used as standard for safety data 9. Safety II data being captured through Ulysses (Proxy through excellence reporting currently) 10. Membership of safety and governance team in a number of HIVE RDGs confirmed 11. Project 2v has delivered a draft hot debrief tool and is developing a training package 12. Strengthened approach to the management of assurance processes associated with implementation of NICE guidance 13. Strengthened approach to the management of assurance processes associated with national audit 14. HED system being procured to support mortality and effectiveness data requirements	**6 (3x2)**

2	Strategic Aim: To improve patient safety, clinical quality and outcomes

PRINCIPAL RISK (What is the cause of the risk?): If effective infection prevention and control measures are not in place then COVID-19 acquisition will occur in staff and patients. (Revised risk previous component of MFT/003111)

Enabling Strategy: **INFECTION PREVENTION AND CONTROL STRATEGY**

Group Executive Lead: **GROUP CHIEF NURSE**

RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Increase in serious harm to patients**
2. **Increase in nosocomial infections**
3. **Increase in staff outbreaks**
4. **Reputational damage because of safety concerns**
5. **Poor staff experience**
6. **Regulatory consequence**

Associated Committee: **INFECTION CONTROL COMMITTEE**

Operational Lead: **ASSISTANT CHIEF NURSE IPC/TV**
CLINICAL DIRECTOR OF INFECTION PREVENTION AND CONTROL

Material Additional Supporting Commentary (as required):

Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
25 (5x5)	**A1. 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** – All non-elective patients are screened upon admission – Preadmission screening implemented for elective admission – Screening protocols for patients discharged or transferred to another health care or residential setting in place – Joint Protocols are in place – Good infection prevention and control education and practice throughout the Group – Escalation plans in place as per trust gold command and GM Gold command - 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: o Risk oversight committee o Quality & Performance Scrutiny Committee o Group Infection Control Committee o COVID-19 Expert Group established - Microbiology and Virology support in place – Use of HPV/UVC in addition to PHE guidance – Covid and non-Covid clinical areas defined across the Trust. All Non-elective admissions tested and elective admissions as per guidance – Guidance for reducing isolation facilities produced in April 21 by the IPC team to support recovery of elective programmes whilst still maintaining all IPC measures and keeping staff and patients safe. – Patients who test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced – Trust policy on managing patients who present with symptoms in place – Good infection prevention and control education and practice throughout the Group – PPE assessments in place o Use of PPE to be used in extremis and agreed with Strategic oversight group following a risk assessment o Standard Operating Procedures developed for decontamination of visors o Staff advised to undertake a risk assessment if there are shortages of PPE for example NMC guideline o Fit testing databases are in place in hospitals/MCS, Trust level database under development - The training hub includes a series of COVID-19 training resources, local induction includes IPC measures.	B1. Some COVID-19 positive individuals present at hospitals as asymptomatic patients B2. Redeployed staff may not be confident in an alternative care environment. Anxiety of staff working in COVID-19 Wards. B2 Cleaning Policy Requires updating (pending new national guidance on cleaning standards) National Guidance released May 21, project group working on implementation B3. 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. B4. Plans need to be flexible as situation changes	C1. Patient streaming at access points. Emergency Department is zoned to provide designated areas. C1. Screening of non-elective admissions recorded on ED systems C1. Plans in place to screen elective patients 48 hours prior to admission, SOP's developed screening of elective patients in place screen results available via MFT systems C1. Joint Protocols are in place C1. Keeping Safe Policy in place focusing on the 'Four pillars of working safely' C1. Hospitals have identified green, yellow and blue areas and are currently presenting plans of flow throughout the patient journey. C1.Development of surveillance tool to highlight hotspot areas incorporating NHS guidance on probable/definite hospital acquisition C1. Audit tool developed so individual wards and departments can audit compliance to the guidance. C1. Cleaning audits developed C1. Hand hygiene audits in place C1. Clinical Sub-Group in place to oversee adjusted or adapted systems and processes approved within hospital settings	For All Existing Controls, plans need to be flexible as situation changes Hospitals to re-assess as situation evolve	20 (4X5)	E1. Hospitals have identified green, yellow and blue areas and are currently presenting plans of flow throughout the patient journey. E1. Patient placement guidance in place E1. Keeping Safe - Protecting You – Protecting Others Document approved and in place E1. All patients admitted via ED are screened for COVID-19, data is reviewed daily E1. Areas such as ICU, radiology and other areas which have a transient patient population are identifying flow throughout the departments to ensure risk level to patient minimized. E2. Increase of IPC support to COVID -19 Wards E2. Use of posters/videos FAQ's E2. Multiple communication channels – daily briefing/dedicated website E2. Microbiologist support E2. Virology support E2. 7 day working from IPC/Health and Wellbeing	ASSISTANT CHIEF NURSE IPC/TV CLINICAL DIRECTOR OF INFECTION PREVENTION AND CONTROL	September 2020	Infection Prevention and Control Committee	NHSE Infection Prevention and Control Board Assurance Framework re-issued on 23 October 2020, assurance and controls have been assessed, a further update in February 2021 has been provided - an additional 43 indicators have been include, assessments completed against each indicator with mitigating actions in place Plans in place to address gaps in assurance based on national guidance as available Patient placement guidance in place – further guidance for reducing isolation facilities produced in April 2021 by the IPC team to support elective recovery and non-elective patient flow by escalating and de-escalating areas. 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 Covid 19 Outbreak policy written, and ratified Developed guidance around the use of alternate PPE as required, monitoring of compliance with IPC practices is in place. Introduction of masks and face coverings week commenced 15th June 2021 Sitrep reporting for nosocomial outbreaks in place. A COVID infection dashboard is in development. Estates/environment review has progressed with permanent structures to entrances now in place	**6 (3X2)**

2	Strategic Aim: To improve patient safety, clinical quality and outcomes - CONTINUED

PRINCIPAL RISK (What is the cause of the risk?): If effective infection prevention and control measures are not in place then COVID-19 acquisition will occur in staff and patients. (Revised risk previous component of MFT/003111)

Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
25 (5x5)	**A2. The Trust provides and maintains a clean and appropriate environment in managed premises that facilitates the prevention and control of infections** – Estates and Facilities /PFI partners and IPC Team meeting to review cleaning frequencies in line with updated guidance – Increased cleaning in wards where there has been a cluster/outbreak of COVID-19 amongst patients who were previously negative – Enhanced cleaning specifications in place for clinical and non-clinical areas – Linen from possible and confirmed COVID-19 patients is managed in line with PHE national guidance and the appropriate precautions are taken – Plans for identification and management of clusters/outbreaks of COVID-19 in green zones in place – Appropriate floor markings and signage in place being overseen by Hospital task and finish groups to ensure with blue/yellow/green areas – Dedicated entrances for blue/yellow/green patients where possible – Signage on entrances – Screens in place at reception areas – Signage on entrances advising pathway for symptomatic patients – Hygiene Programme of review of air flow and ventilation undertaken throughout the pandemic – All clinical waste related to confirmed or possible COVID-19 cases is handled, stored and managed in accordance with current national guidance **A3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance** – Specific antimicrobial policies related to COVID-19 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 – IPC 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	B5. patients with suspected COVID-19 and Shielded patients encouraged to wear surgical facemask when moving around the hospital B5. Policy in place for wearing of facemasks in all areas B5. Point of care testing at implementation stage B7. Avalilability of some PPE B7. Geographical location of support services (e.g. Radiology) and provision of essential services (e.g. monitoring for Cardiac patients) B7. Some areas of estate particularly old and in poor condition	C1. Recording of staff concerns raised C1. Incident reporting system C2. Programme of training for redeployed staff including use of PPE, maintaining a safe environment C2. Bespoke training programme for Clinical leaders to become PPE expert trainers C2. IPCT undertake regular reviews/ and provide visible presence in cohort areas Staffing levels increased C3. Quarterly reports from AMC to Trust IPC and Medicines Optimisation Board from AMC C3. Appropriate policies reviewed and approved by the AMC C3. Specific antimicrobial policies related to COVID-19 are available on the Trust's Microguide platform. C3. Bimonthly antimicrobial stewardship committee (AMC) meetings are continuing (virtual platform) C3. Monthly antimicrobial stewardship (AMS) audits on all ward areas C3. Microbiology support available 24 hours a day. C3. Antimicrobial prescribing advice available from pharmacy 24 hours a day C3. ICU ward rounds C3. Increased AMS support to COVID-19 cohort areas C3. Ad-hoc reporting to Clinical Subgroup identifying areas of concern in terms of antimicrobial prescribing. C4. Policies/guidance in Acute sector updated to reflect pandemic C4. End of Life Policy adapted for current need C4. Controlled entrance & exits to Trust to minimise risk of cross infection		20 (4X5)	E2. Domestic staff have access to EHWB services E2. Increase of IPC support to COVID -19 Wards E2. Domestic staff have access to EHWB services E2. Increase of IPC support to COVID -19 Wards E2. Use of posters/videos FAQ's Walk rounds led by IPC to review cleanliness of hospital facilities - undertaken with cleaning management teams and using site management checklists. E2. Use of window and other air filtration systems are being considered in older estate. E3. Audits and review of AMS practices and prescribing needs to be sustainable whilst the hospital is split into zones. E4. Website regularly to be updated by Comms/EPPR Team E5. Assessment underway against new National Cleaning Standards to be in place in all clinical areas by October 21	ASSISTANT CHIEF NURSE IPC/TV CLINICAL DIRECTOR OF INFECTION PREVENTION AND CONTROL	September 2020	Infection Prevention and Control Committee	Regular and up to date information is published in this Resource Area, including the following key topics: – Emergency Planning, Resilience and Response – Employee Health & Well Being – Research and Innovation for COVID-19 – Infection Prevention & Control Hospital/MCS COVID-19 Resources – Risks identified on Trust risk register and locally on Hospital/MCS risk registers/regularly updated. Increase in IPC team on call/availability out of hours rota 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 Patients with suspected COVID-19 and Shielded patients encouraged to wear surgical facemask when moving around the hospital Point of Care Testing has been implemented in ED's Continue to cohort patients as per policies Anti-Microbial strategy under development led by the Chief Pharmacist, and reporting to the Medicines Optimisation Board	**6 (3X2)**

2	**Strategic Aim:** **To improve patient safety, clinical quality and outcomes**

PRINCIPAL RISK (MFT/004513):

Under delivery of activity / capacity which will impact on achievement of national operational standards for urgent and elective care, including cancer and diagnostics, due to long standing issues of: demand pressures, capacity, workforce and estate constraints, and the ongoing Covid19 pandemic.

This risk replaces previous individual risks related to national standards, capacity, covid and the associated recovery (MFT004288, MFT004286, MFT003111, MFT004284).

This risk is under review in respect of the recent merger of North Manchester General Hospital into the MFT organisation at 1st April 2021, and the impact on performance delivery.

Enabling Strategy:
- Quality & Safety Strategy
- Transforming Care For The Future Strategy

Group Executive Lead:

Group Chief Operating Officer

RISK CONSEQUENCES

1. Increase risk of serious harm to patients
2. Poor patient experience
3. Reputational damage to Trust
4. Low system confidence – increased scrutiny from regulators

Associated Committee:
- Quality & Safety Committee
- Performance And Quality Scrutiny Committee
- Group Risk Management Committee
- Board Of Directors

Operational Lead:
Hospital / MCS Chief Executives

Standard	Performance		
	March 21	April 21	May 21
A&E 4 hour	82.42%	78.86%	75.74%
RTT	55.61%	54.92%	Not available
52 weeks	13,820	16,882	16,209
Waiting list	115,222	134,434	137,393
Diagnostics	19.14%	25.81	23.25%
Cancer 2ww	95%	86%	Not available
Cancer 31 Days	94%	93%	Not available
Cancer 62 Days	70%	68%	Not available

Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
20 (4x5)	1.1 MFT Covid Governance Framework established including: • Strategic Command Group - chaired by COO • Tactical response - run by Corporate Directors • Operational Response - Hospital Management 1.2 Regional Covid Governance Structure, which MFT is represented at including: • GM Gold • Hospital / Community Cells • NW EPRR Single Point of Contact 1.3 Hospital and Group escalation plans and decision-making frameworks: revised in October 2020 to prepare for future waves of the pandemic and approved via the MFT Strategic Command Group. 1.4 On call Structures have been revised and adapted to support the hospital/MCS response to the pandemic, in addition to business as usual operational running. Further supported by the strategic and tactical incident management arrangements. 1.5 In line with national planning guidance for 21/22, activity planning is underway, including performance trajectories for managing the longest waits and cancer. 1.6 Reporting in place to track activity levels against the revised planning expectations and associated performance trajectories. *(Continued below)*	2.1 Capacity shortfalls requiring reliance on private sector. 2.2 Surge of demand to pre-Covid levels. 2.3 Primary care demand manage ment.	3.1 Reporting to the Executive Board and Committees in relation to the Covid Pandemic, Recovery programme and performance. 3.2 MFT Covid19 Recovery Programme 3.3 Regular Strategic and Recovery meetings taking place. 3.4 Minutes and papers relating to Trust Committees. 3.5 Hospital Activity, capacity and annual plans. 3.6 Internal/external audits of data quality. 3.7 Annual Review and NHSI sign off Trust Access Policy.	None	20 (4x5)	Key actions are outlined in the Risk Report to the Group Risk Committee. Overarching MFT recovery programme in response to the Covid19 pandemic, of which the outpatient, elective, urgent care and cancer workstreams align to national constitutional standards. Urgent Care and Flow transformation workstreams continue to progress work aimed at a reduction in footfall in type 1 EDs across MFT. Supporting development of specific MFT and site based programmes of work and actions to deliver performance improvements. Effective management of elective waiting lists to ensure that MFT treats its most clinically urgent patients first. Further embedding of MESH meetings and prioritisation process at site and Group level. Focus on theatre capacity and efficiency, pre-assessment pathways, workforce implications, and use of the Independent Sector. Deliver programmes of activity to increase delivery of outpatient activity, reduce wait times, and optimise virtual technologies and other transformational aspects to improve patient access and experience. Other priorities include waiting list clinical triage and demand management protocols. Cancer Workstream focus: Endoscopy capacity, implementation of rapid diagnostic centres, implementation of best practice pathways, continued roll out of the Living With and Beyond Cancer programme and the Cancer Excellence Programme both of which were in place prior to covid, linking in with GM Cancer and GM Surgical Cancer Hub. Diagnostics: is incorporated within a number of recovery workstreams, In addition, the Trust is linking in to GM structures for Diagnostics. Workforce is a key element to all recovery workstreams, with HR representatives on these groups to ensure the workforce implications are considered and addressed.	Julia Bridgewater	Ongoing throughout 2021/22	Quality and Performance Scrutiny	Progress against the workstreams is being reported into the Strategic Covid Group, The Board of Directors, and Group Risk Management Committee. The performance position against national standards is reported via the Covid Recovery and Performance report to the Board of Directors. *Moved into controls*	16 (4X4)

2	Strategic Aim: To improve patient safety, clinical quality and outcomes

PRINCIPAL RISK (MFT/004513):

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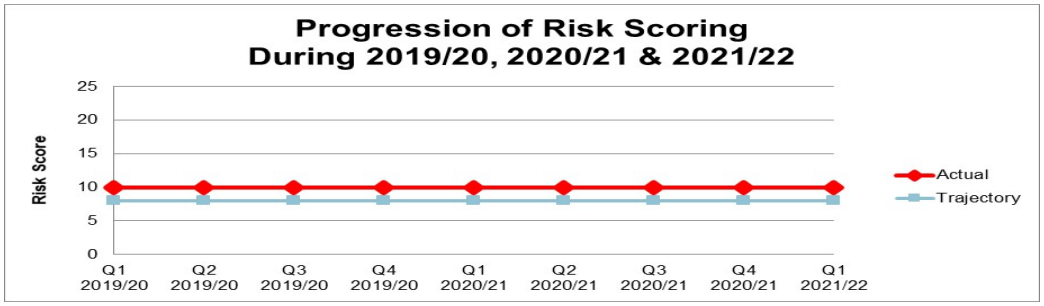
Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*
20 (4x5)	**CONTINUED** 1.7 MFT Recovery programme established following wave one of the pandemic, underpinned by several workstreams several which focus on recovery of activity levels and associated performance against national operational standards related to: Outpatients, Elective Access, Cancer, Urgent Care. 1.8 Governance and reporting structure in place to support the Recovery Programme, with a Recovery and Resilience Board established, and routine reporting into the MFT Strategic Covid Group. 1.9 MFT Board and Committee activity and performance reporting in place 1.10 MFT Operational reporting in place to support hospital teams in the management of performance standards. 1.11 Patient Access Policy 1.12 MFT EPRR Policies and Plans to support organisational response to Major Incident and Business Continuity incidents 1.13 MFT EPRR Governance Framework including: • MFT EPRR Committee • Hospital Site Forums • MFT EPRR annual assurance statement, against the national core standards for EPRR which underpin the Trust compliance with the Civil Contingencies Act. Associated action plans in place, and reporting / assurance against these has been provided to the Trust Quality and Performance Scrutiny Committee, with delivery of action monitored through the MFT EPR Committee. 1.14 Audits are routinely undertaken, by internal and external audit, around the national constitutional standards to provide assurance of performance reporting to the Board of Directors. 1.15 Covid contact tracing 1.16 Vaccination programme 1.17 Reason to reside moved into business as usual processes 1.18 Planned transformation Urgent Care and Flow workstreams have been implemented and continue to be developed

2	**Strategic Aim: To improve patient safety, clinical quality and outcomes**	
PRINCIPAL RISK (What is the cause of the risk?): If appropriate safeguarding systems and processes are not in place then Children and Adults at risk of abuse or neglect may not be safeguarded from harm	Enabling Strategy: **QUALITY & SAFETY STRATEGY**	
	Group Executive Lead: **CHIEF NURSE**	
RISK CONSEQUENCES (What might happen if the risk materialises?): **1. Adults and children at risk of abuse or neglect may come to harm** **2. Failure to comply with statutory and regulatory safeguarding standards**	Associated Committee: **SAFEGUARDING COMMITTEE**	
	Operational Lead: **DEPUTY CHIEF NURSE /ASSISTANT CHIEF NURSE (SAFEGUARDING, QUALITY AND PATIENT EXPEREINCE)**	



Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
15 (5x3)	A1. Safeguarding Governance Structures in place. A2. Safeguarding policies and procedures. A3. Trust Safeguarding Teams actively support staff. A4.Directors of Nursing/Midwifery/ Healthcare Professionals accountable for safeguarding within each hospital/MCS/LCO. A5. Named Doctors and Named Nurses provide professional support and advice to staff. A6. Senior representation at all levels of the safeguarding Partnership Arrangements to support statutory duty to cooperate. A7. Safeguarding adults and children's training programme in place as per Intercollegiate guidance underpinned by learning from Adult and Children Practice Reviews/DHRs. A8. Safeguarding Supervision process in place. A9. Learning Disability flag in place to alert Matron review. A10 Reports provided to statutory meetings if Trust staff are unable to attend. A11. Child Protection Information Sharing System (CP-IS) in place in all relevant areas except SMH maternity services. A12 AOF monitoring (LCO)	B1. Mental Capacity Act (MCA) assessments and Deprivation of Liberty Safeguards (DoLS) are of inconsistent quality B2. DoLS applications are often not authorised by Local Authority due to lack of capacity B3. Level 3 Safeguarding training compliance is below the required threshold of 90% B4. The Trust is not yet compliant with the changes to Statutory Intercollegiate Guidance, which requires increased numbers of staff to receive level 3 adult safeguarding training B5. LD Specialist Nurse Capacity is very limited B6. LD and/or Autism Strategy not yet finalised	C1. Annual Safeguarding Report to Board of Directors. C2. Hospital/Managed Clinical Service/LCO annual Safeguarding Work Programme, monitored by Safeguarding Team. C3. Annual Hospital/MCS/ LCO safeguarding assurance processes, observed by NED, to assess compliance with CQC and statutory requirements. C4. Completion of SCR actions - reported to the Safeguarding Committee. C5. Local Safeguarding Children's Board Section 11 audit - reported to the Safeguarding Committee. C6.Submission of safeguarding adults Annual Assurance statement and supporting evidence. C7. Trust incident reporting system data C8. Regulatory inspection process C9. Training compliance data C10. Annual safeguarding audit programme C11. Safeguarding supervision data	C3 Annual assurance process stepped down during Covid-19 response.	**10 (5x2)**	B1. Deliver MCA and DoLS training to relevant staff through Level 3 Adult Safeguarding Training B1. Audit the quality of MCA assessments and DoLS applications B2. Submit DoLS applications in accordance with statutory requirements B3. Deliver targeted safeguarding training to meet Intercollegiate requirements B4. Hospitals/MCS/ LCO to deliver agreed trajectories B5. Develop Business Case to increase capacity to meet patient needs B6. Finalise and launch a System-wide LD and/or autism Strategy B6. Deliver the Trust's LD work plan C3. Undertake table-top review of Hospital/MCS/LCO safeguarding assurance documents and evidence and scrutinise any areas of concern.	Assistant Chief Nurse (Safeguarding)	March 2021	Safeguarding Committee	A11. The installation of CP-IS within SMH maternity services has been slightly delayed due to pressures within the IT department, system incompatibilities particularly so during the COVID 19 pandemic response. The implementation for St Mary's at Oxford Road is currently being reviewed and is expected by the end of Q2 2021/22. As part of the health service response to vulnerable children during the Covid-19 pandemic NHSE/I requested NHS Digital to roll out CP- IS within all 0-19 years' services. In Manchester and Trafford community health services CP- IS information is shared by Child Health with the Manchester and Trafford 0-19 services to ensure Practitioners are aware of children on their caseload who are Looked After or on a Child Protection Plan. CP-IS is fully implemented in Manchester community services and Trafford community services. B1. Training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) is delivered as part of the Adult Safeguarding Level 3 training (compliance is shown at B3 below). Additional bespoke MCA training is being delivered and podcasts on the Mental Capacity Act are available to staff on the safeguarding intranet site. DoLS re-audits were undertaken in 2020 and actions were identified to improve the quality and compliance with DoLS criteria. DoLS is included in the safeguarding audit calendar for 2021 - a DoLS audit will be completed using a DoLS tracking tool. Two Mental Capacity/Mental Health Officers are now in post who monitor the quality of DoLS applications completed and support staff training. B2. The number of DoLS applications across MFT continues to be high however there continues to be low levels of assessments authorised by the LA. Of **583** DoLS applications made by MFT in Q3 of 2020/21, only 7 were authorised, 324 applications were awaiting assessment at the end of Q4 and 167 were no longer inpatients. The Safeguarding Mental Health Matron is leading work with Manchester LA and Trafford LA DoLS leads to continue to address this issue. B3. Competencies have been matched to roles in accordance with revised Intercollegiate Guidance. Improvement plans were developed and implemented by Directors of Nursing to improve compliance. Overall safeguarding training compliance at 31st March 2021 was **90.44%,** which meets the Trust target of 90% and exceeds the CQC target of 85%, demonstrating continued improvement across all training levels. However, whilst level 1 and 2 adults and children's training exceeded 90% at the end of Q4, level 3 children's training has increased to **79%** and level 3 adult training has increased to **52%** of the staff mapped to achieve the training in the three year plan to complete this training by end March 2022.To meet full compliance by March 2022 the Trust target was for 62% staff trained by end of Q4. A review of the mapping of roles and responsibilities to safeguarding training across the hospitals/MCS/LCO is being completed by the safeguarding team and senior hospital leads with a plan to produce a revised safeguarding training strategy in 2021-22 Q2. An online safeguarding training programme has continued to be delivered during the Covid-19 response, which involves completion of a participatory workbook to evidence learning. The safeguarding team with the learning and development team have commissioned Dynamic to produce a revised safeguarding training package with an online content but including virtual/participatory learning, an implementation plan to deliver this training package is being developed. Prevent training is delivered by e-learning via the MFT learning hub. Current compliance is 90% compliant with level 1-2 training and 91% compliant with 3-5 prevent training - this performance exceeds the national NHSE/I requirement of 85% for Level 3 Prevent. B4. Face to face level 3 safeguarding children and adults training remains paused due to Covid-19 however the online safeguarding training programme with the requirement to complete a 'workbook' to evidence learning continues and has received positive feedback and evaluation. B5. Following a successful business case to expand LD Specialist Nurse capacity and recruitment to North Manchester General Hospital, 3xband 7 and 1xband 6 posts have been recruited to with recruitment to 2xband 6 post currently being finalised B6 The LCO Director of Nursing is now leading the MFT LD Steering Group. The Director of Adult Social Services (DASS) is the Executive lead for the system-wide LD Strategy with the LCO Chief Operating Officer as the operational lead and the Assistant DASS is the Programme Director with PMO support. System leadership includes MHCC, MFT, Primary Care, GMMH and MLCO. The Directors of Nursing continue to lead local improvements within hospitals/MCS. B6. The updated LD work programme informed by self-assessment against NHS I learning disability improvement standards for NHS trusts continues. Regular updates are provided to the Safeguarding Committee. C3. Hospital/MCS/LCOs have been required to maintain safeguarding assurance templates, supported by evidence. The Assistant Chief Nurse (Safeguarding, Quality and Patient Experience) will undertake a table top review of the assurance templates in Q2 of 2021/22 and Directors of Nursing will be invited to meet with the Deputy Chief Nurse, Assistant Chief Nurse and NED to discuss any areas that are not sufficiently evidenced.	**8 (4x2)**

2	Strategic Aim: To improve patient safety, clinical quality and outcomes

PRINCIPAL RISK (What is the cause of the risk?): **If we do not comply with appropriate building regulations or maintenance requirements there is a risk to the critical infrastructure of the hospitals that could result in harm to staff, patients or the public**	Enabling Strategy: **QUALITY & SAFETY STRATEGY** **ESTATES STRATEGY**
	Group Executive Lead: **CHIEF OPERATING OFFICER**
RISK CONSEQUENCES (What might happen if the risk materialises?): **1. Inability to use public, staff or clinical areas as intended, leading to inability to provide treatment as planned** **2. Potential impact for harm to staff, patient of public**	Associated Committee: **CEO FORUM**
	Operational Lead: **GROUP DIRECTOR OF ESTATES AND FACILITIES**
	Material Additional Supporting Commentary (as required):

Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
15 (3x5)	A.1 Detailed business continuity plans to mitigate the impact of any failure A.2 Multiple redundancy and layered systems to prevent the escalation of an issue (eg fire alarms; fire doors and sprinkler system; HV backup generation). A.3 Agreed maintenance regimes to ensure the infrastructure is maintained to the required level A.4 Internal & external reviews of systems and processes to highlight gaps and required actions	B.1 Not all maintenance regimes have been adhered B.2 Not all infrastructure schematics accurately represent the 'as built' estate B.3 Given above points redundancy systems may not operate as planned B.4 Some controls are reactionary, based on minimising impact should an issue occur B.5 NMGH risks undergoing detailed assessment aligned to Trust survey work	C.1 Ongoing certification (internal or external as required) of actions completed by the team undertaking the remedial actions reducing the number of outstanding defects. C.2 Schematics are being updated on a periodic basis to reflect the as built environment C3. Authorising Engineers / Independent Advisers in place for all life-critical services that provide external independent assurance reports on a periodic basis	D.1 Survey and remedial works take a significant period to complete & until complete full assurance cannot be gained. D.2 Some schematics remain outdated in the review period and the update process will take several years to complete D.3 The external audits highlighted areas of further work which is being carried out but full assurance cannot be gained until works are complete D.4 Some concerns have been raised over the adequacy of the existing survey data, in particular relating to Asbestos & NMGH	15 (3x5)	E.1 Complete surveys and agree programme of remedial works by site and infrastructure system E.2 Infrastructure schematics updated in line with the survey and remedial work E.3 Undertake new surveys of Asbestos on all sites and of critical infrastructure at NMGH	Chief Operating Officer	Assurance task complete Remedial actions will run for a prolonged period (circa 24 months)	CEO Forum	Survey and remediation work ongoing Fire compliance risk now being shared at a Hospital level Significant progress on Fire Compartmentation remediation during 2020 whilst areas of the Main Hospital Building on ORC were empty due to Covid. Jointly commissioned compliance audit being arranged with ProjectCo at Oxford Road. Workstream in place with Sodexo & Project Co at Wythenshawe to improve Trust access to maintenance records. Additional group-wide Asbestos Management posts and NMGH Authorised Persons out to advert to strengthen existing teams.	**6 (3x2)**

2	**Strategic Aim: To improve patient safety, clinical quality and outcomes**

PRINCIPAL RISK (What is the cause of the risk?):
If the Trust fails to recruit and retain a nursing and midwifery workforce to support evidence based nursing and midwifery establishments due to national Nursing and Midwifery workforce supply deficit, the quality and safety of care may be compromised

Enabling Strategy:
QUALITY AND SAFETY STRATEGY;
NURSING, MIDWIFERY & AHP STRATEGY

Group Executive Lead:
CHIEF NURSE

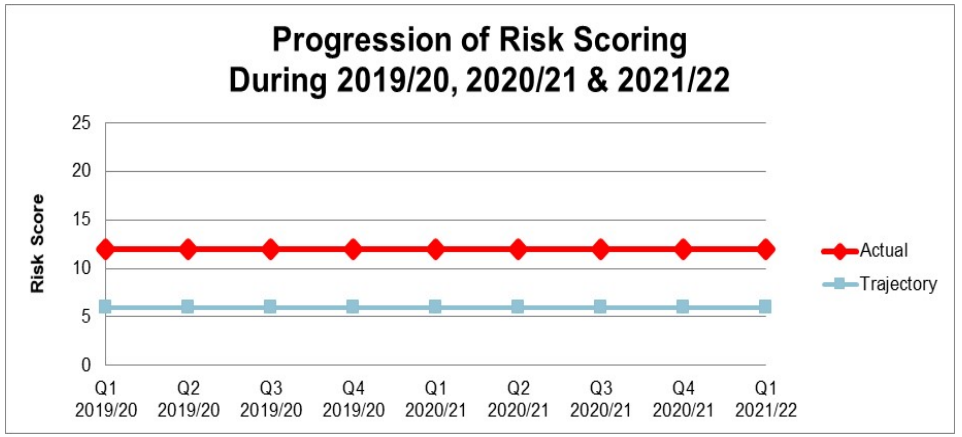
RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Compromised patient care**
2. **Adverse patient experience**
3. **Increased complaints**
4. **Failure to comply with NHSI regulatory standards**
5. **Inability to recruit well trained nursing and midwifery staff further compounding the staffing issue**
6. **Inability to offer a quality training experience to students**

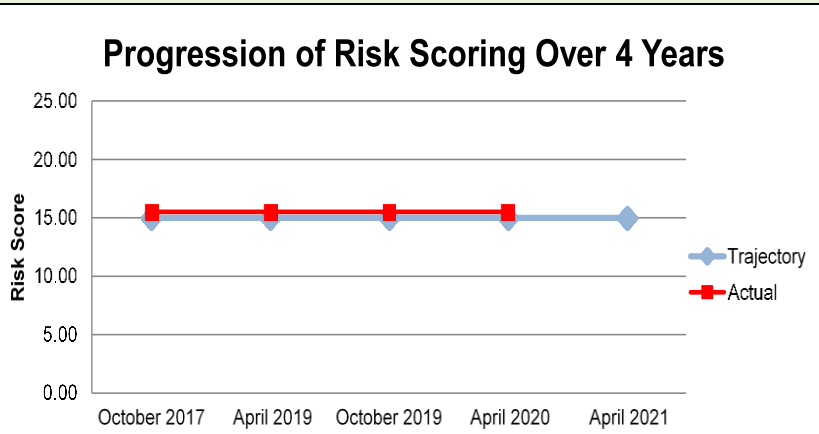
Associated Committee:
NMAHP PROFESSIONAL BOARD
HR SCRUTINY COMMITTEE

Operational Lead:
DIRECTOR OF NURSING (WORKFORCE & EDUCATION)

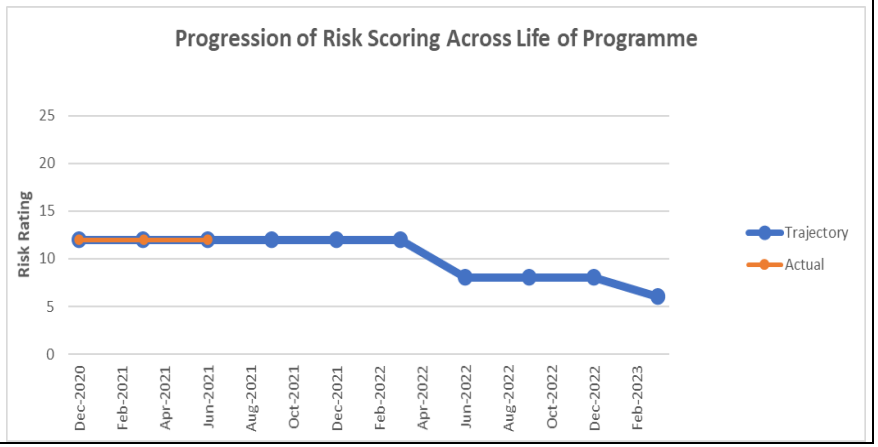
Material Additional Supporting Commentary (as required):



Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
12 **4x3**	A1. Reports on controls to- NMAHP Professional Board, Clinical Risk Management Committee and HR Scrutiny Committee, Board of Directors and Group Management Board A2. Domestic and International recruitment campaigns A3. Hospital/MCS workforce dashboards A4.Hospital/MCS Nursing and Midwifery retention strategies A5. e roster KPIs and dashboard A6. Daily safe staffing huddles and staff deployment based on acuity and dependency A7. Temporary staffing reporting processes aligned with finance A8. Triangulation of workforce establishment data with clinical quality metrics A9. Developing and embedding new roles within the Nursing workforce. A10. Establishments reviews undertaken through SNCT census data collections A11. Corporate retention work schemes A12. Pandemic workforce recovery programme A13. Hospital/MCS and Group level pandemic escalation metrics and plans to manage workforce supply A14 NHSP professionals temporary staffing bank and agency workforce model	B1 Nationally recognised shortage of domestic nurses B2 Uncertainty due to the impact of CV19 on graduate workforce supply in 2021 B3 Uncertainty due to the Impact of CV19 on international recruitment pipeline in 2021 B4 Long term impact of CV19 on pre-reg HEI applications for NMAHP programmes	C1 Programme of domestic and international recruitment campaigns C2 Monthly NHSI safe staffing reporting C3 E Rostering - Roster confirm and challenge meetings implemented in all areas to ensure effective rostering of staff and appropriate use of temporary staff C4 Absence manager - monitoring absence and trends to inform workforce requirements C5 Nursing Associates role provides additionality and support to registered nursing workforce C6 Bi-annual Safer Staffing reports to Board of Directors Group Management Board, HR Scrutiny Committee, NMAHP Professional Board, Risk Management Committee. C7 Monthly Nursing and Midwifery workforce dashboards, recruitment pipeline and vacancy trajectories C8 Hospital/MCS AOF workforce KPI's C9 Safer Nursing Care Tool (SNCT) used to support annual inpatient workforce establishment reviews. C10 Safe staffing guidance and staffing escalation process daily risk assessment	D1 Variation in staffing levels and workforce supply within the hospitals MCS/ MLCO. D2 Hospitals/ MCS/LCO CV19 workforce recovery required to meet policy guidance D3 Workforce supply potentially impacted by CV19 response.	**12** **4x3**	E1 Domestic and international recruitment campaigns resulting in substantive appointments of both nurses and midwives E2 International recruitment programme to support pandemic recovery plans E3 Nursing and midwifery workforce supply to address workforce requirements and capacity demand post pandemic. E4 Reduce Nursing and Midwifery vacancies E5 Reduce turnover and improve retention rate in band 5 roles. E6 Review all in-patient ward areas' staffing establishments following reconfiguration of hospital/MCS service models E7 Reduce staff absence, focus on staff health and wellbeing	Chief Nurse' s Team	November 2020	NMAHP Professional Board	E1 Programme of virtual recruitment events planned for the next 12 months. E2 The Trust is to recruit 450 international nurses before the end of March 2022 to support pandemic recovery plans. E3 The registered nurse and midwifery vacancy rate has increased by 240wte (2.4%) in Q1 following the transfer of NMGH (126wte vacancies) and workforce expansion plans (146wte additional posts) E4 A Guaranteed job offer has been introduced for all 3rd year student nurses and midwives who undertake their final year placements at the Trust. E5 Annual rolling turnover rate for nursing and midwifery has reduced to 11.4% (from 12%). E6 Safe staffing census data has been collected in May 2021 to support a baseline staffing establishment review. E6 Nursing and midwifery managers are working closely with NHS Professionals to ensure adequate bank and agency supply to cover sickness absence. E6 Daily staffing escalations meetings in place across the trust. E6 Daily risk assessment completed and escalation level reported to tactical command E7 Hospitals/MCS focusing on programmes to support staff health and well-being	**6** **3x2**

2	Strategic Aim: To improve patient safety, clinical quality and outcomes	
PRINCIPAL RISK (What is the cause of the risk?): If there are malicious attacks to IT system(s), vulnerabilities could compromise or disable access to systems and or data.	Enabling Strategy: **MFT GROUP INFORMATICS STRATEGY** Group Executive Lead: **GROUP CHIEF FINANCE OFFICER**	
RISK CONSEQUENCES (What might happen if the risk materialises?): 1. **Delivery of patient care could be affected by loss of access to systems and/or data leading to patient harm.** 2. **Patient experience could be adversely impacted (e.g. wait times increased) by loss of access to systems and/or data.** 3. **Financial damage.** 4. **Reputational damage.** 5. **Staff morale.**	Associated Committee: **GROUP INFORMATICS STRATEGY BOARD** Operational Lead: **GROUP CHIEF INFORMATICS OFFICER** Material Additional Supporting Commentary (as required): Please note there is a national mandate that Cyber risk scoring remains at 15, despite work being undertaken to reduce severity.	

Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGRESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
15 (5x3)	A.1 Appropriate Controls are in place to manage the threat of Cyber attack and other IT vulnerabilities and security threats.	B.1 Regular reviews are undertaken to manage any gaps in control & mitigate any emergent risk. B2 Recruitment to specific Cyber Security Officer role	C.1 Independent assurance scheduled at regular intervals to ensure best practice in addressing cyber threat and other IT security vulnerabilities	D.1 Emerging Cyber Risk may mean gap in assurance through non-availability of specialist knowledge at point of risk.	15 (5x3)	A.1 Implementation of the Group Informatics Cyber Security Action Plan, which will track and monitor all ongoing Actions at a detailed level. This will ensure continuous monitoring in line with ongoing and emerging risks at a national and global level.	Group Chief Informatics Officer	Ongoing	Group Informatics Strategy Board	• Continual service improvement in key IT infrastructure and raising organisation understanding through appropriate guidance, to reduce the incidence and impact of cyber risk. Additional improvements have been carried out and Cyber Essentials Plus Action Plan updates submitted to NHS Digital for ratification.	**6 (3x2)**

2	Strategic Aim: **To improve patient safety, clinical quality and outcomes**	
PRINCIPAL RISK (What is the cause of the risk?): **The Trust fails to effectively deliver the Hive EPR transformation programme and realise the clinical and operational benefits across the organisation.**	Enabling Strategy: **MFT CLINICAL SERVICES STRATEGY** Group Executive Lead: **GROUP CHIEF OPERATING OFFICER**	
RISK CONSEQUENCES (What might happen if the risk materialises?): 1. High unwarranted variation in clinical and administrative management and operational processes. 2. Poor patient experience, patient safety, quality of care and low staff morale. 3. Failure to meet the Trust objective of achieving financial stability by failure to realise the benefits case. 4. The Trust would remain at a low and worsening level of digital maturity.	Associated Committee: **EPR SCRUTINY COMMITTEE and EPR PROGRAMME BOARD** Operational Lead: **HIVE EPR PROGRAMME DIRECTOR**	

Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGRESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
16 (4x4)	A.1 EPR Task and Finish Committee approved the Full Business Case on the 18th May 2020. A.2 Robust contractual and commercial arrangements in place with the contract signed on the 19th May 2020. A.3 EPR Governance Framework defined and approved by Trust Board EPR Task and Finish Committee. A.4 Terms of Reference defined and approved for EPR Implementation and Benefits Realisation Board. A.5 Introduction of an IT Literacy framework to support rapid adoption of the solution. A.6 Implementation of a data quality and migration strategy. A.7 Implementation of end-user training strategy.	B.1 Changes in the external landscape B.2 Go-live strategy to be developed	C.1 Extensive engagement with key stakeholders and subject matter experts representing all areas of the Trust and patient community C.2 Financial monitoring and effective governance against Group Informatics Capital Plan to ensure focus on EPR Programme and associated Technical Scheme. C.3 EPR Implementation and Benefits Realisation Board, chaired by the COO, with executive directors and Hospital/Managed Clinical Services leadership oversees the delivery of the programme C.4 EPR Scrutiny Committee, chaired by BoD deputy chair, provides BoD oversight. C.5 Internal Audit commissioned to carry out Hive Programme Risk Assurance and provide reports to the Audit Committee C.6 External Assurance Review commissioned to conduct 5 reviews across Programme lifetime.		**12** **(4x3)**	C.5 Review Internal Audit terms of reference for EPR Programme Risk Assurance and update to ensure they are complimentary to external assurance service.	Group Chief Operations Officer	Ongoing	EPR Scrutiny Committee	• External assurance partner has begun first of five gateway assurance reviews in June 2021. • Go-live strategy plan presented to the EPR Programme Board. • HR and IT working on IT literacy programme across the workforce, following Digital Literacy award to the Trust.	**6** **(3x2)**

3	Strategic Aim: **To improve the experience of patients, carers and their families**

PRINCIPAL RISK (What is the cause of the risk?): If the care provided to patients is not responsive to their individual needs and the environment is unsuitable, this could impact negatively on patient experience, outcomes and reputation

Enabling Strategy:

QUALITY AND SAFETY STRATEGY;

PATIENT EXPERIENCE AND INVOLVEMENT STRATEGY

NURSING, MIDWIFERY & AHP STRATEGY

Group Executive Lead:

CHIEF NURSE

RISK CONSEQUENCES (What might happen if the risk materialises?):

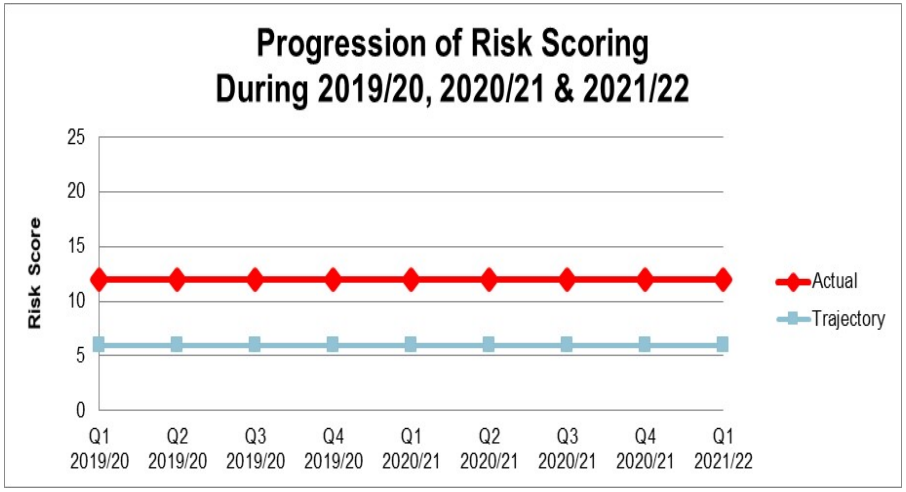
1. **Adverse patient experience**
2. **Increased complaints**
3. **Failure to comply with regulatory standards**
4. **Damage to Trust reputation**

Associated Committee:

QUALITY AND SAFETY COMMITTEE; PROFESSIONAL BOARD

Operational Leads:

DEPUTY CHIEF NURSE, ASSISTANT CHIEF NURSE (SAFEGUARDING, QUALITY & PATIENT EXPERIENCE), HEAD OF NURSING (QUALITY & PATIENT EXPERIENCE)



Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
12 **4x3**	A1. Corporate and hospital/MCS/ LCO Quality governance and delivery structures. A2. Patient Environment of Care Group oversees delivery of work programme and monitors impact. A3. Contract monitoring focused on patient experience outcomes. A4. Monitoring and reporting systems in place for complaints, concerns and compliments. A5. MFT Compliments, Complaints and Concerns Policy A6. Complaints management guidance provided to Hospitals/Managed Clinical Services/LCOs. A7. Accountability Oversight Framework (AOF) monitoring. A8. Improving Quality Programme (IQP). A9. What Matters to Me (WMTM) Patient Experience programme A10. Clinical accreditation programme. A11. Nutrition and Hydration Strategy A12. Quality and Patient Experience Forum	B1. WMTM patient experience programme not fully embedded in all areas. B2. IQP not fully embedded in all areas. B3. Nutrition and Hydration Strategy not fully embedded in all areas. B4. Patient Experience & Involvement Strategy not yet embedded. B5 Food handling training not yet fully rolled out to comply with the EHO recommendations B6 Visiting restricted since March 2020 to reduce Covid-19 transmission B7. Patient Environment of Care stood down during Q3, 2020/21 due to Covid-19 pandemic response	C1. Internal quality assurance processes Clinical Accreditation programme, Quality Reviews, Senior Leadership Walkrounds, Unannounced CQC action walkrounds with annual Accreditation/ assurance report to BoD C2. AOF metrics reporting C3. Quarterly and annual complaints reports C4. Quality of Care Round (QCR) data C5. WMTM patient experience survey data C6. National patient survey data/reports C7. Regulatory inspection processes C8. Friends and Family Test data C9. Joint compliance audits with Sodexo	C1. Senior Leadership Walkrounds paused in March 2020 and again in September 2020 to minimise COVID-19 transmission. Re-commenced in May 2021. A10/C1. Accreditation process paused during COVID-19 response – recommended in May 2021. A7/C2 AOF metric reporting limited during COVID-19 response – recommenced in May 2021. C5. Gaps in WMTM survey data collection during Covid-19 pandemic response. C8. FFT stood down nationally during Covid-19 pandemic response – now recommenced.	**12** **4X3**	B1. Patient Experience Matron to support areas where WMTM is not yet embedded B2. Quality Improvement Team to roll out IQP training to support areas where IQP is not yet embedded B3. WTWA, MRI and RMCH to establish local nutrition groups B3. SMH, MREH and CSS to establish nutrition as a standing agenda item within quality and safety meetings B3. Hospitals/MCS/LCOs to develop and deliver nutrition and hydration implementation plans B3. Establish escalation processes where patients' nutrition and hydration needs are not being adequately met B4. Embed Patient Experience & Involvement Strategy B5 Develop and implement the appropriate food handling training programmes to satisfy the regulatory requirements of the EHO C1. Roster Matrons onto clinical shifts to support quality standards	Chief Nurse's Team	March 2021	Quality and Safety Committee	A4. Full Complaints processes re-introduced in May 2020 and maintained. Virtual and face to face Local Resolution Meetings taking place to support complainants. B1 Patient Experience Matron commenced in post Q2 2020/21 and actively supports embedding of WMTM. B1/B2. Following a pause in the roll out of training cohorts to support Hospital/MCS teams to embed WMTM and IQP, a new programme was launched in Q2, 2020/21 as part of the Covid-19 recovery plan and has been completed for WTWA, MRI and NMGH. B1. Following a pause of the Always Events^{R} Programme, a revised project plan commenced in Q4, 2020/21. B3. Hospital/MCS/LCO/E&F nutrition and hydration updates are monitored at Patient Environment of Care and Quality and Patient Experience Forum. B3 A nutrition & hydration responsive review has been undertaken in Q1 of 2021/22 for consideration by the Quality and Safety Committee with a view to identifying actions to address themes. B.4 Patient Experience & Involvement Strategy 2020-2023 launched in Q2, 2020/21. B5 Food safety training package completed. Food Safety in the Clinical Environment Policy will be launched in August 2021. C1. Matrons were rostered to work alongside clinical staff to support quality standards whilst accreditations were paused. The accreditation programme and Senior leadership walkrounds recommenced in May 2021.	**6** **3x2**

3	Strategic Aim: To improve the experience of patients, carers and their families - CONTINUED									
Inherent Risk Rating Impact / Likelihood *"Without Controls"*	**EXISTING CONTROLS** *"What controls/systems are currently in place to mitigate the risk?"*	**GAPS IN CONTROLS** *"What Controls should be in place to manage the risk but are not?"*	**ASSURANCE** *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	**GAPS IN ASSURANCE** *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	**Current Risk Rating Impact / Likelihood** *"With Controls"*	**ACTION(S) REQUIRED** *"Additional actions required to bridge gaps in Controls & Assurance"*	**RESPONSIBILITY**	**COMPLETION TIMESCALE**	**MONITORING COMMITTEE**	**PROGESS**	**Target Rating Impact / Likelihood** *"Based on successful impact of Controls to mitigate the risk"*
12 **4x3**	A14 Environmental Health Officer (EHO) inspections A15 Interim Covid-19 Visiting Policy (implemented in March 2020) revised in October 2020 sets out actions to maintain a positive patient experience.	(see above)	(see above)	D2. Variation in AOF patient experience scores across the Trust D3 Limited evidence that all staff involved in food handling processes comply with relevant level of food hygiene training	**12** **4X3**	B6 PALS, Patient Experience & Volunteers Service to develop and embed virtual visiting service. C2 Develop revised patient experience AOF metrics to monitor progress during the Covid-19 recovery period. C1 Implement alternate temporary assurance process agreed by Professional Board whilst Accreditation programme paused C1 Review process and re-introduce Senior Leadership Walkrounds in defined areas from April 2021. C4,5&8. Re-establish QCR, WMTM and FFT data collection processes. D1. Review and deliver Patient Environment of Care work programme. D2. Develop and deliver Hospital/MCS/LCO action plans to drive improvement supported by corporate services as required. D3. Develop and deliver food handling training to relevant staff, including level 2 training as indicated.	Chief Nurse' s Team	March 2021	Quality and Performance Scrutiny Committee	D1. Significant improvement in quality of food reported in national patient survey 2019. All other scores within average range. Terms of Reference reviewed for Patient Environment of Care (PEOC)Bi-monthly meeting D2 Hospital/MCS/LCO action plan exception reports monitored on an ongoing basis. D3. 'Food Safety in the Clinical Environment Policy' was ratified at the ICP Committee on 13/1/21. A 'Policy on a Page' document is being developed to provide a summary of the key aspects of the policy. Mandatory food handling e-learning training is being developed by Dynamic. It is intended that staff will complete the food handling training prior to the launch of the policy. New Policy launched during Nutrition & Hydration week 14th -20th June 2021 with the intention that all actions are completed by 3rd August 2021 i.e. level 1 food safety training has been completed, staff have read the policy on a page as a minimum, clinical areas have commenced patient brought in food fridge temperature monitoring. Food safety training level 1 has been developed by dynamic but needs PMO final signoff before goes live. B5 Food task and finish group established with E&F and nursing membership focused on compliance with the regulatory requirements. Food Safety in the Clinical Environment Policy developed. Patient food fridge monitoring booklet drafted. Patient brought in food fridge monitoring booklet developed with 500 copies printed and circulated during Nutrition & Hydration week, 14th -20th June 2021 Food safety training sub-group established to enable compliance with the EHO recommendations. Patient visitor food safety sub-group established. Work completed by the subgroup. Food safety training level 1 has been developed by dynamic but needs PMO final signoff before goes live B6 Virtual visiting service established in August 2020, Q2 2020/21. B6. MFT and St John Ambulance volunteers recruited to provide assisted patient dining service from Q2 2020/21. C1. Alternate temporary assurance process implemented whilst full accreditation programme not possible, which includes observation of clinical areas, assessment of all quality and safety data and assurance meeting of Director of Nursing with Chief Nurse/Deputy Chief Nurse. Clinical observation visits are on-going and assurance meetings conducted for MREH/UDHM and RMCH in Q3. C1. Senior Leadership Walkround recommenced in April 2021 with IPC advice shared C2 AOF patient experience metrics revised and monitoring continued. C4,5&8 QCR data collection re-established in May 2020, Q1 2020/21. WMTM survey re-established from July 2020, Q2 2020/21 and National FFT to reporting to recommenced in December 2020, Q3 2020/21. C6 National Inpatient, Urgent & Emergency Care and Children & Young People's Surveys field work commenced. Maternity survey cancelled nationally but MFT have continued this survey with Picker.	**6** **3x2**

4	Strategic Aim: To Achieve Financial Sustainability

PRINCIPAL RISK (What is the cause of the risk?):

Risk that revised funding arrangements in place from April 2021 for six months only, short term funding, existing cost pressures, WRP of £50m and operational pressures, as a result of recovery from COVID-19, may prevent the Trust from delivering its financial target and thus long-term sustainability.

RISK CONSEQUENCES (What might happen if the risk materialises?):

Failure to deliver the required surplus identified in the financial plan will potentially put the Trust in breach of its license and prevent the Trust from delivering the cash surplus to underpin MFT's capital plan in future years.

Enabling Strategy:
MFT CONSTITUTION & LICENCE REQUIREMENTS

Group Executive Lead:
CHIEF FINANCE OFFICER

Associated Committee:
FINANCE SCRUTINY COMMITTEE

Operational Leads:
HOSPITAL FINANCE DIRECTORS

Material Additional Supporting Commentary (as required):

Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the A.arisk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGRESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
20 (5x4)	A.1. The budget framework has been maintained linked to BAU processes to retain hospital level financial targets and requirements for improvement A.2. Ongoing financial assessment and oversight into all elements of COVID 19 recovery programme including response to ERF. A.3. Progressing implementation of EPR system to support and drive changes and appropriate standardisation of clinical care and operational support processes A.4.Maintained monthly review of financial performance against revised Control Totals that reflect the revised financial regime A.5. Forecasting regime for Hospitals/MCS/LCO to ensure WRP and recovery plans are developed with financial sustainability as a key part of the planning A6 Hospital/MCS/LCO control totals (including Waste Reduction Targets) set in advance of H2 funding regime, the funding expectation in H2 in believed to be set at a "prudent" level		C.1.An extensive framework of review, challenge and escalation is fully embedded and understood within the organisation C.2.Hospitals/MCS/LCO and Corporate teams are assigned an AOF rating against the finance domain based on their forecast performance and the proportion of NR WRP relative to recurrent, which determines the level of progress recognised, intervention and support required, with reviews consisting of Hospital/MCS/LCO CEO/FD's and Group COO and CFO	None	15 (5x3)	MFT will need to continue to work on delivery of its WRP, review the level and requirement for provisions on its Balance Sheet and secure funding in H2 through discussion, funding needs to be broadly in line with H1 as part of the share of system funding in the emerging GM ICS	Group Chief Finance Officer / Hospital/MCS FDs	Ongoing	Finance Scrutiny Committee	As at May 2021, MFT is forecasting to achieve in line with its surplus plan submitted to NHSE/I in May 2021 However, on a straight line basis is behind on delivery of WRP but with an expectation of recovery in the later part of the year. Delivery of recurrent WRPs allied to announcement of H2 funding is key to achieving the target financial sustainability.	**12 (4x3)**

4	Strategic Aim: To Achieve Financial Sustainability

PRINCIPAL RISK (What is the cause of the risk?): The Trust remains at a lower level of digital maturity than its ambition.

Enabling Strategy:
MFT GROUP INFORMATICS STRATEGY

Group Executive Lead:
GROUP CHIEF INFORMATICS OFFICER

RISK CONSEQUENCES (What might happen if the risk materialises?):

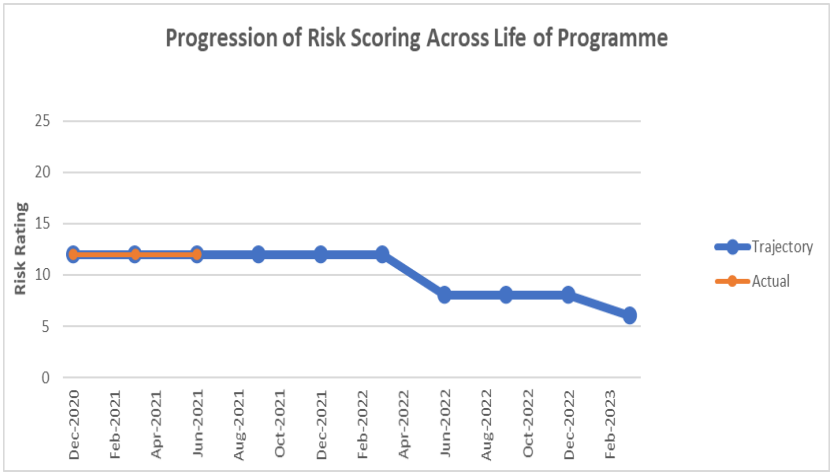
1. **Inability to deliver against Trust strategies.**
2. **Inability to deliver benefits associated with transformational programmes of work.**
3. **Poor patient care and or experience.**
4. **Reputational damage.**
5. **Financial loss.**
6. **Low staff morale.**

Associated Committee:
GROUP INFORMATICS STRATEGY BOARD

Operational Lead:
Group CIO, Corporate Directors, and Hospital CEOs.

Material Additional Supporting Commentary (as required):

- Following Covid-19 and recovery plans Informatics continue to have significant resourcing pressures due to increase demand on services;
  - North Manchester acquisition
  - HIVE EPR,
  - Capital plan 21/ 22
  - Business as usual service plan
- Increased demand on Information services to support modelling work and changes to information reporting requirements at a GM and National level
- Support of the recovery workstream which has a heavy reliance on digital solutions



Inherent Risk Rating Impact / Likelihood *"Without Controls"*	EXISTING CONTROLS *"What controls/systems are currently in place to mitigate the risk?"*	GAPS IN CONTROLS *"What Controls should be in place to manage the risk but are not?"*	ASSURANCE *"What evidence can be used to show that controls are effectively in place to mitigate the risk?"*	GAPS IN ASSURANCE *"What evidence should be in place to provide assurance that the Controls are working/effective but is not currently available?"*	Current Risk Rating Impact / Likelihood *"With Controls"*	ACTION(S) REQUIRED *"Additional actions required to bridge gaps in Controls & Assurance"*	RESPONSIBILITY	COMPLETION TIMESCALE	MONITORING COMMITTEE	PROGRESS	Target Rating Impact / Likelihood *"Based on successful impact of Controls to mitigate the risk"*
16 (4x4)	A.1 Monitoring of: • Work underway to agree Demand Management approach and a complete portfolio view for Informatics • Capital Planning process for 2021/2022 is complete and in delivery • Active engagement with Key stakeholders to develop innovation and Artificial Intelligence to plan for a new strategy • Delivery of Informatics Plan. • Benefits Realisation - Qualitative and Quantitative of Capital, NMGH and HIVE programmes • Digital Maturity Index for Trust. • Integration Steering Group monitoring of Informatics PTIP Plan. • EPR Governance Framework defined and approved by Trust Board EPR Task & Finish Committee. • EPR Scrutiny Committee Terms of Reference defined. • EPR Implementation & Benefits Realisation Programme Board Terms of Reference defined. • EPR Task and Finish Committee approved the Full Business Case on the 18th May 2020 the contract was signed on the 19th May with the contract becoming effective on the 26th May 2020 • Informatics PTIP Reporting for NMGH	B.1 Changes in the external landscape. B.2 Refresh of the Digital Strategy to align with the NMGH digital strategy	C.3 Monitoring against HIMSS digital maturity Index. C.4 Regular updates to Hospitals and Group C.5 Informatics Membership on Boards. C.8 Review of Informatics governance framework completed and revised structure and associated processes implemented including revised terms of reference for new Portfolio Board C.9 Governance for the management and implementation of EPR approved. C. 11 Risk relating to capacity of Informatics resources logged with controls in place to mitigate. C.12 Informatics continues to work on the COVID recovery stream to deliver digital solutions C13 Revised managing of all change demand C14 Progress of EPR HIVE to phase 1 C15 Recruitment to additional 59 roles following NMGH transaction C16 Demand Management work to identify pressure and a full portfolio of Informatics work to enable prioritisation and capacity completed C17 Approved capital plan for 21/22	D.1 The significant workload to understand the landscape of the MFT organisation and the planned programmes of work.	**12 (4x3)**	A.1 Implement strategic EPR solution for MFT organisation A.2 Appropriate engagement with Workforce Committee and wider Trust, to ensure staff are skilled to meet the needs of our digital organisation. A.3 Operational readiness work programme is in progress to support the cultural change. A.4 Continued monitoring of the delivery roadmap for the EPR tactical work until the strategic solution is implemented. A.6 Recruitment of programme and technical resources to support implementation and delivery has commenced and is continuing. A.7 Refresh of the Informatics Portfolio of work to include all new activity and highlight shortened timelines for delivery of approved programmes of work. A.8 Plans underway to review Informatics Digital strategy A.10 Focus on a targeted recruitment campaign to secure appropriate skills capability to support current portfolio of work, in particular key transformation programmes and Information Services.	Group Chief Informatics Officer	Ongoing	Group Informatics Strategy Board	• Delivery of 20/21 capital plan • Approved capital plan for 21/22 and continued active monitoring of roadmap including cross portfolio meetings across programmes • Demand Management work in progress • Robust Monthly Monitoring against plans • Refreshed and strengthened Informatics Governance – revised ToRs for GISB, GIPB and GIGB	**6 (3x2)**

5	**Strategic Aim:** To develop single services that build on the best from across all our hospitals

PRINCIPAL RISK (What is the cause of the risk?):
There is a risk that commissioners will further consolidate specialised services at a national level (e.g. ACHD), where MFT is not made the designated provider.

Enabling Strategy:
GROUP SERVICE STRATEGY / CLINICAL SERVICES STRATEGIES, GROUP QUALITY STRATEGY, GROUP WORKFORCE STRATEGIES

Group Executive Lead:
GROUP DIRECTOR OF STRATEGY

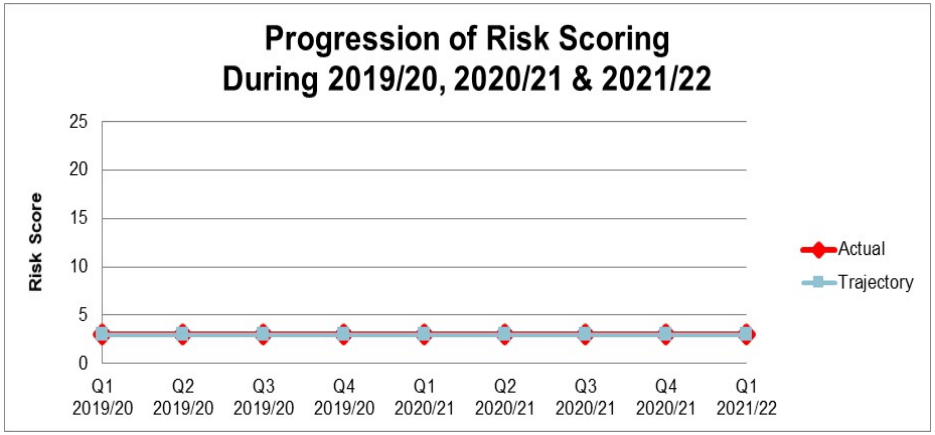
RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Loss of Service**
2. **Reduction in a range of services (offered within GM and across NHS)**
3. **Damage to reputation**
4. **Loss of staff**
5. **Reduction in research opportunities**

Associated Committee:
GROUP SERVICE STRATEGY COMMITTEE

Operational Lead:
DIRECTORS OF STRATEGY

Material Additional Supporting Commentary (as required):



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6 (2X3)	A.1 Internal/Annual review process for service reconfiguration to strengthen key specialised services (QSIS) (High) A.2 Active involvement in strategic clinical networks (eg cardiac, cancer) (Medium) A.3 Regular discussions with NHS England and foundation trust colleagues through the Shelford group (High) A.4 Active involvement in Operational Delivery Networks (High) A.5 Regular meetings with NHSE (Medium) A.7 Early notification of consolidation expected through national representation on clinical reference groups (Low) A.8 Partnership groups not meeting however in regular dialogue with NHSEI regarding service changes related to COVID (High)	B.1 Management capacity within corporate hospital and MCS teams to identify ongoing risks and issues against each of our specialised services (as flagged through quality surveillance reviews and other national and local reviews). B.2 Lack of Group wide review of compliance against all aspects of national clinical service specifications. B3 Lack of performance information on specialised services	C1 Award of: • National tender for Auditory Brainstem Implantation - one of only two providers in the country. • CAR-T designation for adults and children • Northern Paediatric MS service (MFT lead with Alder Hey and Newcastle), Genomics Lab Hub C.2 Outcome of 19/20 quality surveillance reviews. 87 services achieved 100%, 53 services achieved 80-99% compliance (note 20/21 process suspended due to COVID). C.3 Outcome of Peer Reviews C.4 AOF Domain provides assurance that services are consistently delivering against milestones providing a view of strategic progress/ maturity	D.1 No Gaps in assurance.	**3 (3X1)**	B.2 Annual surveillance reviews are unlikely to go ahead this year. The annual Trust wide review will recommence 21/22.	Group Governance Team	October 2021	GSSC	Ongoing	**3 (3x1)**
						B.2 Plans to address areas of non-compliance continue to be included in Hospital/ MCS plans for 20/21. Delivery of this may be affected and therefore residual issues will be included in 21/22 plans.	Hospitals / MCS	Ongoing	GSSC	Ongoing	
						B.2 Any National specialised services under review by NHSE to be analysed / risk rated by the strategy team as part of the corporate team's regular risk management process.	Group Strategy Team	Q1 21/22	GSSC	Ongoing	
						A.5 Maintenance of control - maintain regular dialogue with NHSE contacts regarding portfolio of national clinical service reviews.	Group Strategy Team	Ongoing	GSSC	Ongoing	
						A.1 Continued review of single service progress across MFT e.g. single governance, single clinical teams through COVID reviews.	Hospitals / MCS	Q2 21/22	SS Board	Underway	
						B3 Specialised services dashboards to be reviewed by GSSC.	Hospitals / MCS	Q4 21/22	GSSC	Underway	

5	**Strategic Aim:** To develop single services that build on the best from across all our hospitals

PRINCIPAL RISK (What is the cause of the risk?): There is a mismatch between MFT and Greater Manchester Health & Social Care Partnership plans for the development of services

Enabling Strategy:
GROUP SERVICE STRATEGY / CLINICAL SERVICES STRATEGIES (in development)

Group Executive Lead:
GROUP DIRECTOR OF STRATEGY

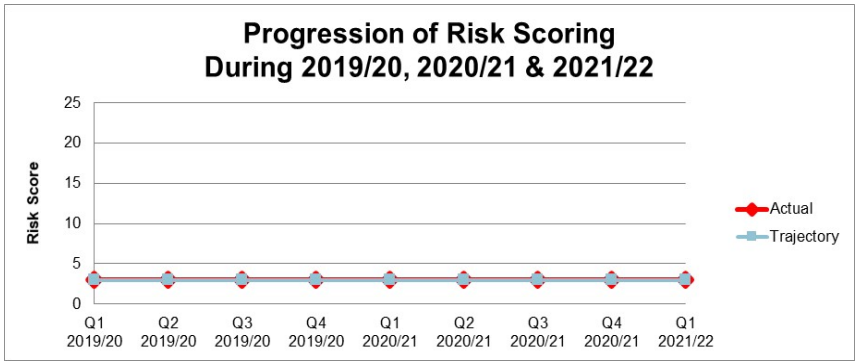
RISK CONSEQUENCES (What might happen if the risk materialises?):

1. **Loss of united voice for GM**

Associated Committee:
GROUP SERVICE STRATEGY COMMITTEE

Operational Lead:
DIRECTORS OF STRATEGY

Material Additional Supporting Commentary (as required):



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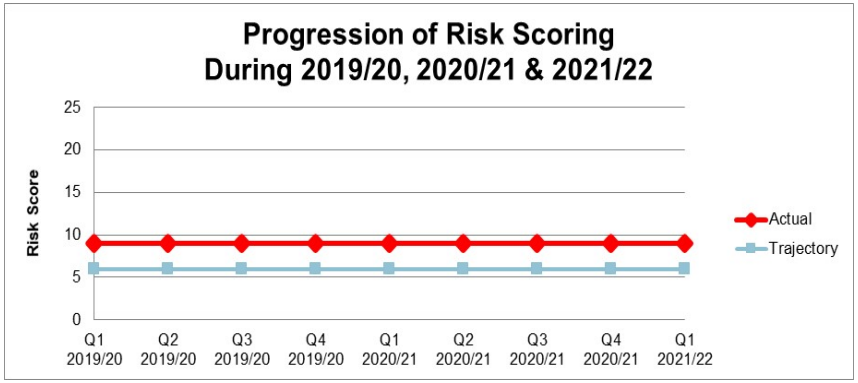
8 (4X2)	A.1 MFT representatives on GM boards inc Health and Care Board, Partnership Executive Board, Provider Federation Board, Chairs' group, HR, Directors of Finance, Directors of Strategy, Directors of Ops, JCB Executive Group etc. A.2 MFT representatives on Improving Specialist Care (ISC) Board, ISC Executive, ISC Clinical Reference Group A.3 Strengthened role of PFB enables providers to engage as a group within GM A.4 Process in place for GM decision making which involves and recognises the Trust's decision making requirements A.5 Development of MFT group and individual clinical service strategy, takes GM decisions into account to form coherent strategies for the Trust that align with GM decisions. A.6 Involvement of key GM stakeholders in development of Group and Clinical Service Strategies A.7 New governance for COVID level 4 incident. MFT representation on GM Gold and GM COVID Recovery groups.	B.1 Complete MFT Group and Clinical Service Strategies	C.1 MFT designated lead provider for specialist emergency care and emergency general surgery (Healthier Together) C.2 MFT (Wythenshawe) designated lead provider for urology cancer surgery (ISC) C.3 MFT designated lead provider for Haematological Malignancy Diagnostics Services across GM C.4 GM PACS procurement in alignment with MFT aims C.5 Positive response to outcome of MFT Group service strategy and waves 1-3 of our clinical service strategies from key GM stakeholders C.6 The Joint Commissioning Board has agreed, subject to consultation, GM Models of care for breast, vascular and respiratory services.	D.1 Outcome of GM decisions in respect of paediatric medicine and cardiology models of care. D.2 Response from GM stakeholders to the MCS clinical strategies.	3 (3X1)	A.1 Maintenance of control - Ensure regular MFT representation at all GM meetings	MFT Strategy team	On-going	GSSC	Mapping of all meetings and MFT coverage underway	3 (3X1)
						B.1 Finalise MFT group clinical service strategy	MFT Strategy team	Q1 19/20	GSSC	Completed. Group Clinical Service Strategy approved by BoD (July 2019)	
						D.2 Complete underpinning clinical service level strategies engaging with GM stakeholders in development.	MFT Strategy team	Q1 19/20	GSSC	Completed. Clinical services strategies completed and approved by BoD. GM stakeholders engaged and communications plan developed.	
						D.2 Complete service strategies for CSS, engaging with GM stakeholders in development.	MFT Strategy team	Q3 21/22	GSSC	Work completed but not yet approved by the Board.	

7	**Strategic Aim: To develop our workforce enabling each member of staff to reach their full potential.**
PRINCIPAL RISK: (What is the cause of the risk?): Failure to deliver high quality safe care due to the inability to recruit, retain and engage the current and future workforce of MFT.	Group Executive Lead: **GROUP EXECUTIVE DIRECTOR OF WORKFORCE AND CORPORATE BUSINESS**
RISK CONSEQUENCES 1. **Inability to attract, source and recruit staff** 2. **High temporary staff costs** 3. **Low morale, engagement and wellbeing** 4. **Higher number of employee relation cases** 5. **Poor patient experience** 6. **Regulatory consequences** 7. **Damage to MFT reputation** 8. **Failure to deliver services**	Associated Committee: **WORKFORCE & EDUCATION COMMITTEE** **HR SCRUTINY COMMITTEE** Operational Leads: Group Director of HR Material Additional Supporting Commentary (as required):



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12 (3x4)	A.1 A framework of workforce policies and standard operating procedures to support consistent, best practice people management. A.2 Trust Governance structure – inc. Human Resources Scrutiny Committee & Workforce Education Committee A.3 AOF monitoring A.4 Mandatory Training Programme A.5 Workforce Plans A.6 MFT Operational Plan A.7 Equality, Diversity and Human Rights Strategy agreed & Group and Hospital / MCS Committees in place A.8 Workforce Technology Framework A.9 Leadership and Culture Strategy A.10 The Covid-19 recovery programme established to support Trust wide recovery A.11 MFT People Plan A.12 Freedom to Speak Up Reporting Mechanism A.13 Workforce predictive modelling A.14 Employee Health & Wellbeing Service Delivery model.	B.1 Policy development programme has not concluded B.2 Mandatory Training delivery model is still embedding B.3 Key workforce system are not in place for all staff groups and all sites. B.4 Apprenticeship delivery programme to be embedded B.5 Workforce plans are immature and links to activity/demand planning are weak. B.6 SOPs are under-development for a number of workforce processes. B7 Real time, establishment control not in place B.8 Vacancies impact upon service delivery, staff wellbeing and development opportunities	C.1 Trust Workforce KPI monitoring e.g. absence, turnover, ER cases, etc C.2 Trust external and internal audit reports C.3 Staff survey and pulse checks C.4 Regulatory and statutory inspection processes and standards C.5 Internal quality assurance processes (Ward accreditation, Quality Review) C.6 AOF C.7 External accreditations C.8 Hospital / MCS reviews C.9 ISG Board reviews and PTIP progress C.10 Performance against agreed objectives for the Executive Director of Workforce and Corporate Business C.11 HR Scrutiny Committee assurance reports C.12 Freedom to Speak Up reviews	D1. Workforce metrics are limited due to ongoing digitalisation of processes D2. Workforce metrics are not fully triangulated with other data sets e.g .finance, clinical D.3 People plan performance dashboard is under development D.4. Predictive workforce modelling is not currently monitored against actuals D.5 No agreed assurance to evidence COVID-19 recovery programme outputs.	**9 (3x3)**	B.1 Complete policy review programme B.2 Continued oversight of Mandatory Training Steering Group to fully embed new delivery model. B.3 Continued alignment of Workforce Technology Framework with Informatics Strategy B.4. Continued oversight of Apprenticeship Steering Group to fully embed new delivery model. B.5 Development of workforce planning strategy B.6 SOP development oversight by Senior Leadership Team B.7 In conjunction with Informatics and Finance, explore data warehousing to enable real time, establishment control D1 Ongoing implementation of digital processes D2 Progress data warehousing approach to workforce data to enable data triangulation D.3 Development of People Plan performance dashboard D.4 Embed workforce modelling within workforce trend monitoring and demand/capacity planning. D.4 Agree COVID-19 recovery programme outputs.	Workforce Team	March 2022	Human Resources Scrutiny Committee	***B.1 Policy programme has been reinstated following COVID-19 standdown,*** ***B.2 Majority of the 41 recommendations in the Mandatory Training Review have been implemented*** ***B.3 Following a successful national funding bid, the implementation of eRostering for AHPs/HCSs is now underway and the Medical rollout is progressing. Development of the Empactis Health Manager system is on track with the management referral processes due to go live imminently. Case Manager system development is also progressing as per plan. Following the acquisition of NMGH, work also has commenced to begin the introduction of MFT rostering and absence systems to improve workforce grip.*** ***B.5 A new Apprenticeship Steering Group and Operational Delivery Group has been established to oversee the transition to a new apprenticeship delivery model which is fully aligned to business needs. The implementation of Ofstead recommendations is also progressing at pace.*** ***D.1 In conjunction with Informatics, data warehousing has been developed to support sickness absence reporting. This is currently being evaluated to inform a business case for workforce reporting moving forward and would enable triangulation with other data sources.*** ***D2. The MFT People Plan has now been launched. A governance structure has been established and a performance dashboard is under development.*** ***D3. Workforce modelling predictions continue to inform Strategic decision making and have been fed into COVID-19 Recovery planning. Work to embed predictions in existing workforce performance reports is also under way.***	**6 (3x2)**